

Developmental Disabilities Waiver Service Standards

Original Issue: November 1, 2021

Effective Date: November 1, 2021



Page left blank

Acknowledgements

The Developmental Disabilities Supports Division (DDSD) would like to acknowledge the assistance, time, and expertise of many people who contributed to the development of these DD Waiver Service Standards. DDSD received input over many months from people receiving services, family members, providers, organizations, and subject matter experts within both the Department of Health (DOH) and the Human Services Department (HSD). Many stakeholders participated in committees and /or provided written comments. Their time and input were invaluable to the completion of the final DD Waiver Service Standards.

DDSD is grateful for the commitment, time, energy, and creativity of all who worked so hard on this project to improve the lives of people with intellectual and developmental disabilities (I/DD) in New Mexico. We share a common goal and core values to establish a system that provides person centered services in support of people with I/DD to achieve quality outcomes, to have choice, to live meaningful lives, and to engage in meaningful relationships in the community of their choice. These service standards are the framework for providers to operate a quality system of services and supports for people with I/DD.

Statement from Advocates

DDSD invited advocates, persons receiving services, and their families to introduce these DD Waiver Service Standards. Here is what they wrote:

Foremost in creating the New Mexico Developmental Disability service system is alignment with the needs and desires of those receiving the services. That alignment is ultimately the measure of success for any service system. The DD Waiver is a way to provide community-based alternatives to individuals with developmental disabilities. The Centers for Medicaid and Medicare Services (CMS) provide federal funding for all DD Waiver residential and non-residential settings/facilities. This funding requires that all services provide opportunities for DD Waiver service participants to engage in community life, have access to the community, control their personal resources, seek employment and work in competitive settings. These standards will enhance the quality and definition of waiver services and provide additional protections to individuals who receive services. All people have the right to choose where they live.

The person-centered planning process is a key part of the CMS funding requirement. Team meetings afford the opportunity for the person receiving services to communicate in whatever manner they are able, their wishes and desires, the goals they have for their life, and the supports and services they need to achieve these wishes, desires, and goals. The collaboration between the person receiving services, Provider Agencies, friends, and natural supports determine an individualized plan that meets the person's wishes and needs. Ultimately it is the person's quality of life that is the measure of the success of a program. All members of the person's team, particularly the person served and Case Manager (CM), set the tone for creating a comfortable atmosphere in the Interdisciplinary Team (IDT) planning meetings so that the individuals with their voices (or the individual with their voice) or other advocates in the planning meeting can support the concerns of the individuals. The person we are serving is why these systems exist, and therefore why it is so important that we listen and support the person to achieve their goals. The implementation of person-centered services is critical to maintain continual federal funding from CMS.

Table of Contents

| | |
|--|-----------|
| Developmental Disabilities Waiver Service Standards..... | 1 |
| Acknowledgements | 3 |
| Statement from Advocates | 4 |
| Introduction 10 | |
| 1.1. Developmental Disabilities Supports Division (DDSD) Mission | 10 |
| 1.2. General Purpose and Description of Developmental Disabilities Waiver..... | 10 |
| 1.3. General Authority | 10 |
| 1.4. Federal Oversight of States Quality Improvement Strategy (QIS)..... | 11 |
| 1.5. Quality Improvement Strategy (QIS) at the State Level: Developmental Disabilities System Quality Improvement Committee (DDSQI) | 11 |
| 1.6. Purpose of Standards..... | 11 |
| 1.7. Updates | 12 |
| 1.8. Organization of the DD Waiver Service Standards..... | 12 |
| 1.9. Common References | 12 |
| 1.10. Using the DD Waiver Service Standards..... | 13 |
| | |
| SECTION I PLANNING | 14 |
| | |
| Chapter 1: Initial Allocation and Ongoing Eligibility | 14 |
| 1.1 Definition of Developmental Disability..... | 14 |
| 1.2 Central Registry | 15 |
| 1.3 Allocation Process..... | 16 |
| 1.4 Primary Freedom of Choice (PFOC)..... | 16 |
| 1.5 Expedited Allocation..... | 16 |
| 1.6 Allocation Letter | 17 |
| 1.7 Medical and Financial Eligibility | 17 |
| | |
| Chapter 2: Human Rights | 21 |
| 2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements | 21 |
| 2.2 Home and Community Based Services (HCBS): Consumer Rights and Freedom | 22 |
| 2.3 Dignity of Risk and Duty of Care..... | 22 |
| | |
| Chapter 3: Safeguards | 23 |
| 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process..... | 23 |
| 3.2 Financial Rights and Responsibilities of the Person in Services..... | 24 |
| 3.3 Human Rights Committee..... | 25 |
| 3.4 Emergency Physical Restraint (EPR) | 32 |
| | |
| Chapter 4: Person-Centered Planning (PCP)..... | 39 |
| 4.1 Essential Elements of Person-Centered Planning (PCP)..... | 39 |
| 4.2 Informed Choice | 41 |
| 4.3 Choice of Non-Waiver and Non-Disability Specific Options | 42 |
| 4.4 Freedom of Choice of DD Waiver Provider Agencies | 42 |
| 4.5 Conflict-Free Service and Support Coordination | 44 |

| | |
|---|------------|
| Chapter 5: Health | 45 |
| 5.1 Healthcare Coordination..... | 45 |
| 5.2 Medical Stabilization..... | 47 |
| 5.3 Use of Psychotropic Medications | 47 |
| 5.4 Promoting Healthy Relationships and Sexuality | 49 |
| 5.5 Aspiration Risk Management..... | 51 |
| Chapter 6: Individual Service Plan (ISP)..... | 66 |
| 6.1 ISP Development | 66 |
| 6.2 IDT Membership and Meeting Participation | 66 |
| 6.3 Role of Assessments | 67 |
| 6.4 Preparation for ISP Meetings..... | 68 |
| 6.5 ISP Meetings..... | 69 |
| 6.6 DDSD ISP Template..... | 70 |
| 6.7 Planning for Technology Use..... | 74 |
| 6.8 Completion and Distribution of the ISP | 74 |
| 6.9 ISP Implementation and Monitoring..... | 74 |
| Chapter 7: Available Services and Individual Budget Development..... | 76 |
| 7.1 DD Waiver Service Availability and Exclusions..... | 76 |
| 7.2 Children’s Category Services | 76 |
| 7.3 Adult Category Services | 77 |
| 7.4 Budget Submission Process..... | 79 |
| Chapter 8: Case Management..... | 82 |
| 8.1 General Definition and Intent of Case Management Services..... | 82 |
| 8.2 Scope..... | 82 |
| 8.3 Agency Requirements..... | 89 |
| Chapter 9: Transitions | 94 |
| 9.1 Change in Case Management Agency | 94 |
| 9.2 Changes in Service Provider Agencies | 95 |
| 9.3 Out of Home Placement | 96 |
| 9.4 Withdrawal from DD Waiver..... | 96 |
| 9.5 Discharge from Services..... | 97 |
| 9.6 Suspension of Services..... | 98 |
| 9.7 Termination from DD Waiver..... | 99 |
| 9.8 Resumption of Services..... | 100 |
| 9.10 Transfer of Documentation | 102 |
| SECTION II DD WAIVER SERVICES..... | 104 |
| Chapter 10: Living Care Arrangements (LCA)..... | 104 |
| 10.1 Introduction..... | 104 |
| 10.2 Settings Requirements in LCAs..... | 104 |
| 10.3 Living Supports (Family Living, Supported Living and Intensive Medical Living Services)..... | 106 |
| 10.4 Living Supports-Supported Living | 117 |
| 10.5 Customized In-Home Supports (CIHS) | 128 |
| Chapter 11: Community Inclusion | 131 |
| 11.1 General Scope and Intent of Services | 131 |

| | | |
|---|--|------------|
| 11.2 | Employment First..... | 131 |
| 11.3 | Implementation of a Meaningful Day..... | 132 |
| 11.4 | Person Centered Assessments (PCA) and Career Development Plans (CDP)..... | 133 |
| 11.5 | Settings Requirements for Non-Residential Settings..... | 134 |
| 11.6 | Customized Community Supports (CCS)..... | 135 |
| 11.7 | Community Integrated Employment (CIE)..... | 142 |
| Chapter 12: | Professional and Clinical Services..... | 153 |
| 12.1 | General Scope and Intent of Professional Services..... | 153 |
| 12.2 | Behavior Support Consultation..... | 154 |
| 12.3 | Preliminary Risk Screening and Consultation..... | 162 |
| 12.4 | Therapy Services..... | 166 |
| 12.5 | Nutritional Counseling..... | 181 |
| Chapter 13: | Nursing Services..... | 184 |
| 13.1 | Overview of The Nurse’s Role in The DD Waiver and Larger Health Care System..... | 184 |
| 13.2 | General Nursing Services Requirements and Scope of Services..... | 185 |
| 13.3 | Adult Nursing Services..... | 211 |
| Chapter 14: | Other Services..... | 219 |
| 14.1 | Assistive Technology Provider..... | 219 |
| 14.2 | Remote Personal Support Technology..... | 223 |
| 14.3 | Crisis Supports..... | 227 |
| 14.4 | Environmental Modification..... | 230 |
| 14.5 | Independent Living Transition..... | 235 |
| 14.6 | Non- Medical Transportation..... | 237 |
| 14.7 | Supplemental Dental Care..... | 240 |
| 14.8 | Respite..... | 241 |
| 14.9 | Socialization and Sexuality Education (SSE)..... | 243 |
| SECTION III: QUALITY ASSURANCE AND CONTINUOUS QUALITY IMPROVEMENT..... | | 247 |
| Chapter 15: | Provider Enrollment..... | 247 |
| 15.1 | Provider Enrollment Unit..... | 247 |
| 15.2 | Application Process..... | 247 |
| 15.3 | Amendments..... | 249 |
| 15.4 | Moratoria..... | 249 |
| 15.5 | Provider Withdrawal from the DD Waiver..... | 250 |
| 15.6 | Expiration or Termination of Provider Agreement..... | 250 |
| Chapter 16: | Qualified Provider Agencies..... | 252 |
| 16.1 | Caregivers Criminal History Screening Program..... | 252 |
| 16.2 | Accreditation..... | 252 |
| 16.3 | Direct Support Professional Educational and Experience Requirements..... | 253 |
| 16.4 | Professional Licensure..... | 253 |
| 16.5 | Board of Pharmacy..... | 254 |
| 16.6 | Conflict of Interest..... | 254 |
| 16.7 | Compliance with Federal and State Rules and DD Waiver Service Standards..... | 254 |
| 16.8 | DDSD Contract Management..... | 255 |
| 16.9 | Quality Management Bureau (QMB) Surveys..... | 256 |
| 16.10 | Individual Quality Review for Jackson Class Members (JCMs)..... | 258 |

| | | |
|--------------------|--|------------|
| 16.11 | Internal Review Committee (IRC) | 259 |
| Chapter 17: | Training Requirements | 260 |
| 17.1 | Training Requirements for Direct Support Professional and Direct Support Supervisors | 260 |
| 17.2 | Training Requirements for CMs and Case Management Supervisors | 265 |
| 17.3 | Training Requirements for Substitute Care and Respite | 266 |
| 17.4 | Nutritionists | 267 |
| 17.5 | Nurses | 267 |
| 17.6 | Behavior Support Consultants (BSCs) | 267 |
| 17.7 | Therapists (OT, PT, & SLP) | 268 |
| 17.8 | Reporting and Documentation Requirements | 269 |
| 17.9 | Individual-Specific Training | 270 |
| 17.10 | DDSD Core Curriculum Trainer Certification | 273 |
| Chapter 18: | Incident Management System | 275 |
| 18.1 | Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting | 275 |
| 18.2 | ANE Reporting and Evidence Preservation | 275 |
| 18.3 | Immediate Action and Safety Plans (IASP) | 276 |
| 18.4 | Agency Cooperation during Division of Health Improvement (DHI) Investigations | 276 |
| 18.5 | Reports of Death | 277 |
| 18.6 | Corrective and Preventive Action Plans for Substantiated Findings | 277 |
| 18.7 | Notifications | 277 |
| 18.8 | Case Management and DD Waiver Provider Agency Responsibilities for Risk Management | 278 |
| Chapter 19: | Provider Reporting Requirements | 279 |
| 19.1 | Consumer Census and Service Summary per Provider Agency | 279 |
| 19.2 | General Events Reporting (GER) | 279 |
| 19.3 | Reporting to the Statewide Aspiration Risk List | 280 |
| 19.4 | Employment First Reporting Requirements | 281 |
| 19.5 | Semi-Annual Reporting | 281 |
| 19.6 | Regional Office Request for Assistance (RORA) | 282 |
| Chapter 20: | Provider Documentation and Client Records | 284 |
| 20.1 | HIPAA | 284 |
| 20.2 | Client Records Requirements | 284 |
| 20.3 | Record Access for Direct Support Professional (DSP) during Service Delivery | 285 |
| 20.4 | Timely Distribution and Sharing of Records | 285 |
| 20.5 | Creating and Maintaining Records in Therap | 285 |
| 20.6 | Medication Administration Record (MAR) | 291 |
| Chapter 21: | Billing Requirements | 293 |
| 21.1 | General Billing Requirements | 293 |
| 21.2 | Prior Authorization Requirements | 293 |
| 21.3 | Recording Keeping and Documentation Requirements | 294 |
| 21.4 | Electronic Visit Verification | 295 |
| 21.5 | Utilization Review for Program Compliance | 296 |
| 21.6 | Rates and Rate Table | 296 |
| 21.7 | Billable Activities | 296 |
| 21.8 | Non-Billable Services, Activities, Circumstances | 297 |
| 21.9 | Billable Units | 298 |
| Chapter 22: | Quality Improvement Strategy (QIS) | 301 |

| | | |
|---------------------------------------|--|------------|
| 22.1 | Data Sources | 301 |
| 22.2 | QI Plan and Key Performance Indicators (KPI) | 301 |
| 22.3 | Implementing a QI Committee | 302 |
| 22.4 | Preparation of an Annual Report..... | 302 |
| Appendices 304 | | |
| Appendix A | Client File Matrix..... | 304 |
| Appendix B | GER Requirements | 313 |
| Appendix C | HCBS Consumer Rights and Freedoms | 320 |
| Index 321 | | |
| LISTS | | 326 |
| List 1 | Acronyms..... | 326 |
| List 2 | Authorities..... | 330 |
| List 3 | State Agencies, Divisions and Bureaus..... | 331 |
| TABLES..... | | 333 |
| Table 1 | Proposed Budget Levels | 333 |
| Table 2 | Suggested Dollar Amounts ² | 334 |
| DDSD CONTACT INFORMATION:..... | | 336 |

Introduction

1.1. Developmental Disabilities Supports Division (DDSD) Mission

The mission of the Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) is to effectively administer a system of person-centered community supports and services that promote positive outcomes for all stakeholders with a primary focus on assisting people with developmental disabilities and their families to exercise their right to make choices, grow, and contribute to their community.

1.2. General Purpose and Description of Developmental Disabilities Waiver

The purpose of the Developmental Disabilities Medicaid Waiver (DD Waiver) program is to address the needs of people with intellectual and developmental disabilities (I/DD) by providing quality and cost-effective services that support people to remain in their homes and communities as opposed to institutional care.

1.3. General Authority

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, State, and local public programs as well as the supports that families and communities provide.

New Mexico's DD Waiver is the HCBS waiver program operated under the federal oversight authority of the Centers for Medicare and Medicaid Services (CMS). The State operates the DD Waiver as written and approved by CMS. New Mexico's DD Waiver has operated since 1984 and continues to be modified and approved in 5-year renewal cycles. The DD Waiver program is person-centered, and services provided are based upon the expressed desires and direction of each individual DD Waiver participant.

To receive federal matching funds and waiver renewals, CMS must determine that the DD Waiver is administered in accordance with its CMS approved waiver application. Services provided through the DD Waiver are required to comply with current CMS regulations (known as the "Final Rule effective March 1, 2014). The CMS Final Rule requires that eligible people supported through 1915 (c) waivers receive services in the community with the same degree of access as people not receiving HCBS.

The State also has an obligation to protect individual rights and ensure health and safety pursuant to the Americans With Disabilities Act (ADA), Section 504 of the Rehabilitation Act, the Supreme Court's Olmstead Decision, and the Workforce Innovation and Opportunity Act (WIOA).

1.4. Federal Oversight of States Quality Improvement Strategy (QIS)

CMS expects the state to follow a Quality Improvement Strategy (QIS) for the operation of the DD Waiver. CMS monitors the state to ensure that it has the capacity to identify and remediate performance issues on an individual, provider, and systems level. The following are the waiver assurances required by CMS:

1. Level of Care (LOC): The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating new applicants and re-evaluating waiver participant's level of care consistent with the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID).
2. Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.
3. Qualified Provider Agencies: The state demonstrates that it has designed and implemented an adequate system for assuring that qualified Provider Agencies provide all waiver services.
4. Health and Welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver participants' health and welfare.
5. Administrative Authority: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by DOH.
6. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

1.5. Quality Improvement Strategy (QIS) at the State Level: Developmental Disabilities System Quality Improvement Committee (DDSQI)

The QIS outlined in the DD Waiver, approved by CMS, is responsible for trending, prioritizing, and implementing system improvements. DOH–Developmental Disabilities System Quality Improvement Committee (DDSQI) is responsible for implementing and monitoring the QIS. The DDSQI is also responsible for ensuring compliance with the CMS waiver assurances and associated performance measures. Based on review of information and data analysis presented to the committee, the DDSQI is responsible for system wide remediation and monitoring. See [Chapter 22: Quality Improvement Strategy \(QIS\)](#) for more information on QIS for Provider Agencies.

1.6. Purpose of Standards

The DDSD has established standards to guide service delivery and promote the health and safety of people supported by DD Waiver Provider Agencies. All agencies that enter a contractual relationship with DOH to provide DD Waiver services are required to comply with all applicable standards, federal, and state rules.

DD Waiver Service Standards establish provider requirements for service delivery through the DD Waiver Program. These requirements apply to all Provider Agencies and their staff whether directly employed or subcontracted with the approved Provider Agency.

1.7. Updates

These service standards may be updated periodically to communicate changes in policy and program requirements or to reflect amendments to the DD Waiver approved by CMS. When supplements, corrections, and page replacements are issued, DD Waiver Provider Agencies will be notified through e-blasts, website postings, and direct mailings. DDSO will provide a public feedback period before issuing any substantial changes and will issue a Numbered Memo with guidance and transition periods when applicable,

1.8. Organization of the DD Waiver Service Standards

A simple numbering system is employed to ensure readability and ease in referencing sections within chapters. The numbering system is as follows:

1. Chapters are organized and grouped in three sections.
 - Section I: Planning** -consists of chapters related to initial allocation, human rights, and ongoing planning for people enrolled in the DD Waiver program.
 - Section II: DD Waiver Services** -consists of chapters describing provider responsibilities related to the CMS settings requirements, and related to service delivery for each service type available in the DD Waiver.
 - Section III: Quality Assurance and Continuous Quality Improvement**-consists of chapters describing provider responsibilities for enrollment, qualifications and training, administrative practices, and Quality Assurance and Quality Improvement activities to ensure quality service provision.
2. Each chapter is numbered 1, 2, 3, etc. with sections numbered 1.1, 1.2, etc., and subsections numbered 1.1.1, 1.1.2, etc.
3. Lists and Tables and are quick reference tools for information needed by all or most provider types. They are referenced in the body of the document and organized alphabetically at the end.
4. Appendices are referenced in the body of the document and organized as Appendix A, Appendix B, etc.
5. When Sections or Chapters are cross referenced, the reference is linked through a hyperlink in the electronic document.
6. Common terms have page references in an Index.

1.9. Common References

There are many references to both the person receiving services and the agencies providing services throughout these standards. For the most part the term “person” refers to the DD Waiver participant, eligible recipient, or individual in services. The term Provider Agency refers to any agency or sole proprietor with an active Provider Agreement to provide specified DD Waiver services.

Acronyms are numerous in this program. Every attempt has been made to spell out the first use of an acronym as well as spell out instances where it would be helpful to the reader. Otherwise, common acronyms are listed in [List 1 Acronyms](#).

1.10. Using the DD Waiver Service Standards

DD Waiver Provider Agencies must adhere to all standards applicable to the services provided by the agency. There are many shared or common requirements across numerous services detailed in these standards. All applicable standards are no longer confined to a single chapter per service. For example, a Provider Agency of Therapy Services must reference standards related to Billing, Provider Documentation and Client Records, Provider Reporting Requirements, and other chapters as well as the standards described under Therapy Services.

Section I Planning

Chapter 1: Initial Allocation and Ongoing Eligibility

DDSD Intake and Eligibility Bureau (IEB) determines if an applicant meets the definition of developmental disability required for waiver services. While Provider Agencies are not directly involved in the determination process completed by DDSD, they are an important point of contact. Provider Agencies must refer people to the IEB regional office where pre-service activities are initiated.

1.1 Definition of Developmental Disability

DD Waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (ID) or a related condition as determined by DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care (LOC) provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

1.1.1 Intellectual Disability (ID)

An individual is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

1. General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.
2. Significantly sub-average is defined as approximately IQ of 70 or below.
3. Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group. Deficits in Adaptive Behavior is defined as two standard deviations below mean (≤ 70).
4. The developmental period is defined as the period between birth and the 18th birthday.
5. An individual is considered to have a related condition if they have a severe, chronic disability that meets all the following:
 - a. Is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services;
 - b. Is manifested before the person reaches age twenty-two (22) years;
 - c. Likely to continue indefinitely; and

Chapter 1: Initial Allocation and Ongoing Eligibility

- d. Results in Substantial Functional Limitations (Adaptive Behavior scores ≤ 70) in 3 or more of the following areas:
 - i. Self-care.
 - ii. Receptive and expressive language.
 - iii. Learning.
 - iv. Mobility.
 - v. Self-direction.
 - vi. Capacity for independent living.
 - vii. Economic self-sufficiency.

1.2 Central Registry

To qualify for services through an ICF/IID or HCBS Waivers, a person must:

1. Meet the Developmental Disability definition criteria in accordance with NMAC 8.290.400;
2. Have a registration date on the DDS Central Registry;
3. Submit the DD Waiver application and supporting documentation with a “Complete” status as determined by DDS;
4. Meet the Medicaid financial and medical eligibility criteria; and
5. Meet residential requirements established by Medicaid.

The Central Registry Unit (CRU), in the IEB of DDS assists the applicant with the completion of the registration and application process for the waivers. The registration can be completed in-person, by fax, or via telephone. Once a person has completed the registration, they will receive an application packet. This packet includes:

1. The Cover Letter
2. The Central Registry Application Form,
3. HIPAA Notification, and
4. Release of Information Forms.

The application packet requires supporting documentation including clinical reports which indicate an ID or related condition. For intellectual disabilities, this documentation may include clinical tests indicating significant limitations in intellectual functioning and adaptive behaviors. For related conditions, this documentation may include medical reports including the severe chronic disability and reports indicating substantial functional limitations.

The CRU makes the determination of whether the person matches the definition of developmental disability. If the person matches the definition, the applicant receives a “yes” match letter and stays on the Wait List for allocation to the DD Waiver. If the person does not match the definition, the applicant receives a Denial of DD Waiver Registration letter, which includes notice of rights to an Administrative Fair Hearing.

If the applicant is a child younger than eight years old *with* documentation confirming a severe chronic disability but *without* conclusive documentation to determine a “yes” match, the child’s

Chapter 1: Initial Allocation and Ongoing Eligibility

application may be placed in a “Pend” status until the child reaches age 9. At that time, documentation obtained will be reviewed to accurately determine eligibility. Applications that are in “Pend” status are not considered on the DD Waiver Wait List. Applications on children with conclusive documentation to determine a “yes” match are processed, sent the “Yes” match letter and are on the Wait List.

1.3 Allocation Process

When funding is available for an allocation, the next eligible applicant on the DDS Wait List (based on registration date and region) will receive a Letter of Interest and the Primary Freedom of Choice (PFOC) form. The PFOC notifies the applicant of their right to choose between an ICF/IID or a HCBS Waiver. The applicant has 45 calendar days to return the PFOC before the allocation may be closed.

1.4 Primary Freedom of Choice (PFOC)

The applicant completes the PFOC form to select between:

1. An Intermediate Care Facility for Individuals with Intellectual/Developmental Disability (ICF/IID); or
2. The DD Waiver and a Case Management Agency or the Mi Via Self-Directed Waiver and a Consultant Agency.
3. To place their allocation on hold or refuse the allocation:
 - a. The applicant retains their original registration date. The applicant later needs to contact DDS to take the allocation off hold at which time the applicant would be actively awaiting allocation based on their original registration date and available funding; or
 - b. The applicant chooses not to receive services through ICF/IID nor DD Waiver or Mi Via now or in the future. The allocation will be closed, with a notice of rights to an Administrative Fair Hearing, and the applicant would need to re-apply for HCBS with a new registration date should they choose to seek services in the future.

1.5 Expedited Allocation

In special circumstances, a person may be allocated to the DD Waiver by means other than the person’s date of registration in the Central Registry. To qualify for an expedited allocation (Policy Number DIV.13.DDS.CPS.01.02), the applicant must be on the Wait List, be determined to have a Developmental Disability, meet specific criteria, and be approved by a DDS review team and the DDS Division Director or designee. An expedited allocation must meet at least one of the specific criteria a, b or c, and the criterion d as follow:

- a. The person’s current situation meets the statutory definition of abuse, neglect, or exploitation as substantiated by Adult or Child Protective Services or the Division of Health Improvement (DHI).

Chapter 1: Initial Allocation and Ongoing Eligibility

- b. The person’s primary caregiver is no longer able to provide continued care for the person due to death, disability, or progressive decline of the primary caregiver’s health, and an alternate primary caregiver is not available.
- c. The person was most recently on a civil DD commitment pursuant to NMSA 1978, 43-1-13 (as referenced in NMSA 1978, 31-9-1.6,) and continues to need developmental disabilities services to assure health and safety.
- d. Current available resources are inadequate to maintain and/or assure the health and safety of the person.

The expedited allocation process includes the following steps:

1. The DDS Regional Office is the point-of-contact for applicants to determine whether an expedited allocation request would be appropriate. If a person is approved for an expedited allocation, and if that person is ultimately determined to meet all financial and clinical criteria, services would not begin immediately, but would be available sooner than if the person had to wait for allocation based upon the date of registration.
2. The decision to expedite the allocation process for a person is at the discretion of DDS Division Director or designee. DDS may grant or deny an application for expedited allocation, and may limit the number of allocations, based upon factors that may include (but need not be limited to) the availability of funds under the current fiscal year appropriation, the relative merits of an application, the availability of alternative supports for an applicant, and other considerations.

1.6 Allocation Letter

When the IEB receives the PFOC choosing the DD Waiver, copies are made and sent with an Allocation Letter to the appropriate parties, including the applicant, the chosen Case Management Agency, the Medicaid Third Party Assessor (TPA), and the Human Services Department’s (HSD) Income Support Division (ISD). If the person wants to switch to the Mi Via Waiver within the first 30 days of allocation, and no medical or financial eligibility has begun, the transfer is permitted and coordinated through IEB. If the person has already begun the eligibility process, medical and financial eligibility must be completed before they may request a transfer to Mi Via through the regional office. A copy of the approved Waiver Change Form shall be sent to the assigned Eligibility Worker in IEB.

1.7 Medical and Financial Eligibility

After allocation, the applicant must continue to meet financial and medical eligibility. The ISD is responsible for approving the Category of Eligibility (COE) based on both medical and financial eligibility requirements. Once eligibility is established, the 096 COE for the DD Waiver will be assigned.

1.7.1 Initial Allocation

Once the Case Manager (CM) receives a copy of the PFOC, their responsibilities assisting and monitoring this process begin. In general, the CM is responsible for:

Chapter 1: Initial Allocation and Ongoing Eligibility

1. Monitoring whether the person/guardian completes the Application for Assistance form, HSD 100, and submits the application to ISD. Please refer to <https://www.hsd.state.nm.us/>
2. If the process of determining financial and medical eligibility takes longer than 90 calendar days, informing the applicant, guardian, and/or representative payee, as applicable, that a request for an extension from the ISD for their DD Waiver eligibility determination is needed.
3. Compiling the Level of Care (LOC) packet which includes the LOC Abstract Form (MAD 378), History and Physical, completed by the applicant's medical provider, as well as the Client Individual Assessment (CIA) completed by the CM.
4. Submitting the LOC packet to the Medicaid TPA.
5. Monitoring the status of the TPA approval of the LOC and responding to requests for information (RFIs) within required timeframes.
6. Monitoring the applicant's eligibility status at ISD.
7. Updating the Allocation Reporting Form (ARF) in Therap no later than the 15th of each month until the individual is receiving services. This includes submitting approved documentation to the IEB within 5 business days of the agency receiving the approved documents. Failure to provide required documentation timely may result in a civil monetary penalty.

1.7.2 Annual Recertification of Eligibility

All DD Waiver participants must recertify eligibility annually. This includes financial and medical eligibility. An application is mailed to the participant and guardian 45 days prior to the expiration of the COE. DD Waiver Provider Agencies play a critical role in assisting and assuring that all required steps are taken by the DD Waiver participant to complete annual recertification according to the following:

1. Provider Agencies are responsible for monitoring that a person's COE is current and for informing the CM as soon as possible if the COE is expired or near expiring.
2. Provider Agencies should be aware of the COE expiration date and assist the DD Waiver participant and family, as needed, to assure necessary steps are taken to recertify.
3. A DD Waiver budget cannot be processed, and Provider Agencies cannot bill for services without a current 096 COE indicating DD Waiver eligibility.
4. CMs are responsible for all activities described in [Chapter 1.7.1 Initial Allocation](#) except reporting on an Allocation Reporting Form reserved for initial allocation.

1.7.2.1 Annual Financial Eligibility

The steps to meet annual financial eligibility are:

Chapter 1: Initial Allocation and Ongoing Eligibility

1. The person/guardian completes the recertification form, the ISD 122, electronically or submits the completed ISD 122 recertification to the County ISD office or faxes form to Central ASPEN Scanning Area (CASA).
2. The ISD will review the recertification application and either process the application or reach out to the person/guardian using a Help Us Make a Decision (HUMAD) if there are questions or additional information needed.

1.7.2.2 Annual Level of Care

Provider Agencies should support the person to complete activities related to annual LOC assessment as follows:

1. Provider Agencies assist with supports needed for the waiver participant to attend medical appointments timely for an annual History and Physical.
2. The CM submits the annual LOC packet which includes the completed LTCAA Form-MAD 378, CIA and the History and Physical for medical eligibility to the TPA no later than 30 calendar days prior to the LOC expiration date.

1.7.3 Use of the Client Information Update Form (CIU/MAD 054)

The CIU is a tool for communication to the following entities: HSD-ISD , HSD-Medical Assistance Division (HSD/MAD), Managed Care Organizations (MCO), TPA, DD Waiver Case Management Agencies, Mi Via Consultant Agencies, Support Brokers, and other partnering state agencies. The CIU/MAD 054 is available with instructions for completion on the NM Medicaid Portal (<https://nmmedicaid.acs-inc.com/webportal/home>). The CIU shall be completed by the CM to request an update in the following circumstances:

1. Change in address,
2. Change of Case Management Agency or CM/Consultant Agency/Care Coordinator/Support Broker,
3. Level of Care,
4. Status of allocation or transition,
5. Reason for denial or closure,
6. Plan of Care/ISP/SSP dates,
7. Death of the person in services,
8. Nursing facility admission,
9. Hospital facility admission,
10. Move out of the state,
11. Incarceration,
12. Request for a Setting of Care change,
13. Request for a COE Extension,
14. Waiver services not accessed, or
15. Request for resumption of services.

Chapter 2: Human Rights

Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supports, and Provider Agencies have a responsibility to make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person and protecting their human and civil rights.

2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements

On January 16, 2014, CMS published the Final Rule addressing several sections of the Social Security Act. The Final Rule amends the federal regulations which govern 1915 (c) HCBS waiver programs. These rules are an important step forward in federal policy, supporting inclusion, and integrating people with I/DD into the community. All Provider Agencies must ensure they are meeting the new requirements and be in full compliance with all CMS settings requirements by 2022, unless extension granted to states by CMS.

The intent of the CMS Final Rule is to ensure that people receiving long-term services and supports through the 1915 (c) HCBS waiver programs under Medicaid authority, have maximum independence and choice, have full access to benefits of community living, and can receive services in the most integrated setting appropriate. The CMS Final Rule works to enhance the quality of HCBS and provides protections to participants. The HCBS setting requirements focuses on the nature and quality of individual experiences. All HCBS settings (residential and non-residential), including all DD Waiver funded settings must:

1. be integrated in and facilitate full access to the greater community;
2. ensure the person receives services in the community to the same degree of access as people not receiving Medicaid HCBS services;
3. maximize independence in making life choices;
4. be chosen by the person (in consultation with the guardian if applicable) from all available residential and day options, including non-disability specific settings;
5. ensure the right to privacy, dignity, respect, and freedom from coercion and restraint;
6. optimize individual initiative, autonomy, and independence in making life choices;
7. provide an opportunity to seek competitive employment;
8. provide people an option to choose a private unit in a residential setting; and
9. facilitate choice of services and who provides the services.

DD Waiver Provider Agencies are required to ensure the settings in which they provide services meet the above requirements. All Provider Agencies have a responsibility to:

1. monitor settings for compliance;
2. monitor that waiver recipients receive choices; and
3. ensure rights are respected.

2.2 Home and Community Based Services (HCBS): Consumer Rights and Freedom
People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person.

2.2.1 Statement of Rights Acknowledgement Requirements

The CM is required to review the Statement of Rights (See [Appendix C HCBS Consumer Rights and Freedoms](#)) with the person, in a manner that accommodates preferred communication style, at the annual meeting. The person and their guardian, if applicable, sign the acknowledgement form at the annual meeting.

2.3 Dignity of Risk and Duty of Care

Dignity of Risk and Duty of Care apply equally to all people. All Provider Agencies must embrace these concepts in their work with people with I/DD.

Dignity of Risk refers to the fact that everyone has the freedom to make decisions and choices in their lives that may expose them to a level of risk. By taking measured risks and making mistakes people learn and grow. Through successes and failures, necessary skills are learned. Individual identity and sense of self-worth develop, and a healthy desire to pursue relationships and participate fully in community life is fostered.

Duty of Care refers to each person's responsibility to take reasonable care to ensure that their actions (or lack of action) do not cause injury or harm to others. While the Duty of Care seems to be opposite of Dignity of Risk, the Dignity of Risk is a Duty of Care. Provider Agencies which practice "duty of care" enhance the abilities of the person to keep safe by ensuring that they have knowledge of their rights, choices, and how their actions can influence others.

Chapter 3: Safeguards

3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process

There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: <https://nmhealth.org/about/ddsd/>.

3.1.1 Decision Consultation Process (DCP)

Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:

1. The Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision maker has concerns, needs more information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation, or suggestion. This includes, but is not limited to:
 - a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;
 - b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy;
 - c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and
 - d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP).
2. When the person/guardian is not comfortable with or disagrees with a recommendation or does not agree with the implementation of that recommendation,

Provider Agencies follow the DCP and attend the meeting coordinated by the CM.

During this meeting:

- a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.
- b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.
- c. Providers support the person/guardian to make an informed decision.
- d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.

3.1.2 Team Justification Process

DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The Team Justification process is used for non-health related issues and is documented on its own section of the Decision Consultation and Team Justification Form (DC/TJF). The process includes:

1. Discussion and decisions about non-health related recommendations with the person, guardian and/or IDT.
2. The Team Justification portion of the form documents that the person/guardian or team has considered the recommendations and has decided:
 - a. to implement the recommendation in its entirety;
 - b. to implement the recommendation partially;
 - c. not to implement the recommendation currently; or
 - d. to create an action plan and revise the ISP, if necessary; or
3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance (if needed and desired) and accessing supplemental resources if needed and desired.
4. The CM ensures that the Team Justification Process is followed and completes and maintains all relevant documentation.
5. The Team Justification Process cannot be used to justify not following DD Waiver Service Standards.

3.2 Financial Rights and Responsibilities of the Person in Services

A person receiving DD Waiver services is presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.

3.3 Human Rights Committee

Human Rights Committees (HRC) exist to protect the rights and freedoms of all waiver participants through the review of proposed restrictions to a person's rights based on a documented health and safety concern of a severe nature (e.g., a serious, significant, credible threat or act of harm against self, others, or property) . HRCs monitor the implementation of certain time-limited restrictive interventions designed to protect a waiver participant and/or the community from harm. An HRC may also serve other functions as appropriate, such as the review of agency policies on the use of emergency physical restraint or sexuality if desired. HRCs are required for all Living Supports (Supported Living, Family Living, Intensive Medical Living Services), Customized Community Supports (CCS) and Community Integrated Employment (CIE) Provider Agencies.

1. HRC membership must include:
 - a. at least one member with a diagnosis of I/DD;
 - b. a parent or guardian of a person with I/DD;
 - c. a health care services professional (e.g., a physician or nurse); and
 - d. a member from the community at large that is not associated (past or present) with DD Waiver services.
2. Committee members must abide by HIPAA;
3. All committee members will receive training on Abuse, Neglect and Exploitation (ANE) Awareness, Human Rights, HRC requirements, and other pertinent DD Waiver Service Standards prior to their voting participation on the HRC. A committee member trained by the Bureau of Behavioral Supports (BBS) may conduct training for other HRC members, with prior approval from BBS;
4. HRCs will appoint an HRC chair. Each committee chair shall be appointed to a two-year term. Each chair may serve only two consecutive two-year terms at a time;
5. While agencies may have an intra-agency HRC, meeting the HRC requirement by being a part of an interagency committee is also highly encouraged.

3.3.1 HRC Procedural Requirements

1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), their guardian, the case manager (CM) and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, their stated preferences may be brought to the meeting by someone whom the person chooses as their representative. If this designated representative is already a voting member of the HRC, the representative must refrain from voting on this decision.
2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's

informed consent regarding the rights restriction, as well as the person’s timely participation in the review.

3. The plan’s author or designated staff as determined by the plan’s author (e.g., designated agency staff such as the service coordinator or the CM) makes a written or oral presentation to the HRC.
4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.
5. HRC committees are required to meet at least on a quarterly basis.
6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large.
7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation.
8. Each HRC is required to have a provision for emergency approval (within 24 hours) of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video, or conference call, or SComm. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations.
9. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction.

3.3.2 Human Rights Committee Training for Voting Members

All individuals participating in HRCs as voting members must take the training “Human Rights Committee Requirements Training for Voting Members of HRCs” offered by DDSD-BBS prior to voting as an HRC member.

3.3.3 HRC Review Schedule

| Initial | Annual Review | Quarterly Review |
|-------------------------|---------------|--------------------------------|
| Alarms | X | -- |
| Bed rails | X | -- |
| EPR recommended in BCIP | X | Any quarter in which EPR used. |

| Initial | Annual Review | Quarterly Review |
|--|---------------|--|
| 1:1 staffing for behavioral reasons, or 2:1 for medical/behavioral | X | Any quarter in which 1:1 or 2:1 is used and will require a fading plan immediately. |
| Point Systems/Level Systems | X | When in place, will require a fading plan immediately. |
| Protective Devices (for behavioral purposes only) | X | Any quarter in which device(s) is/are used and will require a fading plan immediately. |
| PRN Psychotropic Use | X | Any quarter in which PRN used. |
| Routine use of 911/Law Enforcement or Emergency Services (in BCIP) | X | Any quarter in which 911/Law Enforcement or Emergency services are used. |
| Restitution/Response Cost | X | When in place, will require a fading plan immediately. |

3.3.4 HRC and Behavioral Support

The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues.

Positive Behavioral Supports (PBS) are mandated and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g., building healthy relationships) to increase the person’s quality of life— understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person’s behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBS Plans (PBSPs) not containing aversive interventions do not require HRC review or approval.

Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations.

The HRC will review the plan along with the following additional information when available:

1. baseline, base rate data, or description of the emergent situation signaling the need for a temporary restriction of rights/use of aversive intervention;
2. the person’s current situation and environment;
3. the person’s history, including previous interventions and results;
4. relationship of the PBSP, BCIP, RMP and/or PPMP to the ISP;

5. the possible adverse effects, if any, of the proposed BCIP, or use of PRN psychotropic medications;
6. a timeline or plan to fade the aversive intervention or behavioral supports that include success and failure criteria for discontinuing the proposed aversive intervention; and
7. evaluation or treatment plan that outlines the need for the intervention, written by the qualified BSC, equivalent mental health provider, or another specialized therapist.

3.3.5 Interventions Requiring HRC Review and Approval

HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following:

1. response cost (See the BBS Guidelines for Using Response Cost);
2. restitution (See BBS Guidelines for Using Restitution);
3. emergency physical restraint (EPR);
4. routine use of law enforcement as part of a BCIP;
5. routine use of emergency hospitalization procedures as part of a BCIP;
6. use of point systems;
7. use of intense, highly structured, and specialized treatment strategies, including levels systems with response cost or failure to earn components;
8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons;
9. use of PRN psychotropic medications;
10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand);
11. use of bed rails;
12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or
13. use of any alarms to alert staff to a person's whereabouts.

3.3.6 HRC Prohibitions from Approval

An HRC is prohibited from approving any of the following:

1. Interventions which cause or result in physical pain.
2. Interventions which cause or may potentially cause tissue damage, physical illness, or injury, or require the involvement of medical personnel to assure the person's health and safety, other than medications prescribed by a legally licensed prescriber for treating a physical or mental illness.
3. The use of police presence and/or emergency rooms as a primary strategy of behavioral support. However, this does not exclude the use of emergency services and law

enforcement (as appropriate) to enforce laws or provide needed emergency medical treatment.

4. ***Interventions applied to any person, with or without a diagnosed disability, which are considered ethically and morally unacceptable***, including, but not limited to:
 - a. contingent electrical aversion procedures;
 - b. seclusion and isolation;
 - c. use of time out (for an adult);
 - d. use of mechanical or chemical restraints;
 - e. use of manual application of any physical restraint, except in emergent situations involving imminent risk of harm to self or others (defined as EPR);
 - f. overcorrection;
 - g. forced physical guidance;
 - h. forced exercise;
 - i. withholding food, water, or sleep;
 - j. public or private humiliation (including overreliance on prescribed protective gear or recommended assistive technology that is applied for programmatic convenience, calls undue attention to someone, and is therefore humiliating to the person supported); or
 - k. application of water mist, noxious taste, smell, or skin agents.
 - l. privacy violations (such as body checks and electronic surveillance, remote monitoring in private areas such as bathrooms or bedrooms); or
 - m. restricting a person from exiting their home using locks on doors and windows.

3.3.7 HRC Super Committees

DOH/DDSD Bureau of Behavior Supports (BBS) provides oversight through the periodic review of provider policies and provider use of restrictive practices, review of Positive Behavior Support Plans, including Behavioral Crisis Intervention Plans, training provided to providers, teams and Human Rights Committees, and the provision of technical assistance to providers, teams, and Human Rights Committees when problems are identified that impact the health and safety of the participants. Complex ethical, medical and/or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local Human Rights Committees are heard and resolved in a statewide and state coordinated Human Rights Committee. A trained and well-functioning intra- or interagency HRC meets at least quarterly (emergently when needed), engaging in a thorough review of human rights restrictions. If desired, the HRC may access additional training, technical assistance, and guidance from DDSD/BBS to understand a proposed restriction or to guide the HRCs thinking about a particular situation.

At times, deciding about a proposed rights restriction is difficult and causes significant differences of opinion among HRC members as well as between the HRC and the agency or team. The HRC Super Committee (HRCSC) is an oversight committee that reviews proposed

rights restrictions based on a documented health and safety concern by referral from Provider Agency HRCs. The responsibility of the HRC Super Committee is to assist teams in making difficult decisions, resolving disputes, and reviewing restrictions ordinarily prohibited in the DD Waiver Standards.

3.3.7.1 HRCSC Referrals

HRC Super Committee referrals may include the following:

1. Any proposed restriction relating to privacy violations such as approving restrictions that should be time limited but have not been proposed or handled this way;
2. body checks or electronic surveillance;
3. any other prohibited restrictions from [Chapter 3.3.5 Interventions Requiring HRC Review and Approval](#) or
4. any proposed restriction where there is ongoing and/or severe disagreement within the IDT or members of the IDT and the Provider Agency

3.3.7.2 HRC Membership

1. HRC Super Committee (HRCSC) membership must include two:
 - a. members with a diagnosis of I/DD;
 - b. parents or guardians of a person with I/DD;
 - c. health care services professionals (e.g., a physician or nurse); and
 - d. members from the community at large who are not associated with DD Waiver services.
2. It is preferred that HRCSC membership is composed of past or current HRC members.
3. There should be statewide representation on the committee.
4. DDS/BBS will review referrals, coordinate meetings, train and offer technical assistance to committee participants, and convey findings to referring parties. DDS staff will coordinate the committee but will not be voting members. DDS will review referrals, coordinate meetings, train and offer technical assistance to committee participants, and convey findings to referring parties.
5. HRCSC members must abide by HIPAA.
6. HRCSC members will have had full training or will complete full training or receive refresher training on human rights, HRCSC requirements, and other pertinent DD Waiver Service Standards prior to their voting participation on the HRC Super Committee.
7. HRCSCs will appoint a chair. Each HRCSC chair shall be appointed to a two-year term and may serve only two consecutive two-year terms at a time.

3.3.7.3 HRCSC Procedural Requirements

1. Proposed rights restrictions that meet the specifications listed above shall be referred to the regional DDSD office where the issue exists for technical assistance.
2. If the matter is not resolved, any member of the person's IDT may fill out the HRCSC Referral form; attach it to a RORA and submit the RORA to the relevant regional office.
3. The RORA will be routed to the regional crisis specialist or the BBS Statewide Crisis Coordinator for review and consideration.
 - a. The referring party will be contacted within 3 business days of referral; and will be:
 - i. asked for additional information; or
 - ii. referred for additional training and/or technical assistance; and/or
 - iii. notified that the referral will not be referred to the HRCSC and state the reasons why the referral was not accepted; or
 - iv. notified that the referral has been accepted (a meeting date and time will be provided).
4. Once notified of an HRCSC meeting date and time, the referring party will invite the following to participate (at least 10 working days prior to the meeting):
 - a. the person subject to the rights restriction (regardless of verbal or cognitive ability);
 - b. their guardian, if applicable;
 - c. the case manager;
 - d. a family member (if desired by the person); and
 - e. the Behavior Support Consultant (BSC).
 - f. If the person (and/or the guardian) does not wish to attend, the person's stated preferences may be brought to the meeting by someone whom the person chooses as their representative.
5. The referring party (e.g., the plan's author, designated agency staff such as the agency service coordinator, or the CM) will make written or oral presentation to the HRCSC.
6. The results of the HRCSC review will be reported in writing within 5 working days of the meeting to:
 - a. the person supported,
 - b. the guardian (if applicable),
 - c. the referring party,
 - d. the CM, and,

- e. if a member of the team, the BSC and the mental health and/or other specialized therapy provider(s).
7. A quorum to conduct an HRCSC meeting are all members of the HRCSC that are eligible to vote.

3.4 Emergency Physical Restraint (EPR)

Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. EPR is the use of personal, manual physical force to limit, prohibit, or preclude imminently dangerous behavior by restricting movement through specified and allowed sustained physical contact or holding procedures.

Requirements related to use of EPR are:

1. The use of EPR is permitted when non-physical interventions and de-escalation strategies have failed (e.g., as found in a PBSP) or have been exhausted in the presence of an imminent threat of serious physical harm or property damage that could cause a health and safety hazard.
2. The EPR shall be discontinued as soon as the safety of all individuals in the immediate area is reasonably assured. The intervention is event based, rather than time-based, except when prohibited by the agency approved protocol of crisis prevention and intervention (e.g., in some protocols staff are taught to release a hold as soon as possible, or after three minutes, regardless of de-escalation status of the person).
3. EPR can be used when in a BCIP and use is approved by an HRC and on the rare occasion when a person presents extreme, unique, unprecedented, and unpredicted behavior that requires an immediate physical intervention to ensure safety. When an extreme situation occurs and EPR is utilized, please refer to [Chapter 3, Section I 3.3.1 #8](#).
4. **Prone** (on the ground face down) and **Supine** (on the ground face upward) restraints are dangerous and therefore **are always forbidden**.

3.4.1 BSC Role and Responsibility

The BSC plays a critical role and has responsibilities related to safety considerations for use of EPR. The BSC is required to:

1. Describe potential crisis events that may escalate to emergencies and explore a person's potential to exhibit behavior that compromises the health and safety of self or others with the IDT.

2. Develop an individualized, written BCIP, that, only includes EPR when a last resort. The BCIP will include a hierarchy of intervention strategies designed to minimize or prevent emergency situations from escalating to harmful, injurious outcomes.
3. Develop or revise the BCIP with IDT input in the event of an unprecedented use of EPR. A draft plan is expected within two business days of the emergency IDT. BCIPs recommending EPRs and/or other rights restrictions will be submitted and presented by the BSC to the HRC for review (using the HRC emergency provision if necessary). (See detailed standards for BSC in [Chapter 12.2 Behavior Support Consultation](#)).
4. Provide initial and on-going training to DSP on the PBSP, BCIP, RMP, and PPMP.
5. Identify specific criteria and thresholds to amend and/or retrain DSP on the plans.
6. Collaborate with the IDT to decrease continued, long-term use of EPR. Intensive efforts to reduce dependence on EPR are expected whether the behavior of concern has emerged recently or has deep historical roots in past trauma or in physiological or syndrome-related factors.
7. Participate in post incident analysis of the use of EPR. The analysis requires identifying factors and potential prevention and/or early intervention strategies contributing to the incident, to reduce the likelihood of a similar incident requiring the use of EPR.

3.4.2 Interdisciplinary Team (IDT) Role and Responsibility

The IDT plays a critical role and has responsibilities related to safety considerations for use of EPR. The Provider Agencies on the person's IDT are required to:

1. Participate in an emergency IDT meeting following any use of EPR, whether contained in a BCIP or use is unprecedented:
 - a. examine the factors (antecedent, behavior, and consequence) contributing to the crisis;
 - b. assess whether the contributing factors persist;
 - c. explore alternative interventions that may have been used;
 - d. attempt to predict if the presenting behavior is likely to recur; and
 - e. recommend the use of a BCIP or amended or additional prevention and early intervention strategies in a current BCIP.
2. Consider changes to any aspect of the person's support that appear necessary to minimize or prevent a similar crisis and amend the ISP, PBSP, and/or BCIP accordingly.
3. Participate in training regarding the revised PBSP, BCIP, RMP and PPMP to the level specified in the Individual Specific Training (IST) addendum of the ISP.

3.4.3 Provider Agency Administration:

Provider Agencies supporting people who have challenging behaviors that pose a threat of serious physical harm to self and/or others or result in extreme property damage (causing a health and safety hazard) are required to have a protocol of crisis prevention/intervention for the proper administration of an EPR. Provider agencies may utilize one of the three currently

approved protocols: the Mandt System, Handle with Care: Crisis Intervention & Behavior Management, or Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention. Provider Agencies are also required to promote the least intrusive intervention necessary to assure health and safety and serve to minimize use of EPR. The Provider Agency administration:

1. Establishes methods for evaluating the risk of harm to a person weighed against any expected benefits in harm reduction, to evaluate whether the use of EPR is warranted and is justified.
2. Submits any crisis prevention/intervention protocol not currently approved that addresses the use of EPR to the BBS for review and approval.
3. Establishes systems (timelines, procedures, etc.) to provide DSP with training prior to an assignment where physical intervention and/or EPR may be necessary.
4. Identifies Provider Agency staff to serve as an agency-wide resource regarding crisis management, including EPR. The identified agency staff will be responsible for monitoring staff training and competence to administer EPR effectively. Identified staff will also contribute to EPR reduction efforts on an individual and agency wide basis.
5. Provides crisis prevention and intervention training for DSP and identified agency resource staff. Crisis prevention/intervention training, including the use of EPR, shall include, but not be limited to:
 - a. Interventions that may minimize or prevent the need for EPR (e.g., de-escalation of problem, challenging behavior and emotional distress, relationship building, adaptations to environments, activities and schedules that may suit the individual better).
 - b. Identification of specific behaviors or other physiological precursors that often indicate heightened emotional distress, increasing the potential for a behavioral emergency or crisis.
 - c. Types of EPR and related safety considerations, including information regarding the increased risk of injury when any EPR is used, particularly with extended use.
 - d. Administering EPR in accordance with known medical or psychological limitations that place the person at greater risk of compromised health or emotional status or preclude the use of EPR.
 - e. Reasonable actions that DSP may take to protect individuals, other persons, or themselves from assault or imminent, serious physical harm.
 - f. The simulated experience of administering and receiving EPR, and instruction regarding the effect(s) on the person restrained, including monitoring physical signs of distress, and obtaining medical assistance.
 - g. Participant demonstration of proficiency in administering EPR, developed in accordance with training protocols or by agency determination.

- h. Instruction regarding documentation and reporting requirements of EPR through GER, and via DHI-IMB when used more than once without being in the person's BCIP or when there is an injury and/or abuse, neglect, or exploitation (ANE) is suspected.
6. Documents that DSP and other agency staff have received training in the agency approved crisis prevention/intervention protocol. For DSP, the training must precede assignment to support individuals, who by recent history, exhibit challenging behavior that may necessitate physical intervention and/or EPR to maximize safety.
7. Documents that DSP and/or other staff have received training in each person's BCIP, and PPMP (if applicable) and are able and willing to implement the full hierarchy of crisis prevention and intervention.
8. Establishes and uses decompression/resolution protocols following an incident that used EPR. These protocols must include:
 - a. Incident review with the person to address setting factors and challenging behavior that precipitated the EPR (when appropriate, and if it is unlikely to evoke additional distress).
 - b. Incident review with the staff person(s) who administered the EPR to discuss potential proactive alternatives, prevention opportunities, and assess whether proper procedures were followed.
 - c. Consideration/decision regarding whether any follow-up is appropriate for individuals who witnessed the incident. Agencies may choose to offer counseling after the incident to any involved parties when deemed helpful.
 - d. A post incident analysis with staff conducting the EPR will follow each use within three business days of the event. An agency designated administrator, and the BSC (or agency-wide resource staff if no BSC is on the IDT) will assess the environmental, interpersonal, and activity setting factors that may contribute to the possibility that the person will exhibit behavior resulting in an EPR.
9. All instances of EPR when used more than once without being in the person's BCIP or when there is an injury or suspected ANE will be documented in the GER, as described in [Appendix B GER Requirements](#).
10. The Provider Agency director or their designee, shall verbally inform, as soon as health and safety has been assured after the EPR and by written report postmarked no later than three business days:
 - a. the person's guardian,
 - b. the person's BSC, if applicable, and
 - c. the CM.
11. The comprehensive written report shall include:
 - a. The names and job titles of the DSP who administered the EPR (and observers).

- b. The date, time, and duration, citing onset and end times.
 - c. The name of the administrator who was verbally informed following the EPR.
 - d. A description of activities the person, others, and staff were engaged in immediately before the use of EPR, the behavior prompting the EPR, the efforts made to de-escalate the situation, alternatives to EPR attempted, and justification for initiating the EPR.
 - e. A description of the administration of the EPR, including:
 - i. the intervention used and reasons why the intervention was necessary;
 - ii. the person's behavior and reactions during the EPR;
 - iii. how the episode ended;
 - iv. documentation of injury (if any) to the person and/or staff; and
 - v. any medical care provided during or following the EPR.
 - f. A description of the methods used to monitor the restrained person's health status, including any specific limitations and risks identified during the BCIP, and HCP development. This includes skin color, respiration, or other indicators of physical distress. Other indications of physical distress monitored shall include choking, vomiting, bleeding, fainting, loss of consciousness, swelling secondary to restraint points or verbal and nonverbal indications of acute pain.
 - g. For extended EPR (i.e., lasting 10 minutes or more), the written report shall describe the alternatives to extended EPR that were attempted, the outcome of those efforts, and the justification for administering the extended EPR.
 - h. Information regarding any further action(s) that the agency has taken or may take, including potential changes to the person's PBSP or BCIP, or changes in staff assignments that may or have occur(ed).
 - i. Information regarding opportunities for the person's guardian to discuss the administration of the EPR with program staff.
12. The Provider Agency whose staff administered EPR resulting in an injury or other reportable critical incident to the person, an extended EPR, and/or injury to intervening staff, shall provide a verbal notice to the DOH, DDSD-BBS Crisis Line at: 1-505-250-4292, within 24 hours of the administration of the EPR. A copy of the DHI report and the comprehensive written report must follow within 48 hours (or the next business day). The written report shall include:
- a. a copy of the agency-generated report described above; and
 - b. a DHI and GER record of all EPRs employed with the person for the 60 calendar days prior to the date of the reported EPR.
13. Any Provider Agency administering an EPR to a person more than four times in any four-week period will report to DDSD-BBS via telephone, SComm, within two business days of the fifth EPR.

14. All Provider Agencies supporting individuals with whom an EPR is used are required to collect and analyze data monthly. The analysis will be performed with respect to individuals that had EPR, staff employing EPR, and agency EPR trends. The report will be centrally maintained and made available to the DDSD-BBS, when requested.

3.4.4 Provider Agency Direct Support Professional (DSP)

DSP may work in situations that can be very strenuous and stressful, requiring them to utilize their many hours of training and experience to make split-second decisions regarding the persons that they support each day. DDSD is committed to supporting DSP to make the best decisions possible through training and technical assistance at the individual and agency level. DSP are responsible for:

1. Implementing an EPR:
 - a. In accordance with a person's BCIP, when all efforts to de-escalate, the crisis have failed to reduce the risk of imminent, serious physical harm.
 - b. Using strategies within the Provider Agency's approved crisis prevention/intervention protocol.
 - c. Using the amount of force necessary to protect the person or others from physical injury or harm.
 - d. Using the safest method available, and appropriate for the situation as described in the BCIP, and while considering the following safety requirements:
 - i. No EPR shall be administered in such a way that the individual is prevented from breathing or speaking. The health status of the individual must be continuously monitored during the administration of an EPR with attention to the specific limitations and risks identified during the behavioral BCIP, development. This includes changes in skin color, respiration, or other indicators of physical distress. Other monitored indications of physical distress shall include choking, vomiting, bleeding, fainting, loss of consciousness, swelling secondary to restraint points, and verbal and nonverbal indications of acute pain.
 - ii. EPR shall be administered in such a way to prevent or minimize physical and psychological harm. If, at any time during an EPR, the individual demonstrates significant physical distress through the above indicators, the individual shall be released immediately, and DSP shall immediately seek medical assistance.
 - iii. An EPR shall be released immediately upon a determination by the intervening staff that the person is no longer at risk of causing imminent physical harm to him or herself or others. If, due to unusual circumstances, an EPR continues for more than ten minutes, it shall be

considered an "extended restraint" for purposes of the reporting requirements.

2. Using immediate physical intervention, possibly including EPR, if necessary, to substantially reduce the risk of serious harm even if a supported person presents unique, unprecedented, and unpredicted behavior (and there is not a BCIP in place).
3. Verbally informing their administration as soon as possible and by written report (GER,) no later than the next business day whenever an EPR is administered. The written report shall be provided to the agency director or their designee.

3.4.5 Human Rights Committee Review of EPR

The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included in a plan.

Provider Agencies with an HRC are required to ensure that the HRCs:

1. participate in training regarding required constitution and oversight activities for HRCs;
2. review any BCIP, that include the use of EPR;
3. ensure that plan reviews occur:
 - a. at least annually,
 - b. in any quarter where EPR is used, and
 - c. whenever any change to the BCIP is considered.
4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and
5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.

Chapter 4: Person-Centered Planning (PCP)

4.1 Essential Elements of Person-Centered Planning (PCP)

Person-centered planning is a process that places a person at the center of planning their life and supports. The CMS requires use of PCP in the development of the ISP. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community.

4.1.1 Person-Centered Thinking

Person-centered thinking involves a process of examining the individual's values, strengths, needs and skills to set the foundation for ISP development. Person-centered thinking respects and supports the person with I/DD to develop strategies to:

1. have informed choices;
2. exercise the same basic civil and human rights as other citizens;
3. have personal control over the life they prefer in the community of choice;
4. be valued for contributions to their community; and
5. be supported through a network of resources, both natural and paid.

Person-centered thinking must be employed by all DD Waiver Provider Agencies involved in PCP and the development and/or modification of a person's ISP. Person-centered thinking involves the use of discovery tools and techniques. Person centered thinking must involve one or more activities that:

1. Develop specific assessments that may be required per service type.
2. Document discovery interviews with (at a minimum) the person, the guardian and or family member(s) (if applicable) which may include:
 - a. what is working/not working,
 - b. specific aptitudes, skills, and abilities,
 - c. Good day/Bad Day for the person,
 - d. what is important to/important for the person, and
 - e. what the person does and does not want in their overall employment or retirement life.
3. Identify characteristics of people who support the person best.
4. Identify what people like and admire about the person.
5. Use relationship and community maps.

6. Use preferred communication methods such as charts, plans/books, assistive technology, etc.; and preferred styles to communicate.
7. Use religious/spiritual/cultural and ethnic considerations, preferences, restrictions. (i.e., religious food restrictions, cultural dress restrictions, etc.)
8. Use other person-centered thinking tools available or developed by a Provider Agency.

4.1.2 Person-Centered Planning

The person with I/DD is at the center of the process. PCP is facilitated by the CM, and the person is encouraged and supported to direct the process as much as possible. No matter what the nature or severity of a person's disability, there are many ways to identify a person's strengths, abilities, preferences, needs, and goals with the person's participation.

The required elements of person-centered planning are to:

1. allow the process to be driven by the person;
2. allow the process to include people chosen by the person;
3. provide necessary information and support to the person to ensure that they direct the process as much as possible;
4. describe how the individual communicates their needs, wants and choice;
5. schedule the meetings at times/locations convenient to the person, preferably chosen by the person;
6. respect cultural considerations for the person;
7. use plain language, and communicate in a format that the person prefers such as English, Spanish or American Sign Language and/or aided with use of Assistive Technology (AT);
8. use strategies and ground rules to facilitate agreements as well as for solving disagreements or conflict among IDT members;
9. offer choices regarding the services and supports that the person receives, without fear of retaliation or undue influence by a Provider Agency;
10. follow established methods to request updates to the ISP;
11. use what is important to and for the person as the key factor to ensure delivery of services in a manner that reflects personal preferences and ensures optimal health and welfare;
12. clearly identify the strengths, preferences, needs (clinical and support), and Desired Outcomes of the person;
13. include personal goals and preferences related to the development of relationships, community participation, employment, income and savings, healthcare and wellness, education, etc. based on informed choice;
14. identify risk factors;
15. create plans to minimize adverse outcomes and manage risk; and

16. include assessments for review prior to the development of an ISP.

4.1.3 Person-Centered Practice

Person-centered practice is aligning services and resources to support people to achieve individual-specific goals and outcomes. The IDT, facilitated by the person and their CM, is responsible for:

1. developing the ISP;
2. indicating the supports needed; and
3. identifying the agencies responsible for providing the services and supports in the ISP.

4.2 Informed Choice

Person-centered practice must include informed choice. Informed choice is when a person decides based on a solid understanding of all available options and consequences of how that choice will impact their life. Options are developed through a partnership with the person and knowledgeable supports, including IDT members and non-paid supports who empower the person to make informed choices. Informed choice generally includes the following activities:

- a. assessing the person's interests, preferences, strengths abilities and needs;
- b. discussing with the person/guardian what was learned through current assessments;
- c. providing understandable information about different options and resources available;
- d. providing opportunities for experiences, trial, and error; and
- e. considering potential impact on the person's life, health and safety and creating strategies to address any related issues that may arise.

Individuals, family members, guardians, natural supports, and Provider Agencies have a responsibility to support people with I/DD to make informed choices and to encourage them to speak up about their lives without feeling intimidated.

DD Waiver Provider Agencies on the IDT are required to:

1. support informed choice about employment through activities listed in [Chapter 11.2 Employment First](#);
2. increase a person's experiences with other paid, unpaid, publicly funded and community support options;
3. listen to the person receiving services and respect their choices;
4. support people to lead their meetings, programs and plan development and speak openly about their services, without being fearful of retaliation;
5. support and not replace use of natural and non-disability specific resources available;
6. work with the CM to document efforts demonstrating choice of non-waiver and non-disability specific options in the ISP through IDT meeting minutes or companion documents, especially when a person only has DD Waiver funded supports;
7. ensure the people have access to augmentative communication and AT which aid the person in participating in meaningful activities;

Chapter 4: Person-Centered Planning (PCP)

8. be aware of the levels and/or limitations of guardianship, the timelines for appointment and the parameters of authority for each person;
9. understand the Court Order appointing guardianship and appropriately involve the guardian in decisions when providing services to DD waiver participants;
10. be aware of and support new or existing Advanced Directives including Do Not Resuscitate; Do Not Intubate or other Directives or orders; and
11. support the person or their family if a waiver setting is unwilling to accommodate their wishes around CPR or DNR orders.

4.3 Choice of Non-Waiver and Non-Disability Specific Options

PCP must include documentation of a discussion about local paid and unpaid resources that may be available to meet a person’s needs. This must include options for supports, resources, employment, activities, and relationships with non-waiver-related programs and non-disability specific options.

4.4 Freedom of Choice of DD Waiver Provider Agencies

People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. The CM Agency Change Forms are maintained by each Regional Office. The SFOC is maintained by the Provider Enrollment Unit (PEU) and made available through the SFOC website: <http://sfoc.health.state.nm.us/>.

4.4.1 Service Provision

Provider Agencies that have a current Provider Agreement with the DOH and who do not have a state-imposed or an approved self-imposed moratorium must provide services to individuals who have signed forms. Provider Agencies must adhere to the following requirements:

1. Once a Provider Agency has received the signed SFOC form and an approved budget, the agency has up to 60 calendar days in which to begin providing services to the person. Under extreme circumstances an extension of the 60 calendar days can be approved by DDS.
2. Provider Agencies cannot require individuals and/or guardians to complete an admission packet or screen individuals through an admissions committee.
3. If Providers are unwilling to honor a Do No Resuscitate (DNR) or No CPR order or Advanced Directive, they must notify the person or their Guardian prior to Admission. This must also occur as part of readmission planning if a significant change of condition has occurred with a significant change in resuscitation status, including hospice orders or if a DNR or No CPR order or Directive in place. This information must be shared in a timely manner to allow the person or their Guardian to make discharge plans
4. Provider Agencies cannot maintain a “waiting list”.

Chapter 4: Person-Centered Planning (PCP)

5. If for any reason a Provider Agency determines it is unable to accept new individuals into service, the agency is required to request a self-imposed moratorium from the PEU and must continue to accept individuals until they have received notice from the PEU that their self-imposed moratorium request has been approved.
6. Provider Agencies cannot deny services to any individual once a SFOC form has been signed, unless DDSD has granted an exception to the Provider Agency.
7. To obtain an exception, the Provider Agency must:
 - a. complete and submit the SFOC Exception Request Form to the applicable DDSD Regional Office; and
 - b. include information that demonstrates the agency does not have the capability to ensure the health and safety of that individual or others prior to their moratorium expiration date.
8. Provider Agencies with an approved exception to the SFOC must:
 - a. be in communication with the appropriate DDSD Regional Office to identify what is essential to support the type of individual the Provider Agency was unable to support;
 - b. have developed the capacity to support the individual(s) for which they originally received the exception by the moratorium expiration date;
 - c. take the appropriate steps to ensure they are fully capable of serving all individuals on the DD Waiver by the moratorium expiration date.

4.4.2 Annual Review of SFOC

Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if they are not satisfied with services at any time.

1. The SFOC form must be utilized when the person and/or legal guardian wants to change Provider Agencies.
2. The SFOC must be signed at the time of the initial service selection and reviewed annually by the CM and the person and/or guardian.
3. A current list of approved Provider Agencies by county for all DD Waiver services is available through the SFOC website: <http://sfoc.health.state.nm.us/>.

4.4.3 Improper Solicitation

DD Waiver Provider Agencies and their staff must not engage in improper solicitation with the intent of influencing a person and/or parent/guardian to select a specific provider. Provider Agencies may develop and distribute information or educational materials about their agency and services. However, Federal Medicaid regulations prohibit the use of marketing materials and practices that are inaccurate or misleading, that confuse, or that defraud an individual. DD Waiver Provider Agencies must not engage in improper solicitation. Improper solicitation includes, but is not limited to, the following actions:

Chapter 4: Person-Centered Planning (PCP)

1. asserting or implying a person will lose benefits if the person fails to select a certain provider;
2. making inaccurate, misleading, or exaggerated statements designed to influence the person's choice of a provider;
3. asserting or implying that the Provider Agency offers unique services while other Provider Agencies also offer the same or similar services;
4. asserting that a specific provider will gain benefits for the individual, e.g., get a service approved when it was previously denied;
5. using gifts or the promise of gifts or other improper incentives to influence or entice an individual to select a provider; or
6. encouraging the use of services or products that are not within the Provider's scope of expertise under the DD Waiver.

4.5 Conflict-Free Service and Support Coordination

DD Waiver Provider Agencies are responsible for assuring PCP occurs, including considerations for conflict free service planning which:

1. prevents program-centered versus person-centered planning;
2. avoids patterns of Provider Agency budget requests being made prior to the ISP development or revision planning;
3. avoids undue influence of the DD Waiver Provider Agency on the person's schedule and/or choice of activities; and
4. prevents Desired Outcomes from being developed before the person's Vision has been discovered, clarified, and analyzed.

If any of the above have occurred or appear to be occurring, DD Waiver Provider Agencies, case managers and individuals have the right to use the Regional Office Request for Assistance (RORA) process detailed in [Chapter 19: Provider Reporting Requirements](#).

Chapter 5: Health

This chapter includes standards designed to promote and protect the health, safety, and well-being of individuals receiving supports through the DD Waiver. This chapter includes standards related to healthcare coordination, medical stabilization, promoting healthy relationships and sexuality, use of psychotropic medication, and aspiration risk management (ARM).

Standards in this chapter involve the interaction, collaboration, and coordination of various IDT members to provide the appropriate level of health supports. It is important for provider agencies to communicate with guardians to share with the IDT any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care.

5.1 Healthcare Coordination

Healthcare Coordination involves deliberately organizing individual care activities and sharing information among all concerned with a person's care to achieve safer and more effective care. This means that the person's needs and preferences are known ahead of time and communicated at the right time, to the right people, and that this information is used to provide safe, appropriate, and effective care.

Healthcare Coordination describes the actions taken by the system to: monitor and manage health related needs, respond proactively to health changes and concerns, facilitate the appropriate delivery of healthcare services, and support the larger process of Healthcare Coordination for the individual, in concert with multiple other entities in the healthcare system.

Healthcare Coordination in the DD Waiver requires:

1. communicating and coordinating between nurses and medical providers to plan treatment strategies for identified diagnoses and medication orders;
2. communicating and coordinating between nurses and CMs to develop treatment and service plans;
3. communicating and coordinating between nurses and DSP as they implement treatment and service plans;
4. coordinating visits with primary care and specialist providers while ensuring that a qualified person who knows the person well, understands their health issues, HCPs and MERPs, and who can communicate with the physician, attends the appointment;
5. communicating with physicians, dentists, and other healthcare providers as indicated;
6. timely sharing of information with the person, guardian, family, IDT, medical and behavioral Provider Agencies;
7. tracking implementation of recommendations made by a medical provider for assessments, treatment, and other services in addition to tracking the outcomes of recommendations;
8. ensuring healthcare needs, conditions, and risk factors are accurately documented in the healthcare record including use of Therap as described in [Chapter 20: Provider Documentation and Client Records](#);

9. actively managing care transitions, including changes in acuity levels, hospital discharge, other transitions related to an Out of Home Placement (OOHP), or changes in providers;
10. ensuring that the DCP as described in [Chapter 3.1.1 Decision Consultation Process \(DCP\)](#) is completed if the person or guardian objects to a HCP, aspects of the HCP or another health-related plan including, for example, a Comprehensive Aspiration Risk Management Plan (CARMP) or another plan such as Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP); and
11. coordinating with the MCO Care Coordination staff and the DD Waiver CM to assure continuity and access to healthcare services as well as availability and access to medications, medical equipment and healthcare supplies.

5.1.1 Designation of a Healthcare Coordinator (HCC)

The HCC is the designated individual on the IDT who arranges for and monitors healthcare services for the person in the DD Waiver program. The HCC is designated as follows:

1. The person or guardian may designate themselves or another member of the IDT to be the HCC.
2. If the HCC is an IDT member other than the person receiving services, DD Waiver Provider Agencies must assist the person to be involved to the maximum extent possible.

5.1.2 Roles and Responsibilities for DD Waiver Provider Agencies in Healthcare Coordination

All DD Waiver Provider Agencies have a role in healthcare coordination and are obligated to:

1. review, update, and follow up accordingly regarding health-related information in Therap and as described in [Chapter 20: Provider Documentation and Client Records](#).
2. promptly participate in IDT meetings convened by the DD Waiver CM when there is:
 - a. a change in health status,
 - b. a health-related concern,
 - c. concerns for health and safety, and/or
 - d. an emergent risk to health and safety.
3. follow requirements detailed in specific service sections of the DD Waiver Service Standards, which include service specific activities related to healthcare coordination.
4. include nursing assessment and consultation in the ISP and on the budget when the person receives health related supports from non-related DSP who require training and oversight by a nurse.
5. complete Individual Specific Training (IST) as described in [Chapter 17.9 Individual-Specific Training](#) on any subtle signs of change or acute conditions.

6. take necessary steps to support screening for aspiration risk and provide ARM supports as applicable and described in [Chapter 5.5 Aspiration Risk Management](#).

5.2 Medical Stabilization

Licensed medical and dental healthcare providers, using professional judgment, may elect to use immobilization, protective stabilization, or sedation to facilitate the safe and effective performance of appropriate medical or dental procedures. The medical or dental professional is responsible for obtaining any needed consent(s) from the person or their parent, guardian or designated healthcare decision maker. These professional decisions do not require review by an HRC. If the physician or dentist orders medication to be given before the procedure, the medication must be delivered and documented on the Medication Administration Record (MAR) according to the order.

5.3 Use of Psychotropic Medications

A psychotropic medication is any medication that alters the chemicals in the brain and consequently impacts a person's emotions and behaviors. Psychotropic medications treat a variety of psychiatric conditions including depression, bipolar disorder, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), and psychosis. While use of these medications can certainly ameliorate behavioral symptoms, they may not be sufficient to improve the quality of someone's life. Effective pharmacological intervention and support also considers the changes to the environments, relationships, skill building opportunities, and the activities available to a person rather than targeting problem behaviors exclusively through medication. Use of psychotropic medication for a person in DD Waiver services includes the following requirements:

1. Any person receiving psychotropic medication should receive an assessment of their need for behavioral health through the Medicaid State Plan and through BSC services.
2. The use of psychotropic medication in the treatment of a diagnosed psychiatric condition must:
 - a. be in accordance with all applicable laws, regulations, and standards of acceptable practice, including the use of psychotropic medication only for conditions that are responsive to medication; and
 - b. be reviewed at a schedule established by the prescriber and person in services or healthcare decision maker.
3. The administration of psychotropic medication is prohibited when the medication:
 - a. is for a chemical restraint, i.e., at a dose and/or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear, severe emotional distress, or other symptoms of psychiatric/emotional disturbance to be eased, managed, and/or treated. The administration of the medication may be regularly scheduled or on an "as needed" (PRN) basis;
 - b. is for substitution of meaningful support services; or
 - c. is in the absence of a comprehensive treatment plan.

5.3.1 BSC and Behavioral Health Requirements for PRN Psychotropic Medication

A PRN psychotropic medication is any chemical agent that is ordered on an “as needed” basis and is used for the effect it exerts on the central nervous system in terms of altering thoughts, feelings, mental activities, mood, and behavior. This includes chemical agents considered psychotropic and chemical agents with psychoactive effects but not considered psychotropic. A PRN psychotropic medication may be prescribed either for an established psychiatric diagnosis or for its effects on behavior. A person should be protected against unnecessary use of PRN psychotropic medication and, as such, the following requirements apply:

1. Any person receiving a PRN psychotropic medication must concurrently receive BSC services.
2. When behavioral intervention involves delivery of a PRN psychotropic medication, the BCIP should reference the separate PRN Psychotropic Medication Plan (PPMP) that is written by the BSC in collaboration with the applicable Provider Agency nurse(s).
3. The BSC indicates where the PRN psychotropic medication is considered within a hierarchy of interventions provided in the BCIP.
4. If behavioral indicators and guidelines for usage are unclear, the Provider Agency nurse seeks clarification from the physician or legally licensed prescriber, including specific information regarding:
 - a. behavioral indicators that the medication is having its intended effect;
 - b. side effects of the medication to watch for; and
 - c. specific medical or behavioral indicators of:
 - i. the need to discontinue use of PRN psychotropic medication;
 - ii. contraindications of the use of PRN psychotropic medication; and
 - iii. the circumstances that would require an immediate call to the prescriber, the emergency room, or 911.
5. At a minimum, the PPMP is a collaborative document that includes the following:
 - a. specific behavioral indications that guide DSP to call the agency nurse for consideration of the PRN psychotropic medication; and
 - b. the Provider Agency’s approval protocol for administering a PRN psychotropic medication in the PPMP.
6. When a PRN psychotropic medication order is terminated, the BSC issues a written statement regarding the change and makes any necessary revisions to the PBSP and BCIP, within 14 days of notice of the termination.
7. The use of PRN psychotropic medication must be reviewed by an HRC as described in [Chapter 3.3 Human Rights Committee](#).

5.3.2 Exceptions to Requirements

Any person receiving psychotropic medication should receive an assessment of their need for behavioral health treatments or therapies through the Medicaid State Plan and/or through BSC

services. People receiving psychotropic or PRN psychotropic medications and their IDT may ask for an exception to the requirement for behavioral health treatment or DD Waiver BSC service requirements by:

1. conducting a meeting (usually an IDT) to discuss the use of behavioral health treatment and/or BSC services;
2. demonstrating conditions that make behavioral health treatment or BSC unnecessary which include:
 - a. the person being on one or two psychotropic medications and without significant behavioral or psychiatric concerns for six months or more; and
 - b. the person and their IDT feeling competent to manage any issues that exist or may re-emerge in the future.
3. documenting the decision not to engage in or to suspend behavioral health treatment or BSC on a Decision Consultation and Team Justification Form (DC/TJF) using the process described in [Chapter 3.1.1 Decision Consultation Process \(DCP\)](#);
4. preparing a letter stating why neither behavioral health treatment nor BSC are necessary and describing how psychotropic medications will be managed (e.g., frequency of visits to PCP, Legally Licensed Prescriber (PhD), or Psychiatrist); and
5. submitting the letter to the BBS Bureau Chief or Clinical Director for approval.

5.4 Promoting Healthy Relationships and Sexuality

All Interdisciplinary Team (IDT) members should promote healthy relationships for persons with I/DD. The DD Waiver offers a variety of behavior support services, i.e., Behavioral Support Consultation (BSC), Socialization and Sexuality Education (SSE), and Preliminary Risk Screening and Consultation for Sexually Inappropriate and Offending Behaviors (PRSC). These services promote healthy relationships and sexuality by a taking an integrated and proactive educational approach to increase awareness, understanding and knowledge of healthy relationships, human sexuality and sexual health education, by screening and addressing community safety needs when a person engages in sexually inappropriate and offending behaviors, and by reducing the impact of interfering behaviors (such as trauma from sexual victimization) that compromise a person's quality of life.

5.4.1 IDT Roles and Responsibilities

To support and promote healthy relationships and sexuality for persons with I/DD, members of IDT must:

1. listen to the person's wants, needs, and desires regarding friendships and emotional and sexual relationships while respecting the person's right to dignity, privacy, and confidentiality;
2. protect a person's right to relationships and consensual sexual expression;
3. protect a person's right to comprehensive sexual health education that provides unbiased factual information delivered in an inclusive and safe setting;

4. protect a person's right to make informed choices for themselves and to have their decisions considered and respected, including decisions about their own bodies;
5. discuss whether the SSE-Friends and Relationship Course (FRC) would enhance the person's ability to form relationships and express their sexuality, while reinforcing their awareness and increasing their capacity to advocate for and build protections from sexual harassment and from physical, sexual and emotional abuse;
6. discuss whether the FRC would enhance the person's ability to realize other goals or Desired Outcomes such as work and community involvement;
7. recommend, as appropriate, to the CM or the BSC to refer the person to the FRC;
8. during the PCP process, determine resources (transportation and DSP support) needed by the person to participate effectively in the FRC;
9. identify whether there are concerns related to sexual victimization (as victim or offender), and assure that appropriate treatments and/or safety measures are provided when needed;
10. refer concerns about sexuality issues to the BBS for technical assistance when needed.
11. participate in Decision Consultation Process (DCP) meeting to assure informed decision-making regarding sexuality services occur (e.g., promoting healthy relationships with SSE attendance, and/or PRSC recommendations); and
12. perform any necessary edits to action plans and TSS reflecting relevant DCP decisions.

5.4.2 BSC Role and Responsibilities

In addition to requirements outlined for the IDT, the BSC must:

1. assist the IDT in determining how to best address the person's socialization and sexuality needs;
2. delineate supports and training to meet socialization and sexuality needs in the PBSA, and outline any strategies that will meet those needs in the PBSP (if required);
3. integrate goals, objectives, and strategies into the PBSP and TSS as indicated when the FRC is needed;
4. provide support and determine whether there is a need for additional behavioral health treatment when there are issues related to sexual victimization;
5. request assistance from BBS on any additional issues or concerns related to sexuality needs;
6. participate in Decision Consultation Process (DCP) meeting to assure informed decision-making regarding sexuality services (e.g., attendance at SSE and/or recommendations for or from a PRSC) occur; and
7. perform any necessary edits to plans (PBSP, BCIP, etc.) reflecting relevant DCP decisions.

5.4.3 CM Role and Responsibilities

In addition to requirements outlined for the IDT, the CM must:

1. discuss the need for SSE and/or PRSC with the person and/or the guardian and present a SFOC when indicated;
2. describe how IDT members will support participation in the FRC and/or PRSC process and integrate findings as appropriate in the ISP and TSS; and
3. respond to BBS staff about IDT follow-up on the FRC and/or the PRSC process.
4. coordinate and conduct a meeting for the Decision Consultation Process (DCP) to assure that informed decision-making occurs to accept all, part, or none of the recommendations regarding sexuality services;
5. complete the DCP Form outlining the final decisions of the individual and guardian on the DCP Form;
6. perform any necessary edits to the ISP, PBSP, BCIP and related documents, and
7. compile team edits of any relevant sexuality recommendations per DCP Form and service provider follow-up (e.g., retraining on changed action plans, TSS, PBSPs).

5.4.4 DSP and Providers of Living Care Arrangements and Community Inclusion Services

In addition to requirements outlined for the IDT, Provider Agencies are required to:

1. assure the person has the resources necessary to participate in the FRC, including transportation and DSP to accompany them as determined by the IDT; and
2. assure that DSP have the supervision, training, and professional support needed to implement strategies outlined in the ISP, PBSP and/or SSE-FRC.

5.5 Aspiration Risk Management

Aspiration Risk Management (ARM) is a disease management program for minimizing the risk of aspiration and aspiration pneumonia in adults (21yrs. and older) and young adults (18-20 years old). Individuals at risk for aspiration are those determined to be at moderate or high risk by nurses using the DDSD Aspiration Risk Screening Tool (ARST). ARM supports are provided by multiple DD Waiver Provider Agencies according to their service type and specialty.

ARM screening is required for all adults and young adults on the DD Waiver who receive Living Supports (Family Living, Supported Living, Intensive Medical Living Services) and Customized Community Supports Group (CCS-Group). Refer to [Chapter 13 Section II 13.3.2.2](#) for additional information.

For all adults and young adults allocated to the DD Waiver who do not receive Living Supports or CCS-Group, but receive other DD Waiver services, Aspiration Risk Screening and ARM supports are optional. ARM supports are explained to the person/guardian by the CM, so that they may make an informed decision. If there is a concern about possible aspiration risk, Adult Nursing Services (ANS) must be added to the budget so that the nursing assessment and ARST can be completed.

1. The ARM supports include the following elements (see Tables A & B):
 - a. Screening using a new ARST each time a screening is warranted;

- b. Collaborative Aspiration Risk Assessment to confirm the risk level and determine the needs;
 - c. Development of the Comprehensive Aspiration Risk Management Plan (CARMP) in [Chapter 20.5.6 CARMP Draft in Therap](#) and sharing the drafted CARMP with the person/guardian;
 - d. Support for the person and guardian during informed decision making;
 - e. Training, implementing, and monitoring of the CARMP strategies;
 - f. Reporting the required ARM related information to the IDT members and the Statewide Aspiration Risk Management Coordinator; and
 - g. Providing ongoing ARM supports.
2. After the ARST is completed, the CARMP is developed. After the CARMP is developed the CM presents it to the person and guardian. The CARMP may be accepted entirely. Parts of the CARMP may be edited or the entire CARMP may be deferred by using the Decision Consultation Process (DCP). (See [Chapter 3.1.1 Decision Consultation Process \(DCP\)](#)). The annual ARST and submission of information for the Statewide Aspiration Risk List (SARL) are **not** optional and **cannot be deferred**.
 3. Aspiration Risk and ARM supports should be documented in the ISP according to requirements outlined in [Chapter 6.6.3.5 Documenting Aspiration Risk Management \(ARM\) Support](#) in the ISP.
 4. The CARMP training is competency-based. DSP may not implement CARMP strategies independently until skill level of competence is demonstrated. DSP with a knowledge level of competence may implement the CARMP if they are working with a DSP who has achieved a skill level of competence and who directly observes and provides in person ongoing support and oversight. (See [Chapter 17.9 Individual-Specific Training](#) for more information about competency-based training.)

5.5.1 Screening for Aspiration Risk Using the Aspiration Risk Screening Tool (ARST)

1. Screening for aspiration risk by a licensed nurse using a new ARST is required:
 - a. annually, 45-14 calendar days prior to the annual IDT meeting;
 - b. within three business days after:
 - i. a significant change of condition, or
 - ii. unplanned weight loss greater than or equal to 10% of body weight or 10 lbs. in the last six months, or
 - iii. initiation of enteral feeding, or
 - iv. following any hospital admission, or
 - v. following outpatient treatment for aspiration pneumonia, or
 - vi. transfer or admission to a new living support agency.
2. When the person is determined to have a low risk for aspiration, the agency nurse:

- a. Documents the result in the ARST and the e-CHAT.
 - b. Repeats the ARST annually and in compliance with [Chapter 5.5 Aspiration Risk Management](#).
 - c. Does not need to take further action.
3. When the person is initially determined to have a moderate- or high-aspiration risk:
- a. The nurse documents the result in the ARST and e-CHAT and notifies the CM within two business days.
 - b. The CM notifies the IDT of the result, within two business days.
 - c. The CM notifies and consults with the person, guardian, and IDT members to determine which additional services are needed to complete the Collaborative Aspiration Risk Assessment.
 - d. The CM schedules the Collaborative Aspiration Risk Assessment within 30 calendar days from the date of the initial screening.
 - e. The nurse contacts the Primary Care Practitioner within two business days of completing the ARST to discuss the need for diagnostic procedures for the initial finding.
 - f. An interim ARM plan is developed within three calendar days, by both the nurse and the Eating Specialist (SLP or OT) when available. The nurse develops and trains an ARM MERP within three calendar days.
4. When a CARMP is already in place, and there is a change of condition or level of risk, the IDT continues with the current CARMP until the IDT reviews the it and makes changes as indicated.

5.5.2 Collaborative Aspiration Risk Assessment

A Collaborative Aspiration Risk Assessment is performed by the IDT when a person is newly identified with a moderate or high risk for aspiration to confirm the risk level and gather additional information. All CARMP strategy sections identified in the CARMP Template must be discussed by IDT to determine if additional assessment is necessary. The Collaborative Aspiration Risk Assessment is performed face-to-face in the person's natural setting within 30 calendar days of the ARST and is coordinated by the CM. Telehealth may be used during a public health emergency or natural disaster if at least one clinician is present with the person.

1. The initial Collaborative Aspiration Risk Assessment includes the person, the guardian, and DSP in addition to the clinicians. The following clinicians are included for the Collaborative Aspiration Risk Assessment to insure informed decision-making by the individual and/or guardian:
 - a. Nurse (Primary Provider Agency/Living Supports agency, or ANS agency, or CCS agency, See [Chapter 13.2.2 Collaboration and the Hierarchy of Responsibility for Nursing Tasks](#)).
 - b. Speech-Language Pathologist (SLP). The SLP may not be needed for ARM services if the person has no oral intake (100% NPO) or if the SLP found their services are

- not necessary. An SLP may remain on the team for communication supports and not be involved in the CARMP for swallowing supports.
- c. Dietitian (RD/LD) except for Risky Eating Behavior (REB), without the presence of nutritional or weight related needs.
 - d. Physical Therapist (PT), to address mobility, positioning or other discipline-specific supports.
 - e. Occupational Therapist (OT), to address sensory, oral hygiene, or other discipline-specific supports including mobility or positioning as needed
 - f. Behavioral Support Consultant (BSC) is required to address risky eating behavior (REB) and rumination but is optional to address other discipline-specific supports.
2. The clinicians may find there are no ongoing needs for continued services and may withdraw. The person and/or guardian have the option to use the DCP ([Chapter 3 Decision Consultation Process \(DCP\)](#)) after the CARMP is developed, using the DCP to modify the implementation of the CARMP ([Chapter 5 Using the Decision Consultation Process \(DCP\) to edit the CARMP](#)).
 3. The CM presents the person and guardian with a Secondary Freedom of Choice (SFOC) form to select any needed Clinician to complete the collaborative aspiration risk assessment and provide ongoing services. If there is an immediate need, the CM may complete and submit a budget revision as an imminent review.
 4. If needed Clinicians are not available on the SFOC, the CM submits a RORA, indicating which services are not available and contacts CSB and/or BBS to obtain support. The CM should also consider making a referral to the SAFE Clinic.
 5. The nurse(s), and other clinicians implementing the CARMP document the assessment results and recommendations in the content of the next annual or semi-annual report to the IDT, that follows the Collaborative Aspiration Risk Assessment.
 6. Clinicians may add recommendations to the interim ARM plan and provide training.

5.5.3 Ongoing ARM Supports

Ongoing ARM supports are required to maintain and support an established current CARMP for adults and young adults. Ongoing support includes: annual screening for aspiration risk using a new ARST, reviewing, revising, training and monitoring of the CARMP strategies, and annual SARL submission.

5.5.4 CARMP Development Process

Tables A & B identify required tasks and timelines for CARMP development. All days refers to calendar days unless stated differently in Roles and Responsibilities.

Table A Newly Identified at Risk: Initial CARMP Development

| | Action | Responsible Party | Timeline/ Due Date | Notes/Applicability |
|----------------------|--|---|---|---|
| 1. | Assessment/Screening /using a new ARST | Nursing | <ul style="list-style-type: none"> • 45-14 days prior to each annual IDT meeting • following a significant change of condition including unplanned wt. loss and new enteral feeding • following hospital discharge • following new agency admission | Required for all adult and young adult DD Waiver participants who receive Living Supports and CCS-Group. Also, those adults and young adults who do not receive Living Supports but choose to receive ARM supports and add required ARM supports to their budget. |
| 2. | Develop and Train Interim ARM Plan, if ARST is moderate or high risk | Nursing, Eating Specialist (OT or SLP) | Within 3 days following notification of ARST result | |
| 3. | Diagnostic Procedures, as needed | Nurse and IDT members | ASAP | As recommended by IDT members and ordered by Primary Care Practitioner. |
| 4 | Collaborative Assessment, if moderate or -high risk | IDT-members | Within 30 days following ARST | MUST BE collaborative and face to face for initial CARMP. Telehealth for CARMP Assessment may be used, if a clinician or other IDT member cannot attend, if the majority of the IDT can be physically present. |
| 5. | CARMP development IDT meeting | CM schedules | Any time after the Collaborative Assessment was completed. | Steps 5 and 6 may be combined by the IDT, if desired. CARMP is developed using Therap. |
| 6 | Develop CARMP | CARMP Authors | Within 60 days following ARST | |
| 7 | Review CARMP with the person and guardian | CM, person and Guardian | As soon as CARMP is completed by all authors, but no later than 67 days following ARST result | The CM reviews for complete sections and shares with the person and guardian. CM dates the final CARMP and “submits” in Therap. |
| Optional step | Decision Consultation Process/DCP (if requested by person and/or guardian) | CM coordinates and IDT members attend meeting, IDT supports final decision(s) | As soon as needed after the CARMP was drafted, but no later than 75 days following ARST result | <ul style="list-style-type: none"> • CM coordinates meeting for DCP to assure informed decision-making. • The individual and guardian may accept all, part, or none of the CARMP. • Final decisions are on the DC/TJF • Team edits & finalizes CARMP per DC/TJF |
| 8. | Train and Implement Final CARMP Strategies | Lead Contacts and DSP | Within 90-days following ARST result | Competency-based training required |
| 9. | Monitor implementation of CARMP Strategies | Lead Contacts | Frequency based on IDT role (monthly or quarterly), | Monitor for effectiveness and appropriate implementation. Retrain as needed |
| 10. | Monitor for signs and symptoms of Aspiration | All service Provider Agencies | Ongoing | According to signs and symptoms identified in CARMP, notify the nurse |
| 11. | Continue with Ongoing ARM Process | | | |

Table B Ongoing ARM Process: Current CARMP Review Revision (All days refers to calendar days unless stated differently in Roles and Responsibilities.)

| | Action | Responsible Party | Timelines/Due Date | Notes/Applicability |
|----------------------|--|--|---|--|
| 1. | Assessment/Screening using a new ARST each time | Nursing | <ul style="list-style-type: none"> • 45-14 days prior to annual IDT meeting. • following a significant change of condition including unplanned wt. loss and new enteral feeding • following any hospital discharge • following new agency admission | Required for all adult and young adult DD Waiver participants who receive Living Supports and CCS- Group. Also, those adults and young adults who do not receive Living Supports but choose to receive ARM supports and add required ARM supports to their budget. |
| 2. | Routine Clinical Re-Evaluation | Nursing, Therapists, BSCs, RDs | Within 45-14 days prior to the annual meeting | As required for Annual Re-Evaluation Report to IDT |
| 3. | Review CARMP and revise as needed using CARMP Draft in Questionnaire in Therap | CARMP authors (Nursing, therapists, BSC's, RD's) | <ul style="list-style-type: none"> • Following the Annual ISP meeting • Complete review and revision 21 days prior to new ISP cycle and as needed | <ul style="list-style-type: none"> • CARMP strategies may be edited at or following Annual ISP meeting in Therap. • Edits are based upon frequency of signs and symptoms identified, ongoing monitoring, re-assessment results, and outcomes status (met or not met, and continue, modify or revise). |
| 4. | Review CARMP with the person and guardian | CM, person & Guardian | Prior to ISP effective date | Assure consistency and share content with guardian |
| Optional step | Decision Consultation Process (if requested by individual and guardian) | CM coordinates and IDT supports. | Prior to ISP effective date | <ul style="list-style-type: none"> • CM coordinates meeting for DCP to assure informed decision-making. • The person and guardian may accept all, part, or none of the CARMP. The CM completes the DC/TJF. • Final decisions are reflected on the DC/JTF. • Team edits CARMP per the DCP in Therap • The CM finalizes the CARMP by adding the date to CARMP, uploading, and "submitting" in Therap. |
| 5. | Train Ongoing CARMP Strategies | Lead Contacts & DSP | Within 30 days following ISP effective date | Competency-based training required |
| 6. | Train New or Revised CARMP Strategies | Lead Contacts & DSP | Within 30 days of introduction | Competency-based training required |
| 7. | Monitor implementation of CARMP Strategies | Lead Contacts | Frequency based on IDT role (monthly or quarterly), | Monitor for effectiveness and appropriate implementation |
| 8. | Monitor for signs and symptoms of Aspiration | All service Provider Agencies | Ongoing | According to signs and symptoms identified in CARMP and report to the nurse |
| 9. | Repeat the Ongoing | CM & | Annually and as Needed (see screening conditions) to assure | Address at Annual IDT meeting and as |

| | | | | |
|--|-----------------------|-------------|---------------------|---------|
| | ARM Process (Table B) | IDT members | process is followed | needed, |
|--|-----------------------|-------------|---------------------|---------|

5.5.5 Using the Decision Consultation Process (DCP) to edit the CARMP

1. After the CARMP is developed or revised, it is presented by the CM to the person and guardian for review. If the person or guardian has questions or wishes to reject all or part of the CARMP, the CM coordinates the DCP. See also [Chapter 3.1.1 Decision Consultation Process \(DCP\)](#).
2. The clinicians who were involved in developing or revising the CARMP, and other IDT members meet with the person and guardian to support informed decision-making by discussing the current recommendations, listening to concerns, and offering alternative resources, solutions, and/or ideas.
3. If the person or guardian continues to reject all or part of the CARMP, the CM completes the DC/TJF, and the relevant “Lead Contact(s)” make the desired edits on the CARMP.
4. The edits are done by using the “strikethrough” feature on the current recommendations, followed by adding the decisions as it appears on the DC/TJF as additional text. The new entries are followed by referring to the DC/TJF and all entries are dated and initialed. This process is completed in Therap.
5. The edited CARMP is dated and titled as a revision by the CM, uploaded to CARMP Draft in Questionnaire in Therap, and “submitted” to finalize the CARMP and the CARMP authors complete the process by following the steps in [Chapter 20 CARMP Draft in Therap](#).
6. Training on the finalized CARMP is conducted, and the CARMP is implemented according to the final decision of the person/guardian. Training and monitoring occur in all the settings where the CARMP is implemented.
7. The DC/TJF, edited CARMP, and SARL are submitted to the State Aspiration Risk Management Coordinator within seven days after the IDT meeting.
8. The CM will review the existing DC/TJF at least annually, before the ISP meeting, with the person and guardian to ensure continuity.

5.5.6 Roles and Responsibilities for CARMP Development

5.5.6.1 Initial CARMP Development-Nurses, Therapists, RDs, BSCs, and CMs

1. The Eating Specialist (SLP or OT), when available, collaborates with the nurse to develop, document, train and implement an interim ARM plan, within three calendar days following notification of the moderate or high aspiration risk, and documents training on a training roster.
2. The CM coordinates collaboration of the nurse, and clinicians as needed to perform a face-to-face Collaborative Aspiration Risk Assessment in the person’s natural setting(s), within 30-calendar days following the ARST, to verify the risk level and identify

additional needs. Telehealth may be used during a public health emergency or natural disaster if at least one clinician is present with the person.

3. If, during the Collaborative Aspiration Risk Assessment, changes to the interim ARM plan are identified, revisions are made immediately, initialed/electronically signed and dated by the relevant discipline(s) and DSP are trained regarding the change.
4. After the Collaborative Aspiration Risk Assessment, the CM schedules an IDT meeting for CARMP development,
5. During the initial ARM IDT meeting, all CARMP authors collaborate, identify the “Lead Contact” for each strategy sections, and the CM coordinates the CARMP Development in Therap,
6. The “Lead Contacts” are required to train, monitor, and report on their identified CARMP strategy sections.
7. The initial ARM IDT meeting may be held concurrently with the collaborative aspiration risk assessment or separately as needed.
8. All “Lead Contacts” provide their name, title, and contact information as an author at the end of the CARMP document.
9. The CARMP must be completed within 30 calendar days following the collaborative aspiration risk assessment in Therap
10. The CM reviews the CARMP, within seven calendar days for incomplete sections and potential discrepancies between sections.
11. If any discrepancies are found, the CM notifies the relevant authors for revision. The relevant authors will confer and resolve the discrepancy within seven calendar days in CARMP Draft, in Therap: Process and Requirements.,
12. The CM reviews the completed CARMP with the person/guardian. If the person/guardian has questions or rejects all or part of the CARMP, the CM schedules a meeting and follows the DCP as described in [Chapter 3.1 Decision Consultation and Team Justification Process](#). Using the Decision Consultation Process (DCP) to edit the CARMP. The CM finalizes the CARMP following the process outlined in [Chapter 20.5.6 CARMP Draft in Therap](#) and notify the IDT.
13. The Primary Provider Agency Nurse, the Primary Provider Agency and all IDT members follow all steps as outlined in [Chapter 20.5.6 CARMP Draft in Therap](#) to ensure completion.
14. The CM, within 7 calendar days following the IDT meeting, submits a SARL Referral Form to the State Aspiration Risk Management Coordinator.
15. The “Lead Contacts” or their designees deliver competency-based training, to DSP and other relevant IDT members, on sections of the CARMP where they are identified as the “Lead Contact”. The “Lead Contact” conducts this training and implementation within

30 calendar days of CARMP completion, following IST requirements as described in [Chapter 17.9 Individual-Specific Training](#).

5.5.6.2 Review and Revision of an Existing CARMP - Nurses, Therapists, RDs, BSCs, and CMs

1. Each discipline completes an ARM reassessment:
 - a. annually,
 - b. following a re-administration of the ARST with a change in risk level,
 - c. following a significant change of condition, or
 - d. following any clinical change which may affect the person's risk for aspiration.
2. The reassessment report includes documentation of clinically relevant findings that reflect the status of the person and any changes that may result in the maintenance, initiation, revision, or discontinuation of CARMP strategies and/or interventions. The reassessment report also include documentation of previously established CARMP strategy monitoring results regarding effectiveness and identifies any edits that were required during the past year.
3. The nurse, and other clinicians are required to participate in the review and revision of the existing CARMP, following the nurse's assessment and ARST screening.
4. The CM schedules the CARMP IDT meeting where the IDT members present assessment or reassessment results and recommendations for CARMP strategy development, revision, or maintenance. The CM coordinates CARMP strategy development, revision, or maintenance efforts using the process in CARMP Draft, in Therap: Process and Requirements. Annual retraining of a CARMP with existing strategies is conducted and completed within 30 calendar days following the ISP effective date.
5. Training for a CARMP with new or revised strategies is conducted by the "Lead Contact" or their designee for the relevant strategy sections and must be completed within 30 calendar days of a strategy revision or introduction of a new strategy.
6. All CARMP training is competency-based and follows IST requirements as reflected in [Chapter 17.9 Individual-Specific Training](#).

5.5.7 General IDT Roles and Responsibilities

5.5.7.1 Nurses, Therapists, RDs, BSCs and CM's

1. During the IDT meeting for CARMP development, review and/or revision the nurses, clinicians and CMs must:
 - a. Complete as much of the CARMP template as possible, including identifying the "Lead Contact" for each strategy section and whether a strategy section is relevant to the person by using the CARMP Draft [Chapter 5.5.4 CARMP Development Process](#).
 - b. If multiple authors collaborated on a single CAMRP, those authors identify who will be the "Lead Contact" that will conduct training, monitor implementation,

- and report on effectiveness and strategy status to the IDT. The “Lead Contacts” may discuss how to share these tasks.
- c. Replace the “Lead Contact” with “n/a” if a CARMP strategy section is not relevant to the person.
 - d. Decide who completes remaining sections of the CARMP template and clarify the requirements to complete competency-based training.
 - e. Discuss where the completed CARMP will be available within each service setting. The entire CARMP will be kept intact.
2. The “Lead Contact” may designate a specific and willing IDT member to train in their place. The designated trainer must be competent to both implement the plan and conduct training on any strategy (in part or entirely). Such designation must be made in writing using the IST Trainer Designation Record as described in [Chapter 17.9 Individual-Specific Training](#). The designee’s name must be included in the “Lead Contact” column of the CARMP. If a designated trainer is identified, the IDT member who assigned the designation continues to be responsible for monitoring and reporting the effectiveness of strategies to the IDT.
 3. Each “Lead Contact” observes CARMP strategy implementations monthly until the implementation is stable. These observations alternate between home and day settings, with no less than a documented quarterly visit for each site thereafter. Observation is intended to determine if CARMP implementation is consistent, correct, and effective, as well as to check on the status of the person.
 4. The nurses, therapists, RDs, BSCs and CMs will:
 - a. Ensure the current CARMP and MERPs are present and available to all staff and are implemented properly, during their visits.
 - b. Report relevant findings, as well as frequency of reported individualized signs/symptoms in progress notes, and in quarterly or semi-annual reports.
 - c. Receive and respond to reports from any IDT member, DSP, individual, and guardian regarding signs and symptoms of aspiration or illness of any kind, by reporting it to the relevant individual, in a timely manner.
 5. The nurses, therapists, RDs, BSCs and CMs participate in the annual ISP and other IDT meetings to discuss:
 - a. the current level of assessed aspiration risk and presenting criteria;
 - b. the frequency of signs and symptoms of aspiration observed over the past year;
 - c. the effectiveness of current CARMP strategies;
 - d. any needed revisions, based on annual or other reassessment;
 - e. status of Desired Outcomes;
 - f. assessment or reassessment results and recommendations for CARMP strategy development, revision and/or maintenance;

- g. risks, benefits, and alternatives for recommended strategies to aid the person and guardian in making informed health decisions;
 - h. the “Lead Contact” for each CARMP strategy section; and
 - i. the development/revision of assigned components of the CARMP collaboratively, using CARMP template for strategies.
6. The nurses, therapists, RDs, BSCs and CMs follow the CARMP Draft process, see Ch. 5.5.8 CARMP Draft in Questionnaire Forms in Therap: Process and Requirements to complete the CARMP development, review, and revision including:
 - a. enter the clinician’s name and/or title in the “Lead Contact” column, and replace previously assigned allocations as “Lead Contact” in the sections of the CARMP that are not relevant for the person with n/a, during the annual ISP and other IDT meetings.
7. The nurses, therapists, RDs, BSCs and CMs completes the CARMP in Therap 21 calendar days prior to the ISP effective date.
8. When the person/guardian disagrees with a recommendation included in the CARMP and/or does not agree with the implementation of that recommendation, the DCP will be followed as described in [Chapter 5.5.5 Decision Consultation Process \(DCP\)](#).
9. The nurses, therapists, RDs, BSCs and CMs provide and document observation and monitoring of CARMP implementation and give constructive feedback to staff as warranted.

5.5.7.2 All IDT Members

1. All IDT members are required to:
 - a. Monitor the person for person specific signs and symptoms of aspiration, as identified in the CARMP during site visits and report any concerns to the nurse. Prompt recognition of an event or illness allows access to prompt treatment
 - b. Implement and maintain the CARMP as a stand-alone document that is used to guide, direct, and teach how to implement person specific aspiration risk management strategies in the home and other service settings.
 - c. Duplicative instructional documents will be removed from all sites and support documentation at the time of CARMP initiation. This includes any duplicative WDSIs, Therapy Support Plans, Mealtime Plans, interim ARM Plans, tube feeding plans, nutrition and, oral hygiene plans that are replaced by the CARMP.
 - d. Assures that the current, intact CARMP is readily available to staff at all service delivery sites.
 - e. Provide and document observation/monitoring of CARMP implementation and provide feedback, complimenting or correcting support and re-train for DSP as needed.

- f. Communicate concerns related to CARMP implementation to agency representatives and DDS as needed.
2. All IDT members may contact the Regional Office nurse, BBS, or/and Aspiration Risk Management Coordinator for assistance or additional resources

5.5.7.3 Additional Nursing Responsibilities

The nurse is required to fulfill the following responsibilities:

1. The nurse assesses for aspiration using a new ARST.
2. The nurse updates the diagnosis list when the SLP diagnoses dysphagia with a bedside swallow evaluation or radiological diagnostic studies, refers to this diagnosis during the ARST assessment, and informs the Primary Care Practitioner of the risk level and CARMP development or revision.
3. The nurse notifies the CM and contacts the Medical Provider, within two business days, when a new moderate or high risk for aspiration is identified during assessment or when the Eating Specialist (OR or SLP) requests additional testing.
4. The nurse creates and conducts training on an interim aspiration plan and MERP and documents any training on a training roster for a newly assessed at risk person. All interim plans are removed once the final CARMP and MERP are in place.
5. The nurse's semi-annual report to the IDT includes:
 - a. the current ARST result and whether the risk level changed since the previous report;
 - b. a synopsis of the past year's CARMP monitoring results including the frequently reported individual signs and symptoms of aspiration and the effectiveness of risk management strategies; and
 - c. strategies and/or interventions that need to be initiated, revised, or discontinued.
6. The nurses collaborate with each other when nursing supports are provided by different agencies in different settings. CARMP development includes approaches appropriate to each nurse's specific setting. Each nurse is responsible for training in their respective settings, using the current finalized CARMP.
7. The nurse develops an aspiration MERP that addresses individualized aspiration risk factors for individuals with a *new* or *continued* final CARMP. The aspiration MERP may not be combined with any other condition. The nurse conducts training on the aspiration MERP within 30 calendar days of the completion of the CARMP and re-trains annually or as needed. The aspiration MERP identifies worsening aspiration signs and symptoms that indicate the need to seek medical assistance before or during a medical emergency. This medical assistance may include taking the person to urgent care, or the hospital, or calling 911.

8. The nurse conducts training on and monitors the “Individual Specific Signs and Symptoms of Aspiration” and the required response.
9. The nurse is required to, at minimum, conduct a monthly face-to-face assessment of the individuals at high risk for aspiration and quarterly face to face assessment of the individuals at moderate risk. This assessment includes monitoring for signs and symptoms of aspiration and respiratory related illness and verifying that supports are being implemented as trained.
10. The nurse must complete monthly face to face assessment for any individuals with feeding tubes. They must observe and document the tube site status, any issues related to feeding, and the person’s weight. The nurse must observe and address any DSP training needs.
11. Nursing assessment should be completed in person when possible although telehealth/remote methods may be used when needed based on prudent nursing practice. During a public health emergency or natural disaster, the nurse may need to rely on telehealth or remote services only.
12. The nurse receives reports from any IDT member or DSP regarding signs and symptoms of aspiration or illness of any kind and must respond in a timely manner.
 - a. Response method will be based on the nurse’s clinical judgment, the nature of the report, and the circumstances of the incident.
 - b. Reports, response, and outcomes are documented in the nursing progress notes.
 - c. The person who reported the signs/symptoms must be notified regarding the action taken, any pertinent outcomes, and any recommendations made.
13. The nurse is the lead for communicating with the Primary Care Practitioner and other healthcare provider agencies related to ARM supports.
14. The nurse follows the DCP when the person with recommendations to receive nothing by mouth (NPO) with or without a feeding tube choose to continue oral eating, including pleasure eating with a feeding tube. The nurse will support the person and/or guardian to quickly collaborate with the Medical Provider to amend NPO orders to allow the IDT to honor this health decision. This is documented in routine nursing notes and the CARMP is revised, trained, and implemented as needed.
15. The nurse seeks additional consultation and resources as needed from DDS staff and other clinical partners.

5.5.7.4 Additional RD Responsibilities

1. During the Collaborative Aspiration Risk Assessment meeting, the RD focuses on the manner and type of nutritional intake. The assessment results include recommendations regarding any interventions warranted are distributed to the IDT and added to the CARMP and trained.

2. The RD provides and documents observation/monitoring of nutritional status and CARMP implementation at least quarterly.

5.5.7.5 Additional Primary Provider Agency Responsibilities

1. The Primary Provider Agency has representation at IDT meetings to offer appropriate input and coordinate and facilitate active DSP participation in Collaborative Aspiration Risk Assessment, CARMP planning, and training.
2. The Primary Provider Agency is required to arrange for and support the utilization of RD and nursing time for all people at risk for aspiration that need ARM supports. This requirement includes notifying the RD and nurse, in a timely manner, about ALL IDT meeting, Collaborative Aspiration Risk Assessment, and CARMP development, review and revision.
3. The Primary Provider Agency must follow the CARMP Draft in Therap: Process and Requirements.
4. The Provider Agency notifies the CARMP “Lead Contacts”, immediately, when a new DSP starts working with the person. The Provider Agency schedules time for the required competency-based training before new DSP implement any CARMP strategy.
5. The Primary Provider Agency ensures that the new DSP will implement CARMP strategies independently until skill level of competence is demonstrated. DSP with a knowledge level of competence may implement the CARMP if they are working in the same location and shift with a DSP who has achieved a skill level of competence and who is readily available for ongoing support and oversight
6. The Primary Provider Agency collaboratively arranges and schedules time for IST with the “Lead Contacts” for the various elements of the CARMP.
7. The Primary Provider Agency ensures that a current, intact CARMP and Aspiration MERP are readily available to staff/DSP in all service delivery sites, at all times, and that all outdated aspiration, mealtime, oral hygiene, tube feeding, and positioning related plans superseded by the CARMP are removed from all service delivery sites to avoid any confusion.
8. Primary Provider Agency supervisory staff monitor DSP for consistent, correct implementation of CARMP strategies and contact the relevant “Lead Contact(s)” for retraining, as soon as implementation concerns are identified.
9. The Primary Provider Agency staff observe the person for signs and symptoms of aspiration that are noted in the CARMP, and immediately notify the agency nurse/ANS directly when these signs and symptoms are identified.

5.5.7.6 Additional Case Manager (CM) Responsibilities

1. The CM revises the person’s ISP within 72 hours after the initial IDT and revise the IST section of the ISP as described in [Chapter 6.6.3.3 Individual Specific Training in the ISP](#).

2. The CM schedules an IDT meeting to assure that ongoing aspiration risk-minimizing strategies are being implemented, when necessary. Any member of the IDT may request such a meeting to assist with successful implementation of the CARMP or to discuss any concerns or suggest revisions to any portion of the CARMP.
3. The CM provides the person/guardian with resources to assist with decision making if the Medical Provider or specialists recommend placement of a feeding tube. (Refer to DDSD Clinical Services web page).
4. The CM includes the following agenda items during the ISP meeting or CARMP IDT meeting:
 - a. current ARST criteria and level of risk;
 - b. status of Individualized Outcomes stated in the existing CARMP, any barriers to their achievement and any appropriate needed changes to those outcomes;
 - c. review of frequency of individual signs and symptoms over the past year, of any concerns related to that frequency, and of any needed changes to the individual signs and symptoms;
 - d. review of current CARMP strategies and whether changes are needed based upon authors' findings during monitoring visits;
 - e. review of the "Lead Contact's" Annual Re-Evaluation Reports;
 - f. discussion of the need for additional assessment or medical referrals;
 - g. documentation of any additional needs related to the person's aspiration risk and of results of a-d above; and
 - h. revisions needed for the Action Plan for Health & Safety Related Supports page of the ISP.
5. The CM follows the CARMP Draft process. See [Chapter 20.5.6 CARMP Draft in Therap.](#)

Chapter 6: Individual Service Plan (ISP)

The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP.

6.1 ISP Development

The ISP is developed annually through an ongoing PCP process. The ISP development must:

1. involve those whom the person wishes to attend and participate in developing the ISP;
2. use assessed needs to identify services and supports;
3. include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, natural supports, and others;
4. identify roles and responsibilities of the IDT members who are implementing the ISP;
5. include the term of the ISP and how and when it is updated; and
6. outline how the person is informed of services which include natural and community resources as well as those funded by the DD Waiver and Medicaid State Plan.

6.2 IDT Membership and Meeting Participation

The Interdisciplinary Team (IDT) membership and meeting participation varies per person.

1. At least the following IDT participants are required to contribute:
 - a. the person receiving services and supports;
 - b. court appointed guardian or parents of a minor, if applicable;
 - c. CM;
 - d. friends requested by the person;
 - e. family member(s) and/or significant others requested by the person;
 - f. DSP who provide the on-going, regular support to the person in the home, work, and/or recreational activities;
 - g. Provider Agency service coordinators; and
 - h. ancillary providers such as the OT, PT, SLP, BSC, nurse and nutritionist, as appropriate; and
 - i. healthcare coordinator.
2. Others the person may want to invite include, but are not limited to:
 - a. advocate (personal, legal, or corporate);
 - b. community representatives;
 - c. interpreter;
 - d. cultural liaison;
 - e. school representatives;
 - f. minister, priest, rabbi, or another spiritual/cultural advisor;
 - g. co-worker;
 - h. healthcare practitioner; and

- i. DDS representative.
3. IDT member participation can occur in person/face-to-face or remotely. Remote/video participation must align with Federal Guidelines for HIPPA Privacy. All confidential protected health information (HIPAA Sensitive PHI) must be sent through SComm in Therap by Provider Agencies required to have SComm accounts.
4. If a required participant is not able to attend the meeting in person or remotely, their input should be obtained by the CM prior to that meeting. Within 5 business days following the meeting, the CM needs to follow-up with that participant and document accordingly.

6.3 Role of Assessments

Assessments are necessary tools to help identify a person's strengths, interests, possible Desired Outcomes and to identify what may best assist in meeting the person's Desired Outcomes. However, assessments and evaluations are not a substitute for input from the person concerning their strengths and potential barriers.

1. It is the responsibility of IDT members to recognize the potential need for a specific assessment through the DD Waiver (e.g., Therapy, BSC, PCA, PRSC, etc.).
 - a. The IDT must identify areas of needed support and provide pertinent information and feedback to be included in the assessment.
 - b. All referrals to a Provider Agency for assessment or treatment must be documented in the person's ISP.
 - c. Initial assessments may be conducted and updated at any time during the ISP year.
2. For Provider Agencies contributing to ISP development for the upcoming year, assessment updates must be provided at least 14 calendar days prior to the ISP meeting to ensure that assessments are used as a tool to contribute to the ISP to address the person's assessed needs and personal goals, either through DD Waiver services or other means.
3. When possible, challenging behaviors should be evaluated medically to determine if there is an underlying medical condition that is causing and/or contributing to the expression of a behavior. Behavioral assessment in collaboration with medical and/or psychiatric consultation is encouraged.
4. It is the responsibility of the IDT to recognize when individual, family or group behavioral health benefits or medical benefits through Medicaid state plan benefits or Medicare would be beneficial and to coordinate with the MCO Care Coordinator for support.
5. For effective planning and ISP development, it is the responsibility of the IDT to review assessments and make referrals for assessments both internal and external to the DD Waiver program based on the person's specific needs.

6.4 Preparation for ISP Meetings

The CM is required to meet with the DD Waiver participant and guardian prior to the ISP meeting. CM must document the Pre-ISP meeting to include all required items as listed below. The CM reviews current assessment information, prepares for the meeting, creates a plan with the person to facilitate or co-facilitate the meeting if desired, discusses the budget, reviews the current SFOC forms and other DDS Process forms such as the Decision Consultation and Team Justification Form (DC/TJF) and facilitates greater informed participation in ISP development by the person.

1. The CM clarifies the person's long-term vision through direct communication with the person where possible, or through communication with family, guardians, friends, Provider Agencies, and others who know the person well. Information gathered prior to the annual ISP meeting shall include, but is not limited to the following:
 - a. strengths,
 - b. capabilities,
 - c. preferences,
 - d. desires,
 - e. cultural values,
 - f. relationships,
 - g. resources,
 - h. functional skills in the community,
 - i. work/learning interests and experiences,
 - j. hobbies,
 - k. community membership activities or interests,
 - l. religious and/or spiritual beliefs or interests, and
 - m. communication and learning styles or preferences and health and safety for use in development of the ISP.
2. The CM shall verify with the person and guardian, if applicable, which members of the current IDT should be invited to the annual ISP meeting.
3. All DD Waiver Provider Agencies should be aware of and respect the right of the person and guardian, if applicable, to discontinue services or change Provider Agencies.
4. The CM shall verify with the person and guardian, if applicable:
 - a. Whether any Decision Consultation or Team Justification processes are currently in place, by reviewing the Decision Consultation and Team Justification Form (DC/TJF) and if so whether the decisions made during these processes are to continue or are to be modified or discontinued.
 - b. Acknowledgement of this discussion will be documented on the DC/TJF and in the CM notes. The CM and IDT shall assure that the person has input in decision-making and does not fear repercussions.

6.5 ISP Meetings

The ISP is developed at least annually and revised as needed. The ISP term of 365 days is established at initial entry into DD Waiver services and cannot be changed. DD Waiver Provider Agencies must be aware of the ISP term for each person they support and prepare accordingly throughout the year.

6.5.1 Annual ISP Meetings

1. The CM must notify all IDT members, and those the individual wants to invite to their meeting, in writing of the annual ISP meeting at least 21 calendar days in advance of the meeting.
2. Meeting should not occur more than 90 calendar days before the ISP expiration, in order to include third quarter reporting and assessment updates.
3. The CM convenes the meeting with IDT members, including those who have the best information regarding progress during the past year, those who know the person best, and that the individual chooses to invite.
4. There must be documentation in the ISP/IDT meeting notes that there was participation by IDT members in the development of the ISP. ISP and signature page will suffice as the ISP meeting notes.
5. The CM documents how remote participation occurs when IDT members are not present at the annual ISP meeting.
6. The CM follows up with IDT members who were not able to participate at the meeting, and documents this accordingly.

6.5.2 ISP Revisions

The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten business days of receipt of any reasonable request to convene the team, either in person or through remote teleconference/video. IDT meetings to review and/or modify the ISP must have meeting minutes or a summary documented in the CM record and are required in the following circumstances:

1. When the person or any member of the IDT requests that the team be convened.
2. Within ten days of a person's life change to take appropriate actions to minimize a disruption in the person's life.
3. When immediate action is needed after a report of ANE is made or if ANE is substantiated.
4. Within ten business days of an ANE Closure letter if issues still need to be addressed.
5. Transition to new provider, program or location is requested.
6. Changes in Desired Outcomes.
7. Loss or death of a significant person.

8. Within one business day after any identified risk of significant harm, including aspiration risk screened as moderate or high according to the following:
 - a. The meeting may include a teleconference.
 - b. Modifications to the ISP are made within **72 business hours** and must be distributed to IDT team members and the DDS Regional Office.
9. When a person experiences a change in condition including a change in medical condition or medication that affects the person's behavior or emotional state. This includes initiation of Palliative Care or Hospice Services.
10. When a termination of a service is proposed.
11. When there is an impending change in housemates the team must meet to develop a transition plan.
12. When there is criminal justice involvement (e.g., arrest, incarceration, release, probation, parole).
13. Upon notice of an OOHP and need to report and plan for a safe discharge as described [Chapter 19.2.1 Events Required to be Reported in GER](#) and [Chapter 9.3 Out of Home Placement](#)
14. Whenever DDS and/or TPA decides not to approve the implementation of an ISP due to the cost or because DDS and/or the TPA believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.
15. For any other reason that is in the best interest of the person, or deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the person's Desired Outcomes of the ISP and the long-term vision.
16. Loss of job or change in employment status.

6.6 [DDSD ISP Template](#)

The ISP must be written according to templates provided by the DDS. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP templates may be revised and reissued by DDS to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDS and be required for use to better demonstrate required elements of the PCP process and ISP development.

The ISP is written by the CM with the IDT input and must be completed according to the following requirements:

1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed.

2. The person does not require IDT agreement/approval regarding their dreams, aspirations, and desired long-term outcomes.
3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes respect and dignity of the individual, health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis.
4. A signature page and/or documentation of participation in person and telephonically must be completed.
5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable.
6. The CM and IDT members must review the individual's technology and telehealth needs. IDT members are to address person centered needs by identifying and discussing with the individual and/or guardian how technology may support their needs and how it may be used. Review current Addendum on Technology/Telehealth.

6.6.1 Vision Statements

The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas:

1. Live,
2. Work/Education/Volunteer,
3. Develop Relationships/Have Fun, and
4. Health and/or Other (Optional).

6.6.2 Desired Outcomes

A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. Desired outcomes must:

1. be directly linked to a Vision;
2. be meaningful;
3. be measurable;
4. allow for skill building or personal growth;
5. be desired by the person, other team members;
6. not contain "readiness traps" or artificial barriers and steps others would not need to complete to pursue desired goals; and
7. not be achievable with little to no effort (e.g., open a savings account or one-time action).

6.6.3 Additional Requirements for Adults

Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See [Chapter 7: Available Services and Individual](#)

Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements.

6.6.3.1 Action Plan

Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome.

1. Action Plans include actions the person will take; not just actions the staff will take.
2. Action Plans delineate which activities will be completed within one year.
3. Action Plans are completed through IDT consensus during the ISP meeting.
4. Action Plans must indicate under “Responsible Party” whether DSP and/or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step. Title of the position of “Responsible Party” must be indicated.

6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI)

After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving their Vision.

6.6.3.3 Individual Specific Training in the ISP

The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must come to an agreement through a team process about who needs to be trained, at what level (awareness, knowledge, or skill), and within what timeframe. (See [Chapter 17.9 Individual-Specific Training](#) for more information about IST.)

6.6.3.4 Documenting Employment First in the ISP

New Mexico is an Employment First state and CMs have requirements to document strategies supporting Employment First in the ISP. (See [Chapter 11.2 Employment First](#) for more information).

1. **Assessment:** The first step in making an informed choice about employment starts with the assessment process. The Person-Centered Assessment (PCA) and minimum requirements are referenced in [Chapter 11.4 Person Centered Assessments \(PCA\) and Career Development Plans \(CDPP\)](#).
2. **Experience:** The second step in making an informed choice includes offering opportunities to explore new experiences in the community to determine interests, abilities, and assess skills for individuals that have no volunteer or work history. It is the responsibility of the provider to offer and document the outcome of these experiences. The outcome of these experiences must be documented by the CM in the ISP Work,

Education and/or Volunteer History section. If new experiences will not be explored, those reasons should be documented in the ISP, as well.

3. Opportunity for Trial Work or Volunteering: The third step in making an informed choice includes offering/providing the person job exploration activities including volunteer options and/or trial work opportunities if the person and guardian are interested. Provider Agencies should assist in accessing these opportunities. These opportunities must be documented by the CM in the ISP in the Work, Education and/or Volunteer History section.
4. Once the first three steps have been fulfilled, then the individual, in conjunction with a legal guardian, if appropriate, can determine whether employment shall be pursued.
5. If employment is the preferred option, then the IDT shall have a discussion of potential impact on the person's benefits and services. This process may require accessing community resources to determine the potential impact. Provider Agencies can assist in providing this information, and the details of the discussion must be documented by the CM in the Work, Education and/or Volunteer History section of the ISP
6. If a person is retired, then this information must be clearly documented in the ISP in the Work, Education and/or Volunteer History section. The reasons for the choice to retire, the retirement date, and other pertinent information should be included in the ISP.

6.6.3.5 Documenting Aspiration Risk Management (ARM) Support in the ISP

When aspiration risk is screened as moderate or high, the CM schedules an IDT meeting for CARMP development. When aspiration risk is screened at low, no meeting is required. Refer to [Chapter 5.5 Aspiration Risk Management](#) for routine screening guidance.

1. The CM revises the person's ISP to reflect the person's risk for aspiration within 72 business hours following this IDT meeting by indicating the risk for aspiration in the Health & Safety Narrative and the development of the CARMP on the Health & Safety Action Plan.
2. The CM revises the ISP Individual Specific Training (IST) section to delete any boxes previously checked for Mealtime Plan, Tube Feeding Protocol and/or Nutritional/Dietary Plan and instead checks the "other" box under the Support Plan column, specifying CARMP and inserting "refer to CARMP" in the "Who Provides Training" column. The CARMP specifies the training responsibility for each section of the CARMP in the Lead Contact column.
3. The CM reminds all IDT members that plans and support programs that were created in the past and duplicate information contained in the CARMP, will be removed from the active chart for the person. This includes the interim aspiration HCP, and all duplicative plans including G Tube or Mealtime, oral care, Positioning Plans, hydration, and Nutritional Plans.

6.7 Planning for Technology Use

DDSD supports a system-wide culture across waiver services that embraces person-centered, equitable access to a full range of enabling technology that has the flexibility to promote independence, individual choice, and respect privacy for people with Intellectual and/or Developmental Disabilities, regardless of level of disability.

1. Identifying technology solutions and supporting use of technology is part of person-centered planning.
2. CM facilitates discussion of technology solutions during planning.
3. When telehealth is used as a service delivery model, assure discussion regarding an individual's technology and telehealth needs are addressed. CM facilitates discussion to address person centered needs by identifying and discussing how technology may support an individual and how it may be used.
4. CM assists the individual and guardian to review Secondary Freedom of Choice (SFOC) for AT and RPST. Choosing AT or RPST provider and planning the budget request for technology entails significant research which may be supported by the CM and other IDT members including discussions:
 - a. how technology may meet the individuals' needs and goals;
 - b. all estimated costs, fees, repairs, warranty limits and contract duration specific to the offered supports, any needed home or environmental adaptations or modifications related to installation and advice regarding proposed individualized response plans; and
 - c. completing of AT Fund application or RPST forms as issued by DDSD.

6.8 Completion and Distribution of the ISP

The CM is required to assure all elements of the ISP, including signature page, and companion documents are completed and distributed to the IDT prior to the expiration of the ISP. DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. ISP must be provided at least 14 calendar days prior to the effective day unless there is an issue with approval. The CM distributes the ISP including the TSS, to the DD Waiver Provider Agencies with a SFOC, as well as to all IDT members requested by the person. The CM distributes the ISP to the Regional Office. When TSS are not completed upon approval of the ISP, they must be distributed when available, no later than 14 calendar days prior to the beginning of the ISP term or the revision start date.

6.9 ISP Implementation and Monitoring

All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See [Chapter 20: Provider Documentation and Client Records.](#)) CMs facilitate and maintain communication with the person, their guardian, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of their services and

that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in [Chapter 16: Qualified Provider Agencies](#). Implementation of the ISP by all DD Waiver Provider Agencies on an approved budget is monitored in the following ways:

1. Case Management site visits (monthly for adults non JCMs), twice per month for JCMs and at least quarterly for children);
2. Case Management site visit must be documented in the DDS published case note template in Therap and must be complete and submitted in Therap by the last day of the month in which the visit was completed.
3. Surveys conducted by Division of Health Improvement (DHI) – Quality Management Bureau (QMB);
4. Regional Office monitoring activities which may include ISP QA activities, site and home visits, and responses to RORAs;
5. CSB and BBS monitoring activities;
6. Individual Quality Reviews (IQRs) for JCMs; and
7. DDS contract management activities.

Chapter 7: Available Services and Individual Budget Development

Chapter 7: Available Services and Individual Budget Development

DD Waiver services are designed to support people to live the life they prefer in the community of their choice, and to gain increased community involvement and independence according to their personal and cultural preferences. Services available through the DD Waiver are required to comply with New Mexico’s DD Waiver approved by CMS and with any subsequent amendments approved by CMS during the five-year waiver renewal period. The individual budget development process must first include PCP, then development of an ISP, and finally identification of service types and amounts to meet the needs and preferences of individuals receiving services.

7.1 DD Waiver Service Availability and Exclusions

DD Waiver services are intended to enhance, not duplicate, or replace, already existing supports the person has in their life. DD Waiver services should be considered under the following circumstances:

1. Natural supports and services normally utilized by the community are preferred over DD Waiver services and supports.
2. Medicaid State Plan benefits are always considered before DD Waiver services and supports.
3. DD Waiver services are only available to individuals under age 21 to the extent that they are different from and do not duplicate services offered under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid School Based Services, services offered by the New Mexico Public Education Department, the State VR Agency, or services offered through the Early Childhood Education and Care Department (ECECD).

7.2 Children’s Category Services

Children’s Category services are available to children, birth to age 18. Each service must be provided in accordance with the applicable regulations and DD Waiver Service Standards.

7.2.1 Services Available for Children

The family of an eligible child, in conjunction with the IDT, may choose any or all the following service options. Case Management with minimum 4 units per year,

1. Behavior Support Consultation (BSC),
2. Crisis Supports,
3. Customized Community Support, Individual (CCS-I), outside of school hours only,
4. Respite,
5. Non-Medical Transportation,
6. Nutritional Counseling,
1. Environmental Modifications,
2. Assistive Technology (AT),
3. Remote Personal Support Technology (RPST), and
4. Socialization and Sexuality Education (SSE).

Chapter 7: Available Services and Individual Budget Development

7.3 Adult Category Services

Adult Category services are available to individuals aged 18 and older. Young adults aged 18-20 may have some service limitations in this category based on their ability to access the EPSDT benefit until age 21. Available services in the adult category are listed below:

1. Case Management.
2. Community Inclusion Services which include:
 - a. Community Integrated Employment (CIE).
 - b. Customized Community Supports (CCS Group includes nursing supports).
3. Living Care Arrangements (LCAs) which include:
 - a. Customized In-Home Supports (CIHS).
 - b. Living Supports - Family Living.
 - c. Living Supports - Supported Living which includes nutritional counseling and nursing services.
 - d. Living Supports - Intensive Medical Living Services (IMLS) which includes nutritional counseling and nursing services.
4. Professional and Clinical Services which include:
 - a. Adult Nursing Services (ANS) (not available to young adults, age 18 through 20 unless ARM supports are needed. Not available to children under 18).
 - b. Behavior Support Consultation (BSC).
 - c. Nutritional Counseling.
 - d. Preliminary Risk Screening and Consultation Related to Sexually Inappropriate Behavior (PRSC).
 - e. Therapy Services (not available to young adults, age 18 through 20 unless ARM supports are needed. Not available to children under 18).
5. Other Services which include:
 - a. Assistive Technology (AT).
 - b. Crisis Supports.
 - c. Environmental Modification.
 - d. Independent Living Transition Service.
 - e. Non - Medical Transportation Service.
 - f. Remote Personal Support Technology (RPST).
 - g. Respite.
 - h. Socialization and Sexuality Education (SSE).

7.3.1 Jackson Class Members (JCM)

Individuals included in the class established pursuant to Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, 757 F. Supp. 1243 (DNM 1990) may receive service types and budget amounts consistent with those services approved in their ISP and in accordance with the Orders of the Consent Decree. JCMs budgets are not submitted to the

Chapter 7: Available Services and Individual Budget Development

Outside Reviewer (OR) for clinical justification according to the process described below. DDS provides instruction to CM's on JCM budget submission and system entry.

7.3.2 Clinical Justification and the Outside Review Process

DDS contracts with an independent third party to conduct a clinical outside review (OR) of services and service amounts requested on an adult or children's budget. DD Waiver services have a set of clinical criteria applied by the OR to determine clinical justification. Clinical Criteria undergoes periodic updates when clarification is needed for the field and the reviewers or when policy or program decisions affect the criteria. The most current Clinical Criteria can be found on the DOH website under DD Waiver Publications:

[https://nmhealth.org/about/ddsd/pgsv/DD Waiver/publications/](https://nmhealth.org/about/ddsd/pgsv/DD%20Waiver/publications/).

7.3.2.1 Clinical Justification

To be considered for a covered service in the DD Waiver approved by the CMS, the following needs to be justified and met. The service must:

1. meet the DD Waiver participant's clinical, functional, medical, behavioral or habilitative needs;
2. promote and afford the person's support for greater independence;
3. contribute to and support the person in remaining in the community;
4. engage the person in the community and reduce the risk of institutionalization;
5. address the person's physical, behavioral, and social support needs (not including financial support) that result in functional limitations (i.e., self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) and/or condition;
6. meet the DDS Clinical Criteria for the service request;
7. justify the need for the requested service amount; and
8. relate to the ISP.

7.3.2.2 Clinical Documentation

Sufficient information and documentation are required to demonstrate that the request for the DD Waiver service is reasonable, necessary, and appropriate based on Clinical Criteria established by the DDS. The ISP is required for all service requests. Some service requests also require specific forms and documentation to be completed. If a specific document is not required, the IDT must identify the documents within the person's case record that justify the need for the service and the service amount. Any pertinent and concise supporting information and documentation is acceptable and will be considered. Documentation required for clinical justification is created during the planning process and should be available to the CM as soon as the DD Waiver services are identified, and no later than 14 calendar days after the ISP meeting. Examples of required clinical documentation as applicable:

1. Person - Centered Assessments (PCAs),
2. Provider reports including semi-annual reports,
3. IMLS or ANS Parameter Tool and Worksheet

Chapter 7: Available Services and Individual Budget Development

4. Nursing assessments including e-CHAT, ARST, and MAAT,
5. Behavior reports including PBSA presented at the annual IDT and PBSP, BCIP, PPMP, and RMP currently in place,
6. Therapy (OT, PT, SLP) assessments,
7. WDSI,
8. TSS,
9. Clinical notes,
10. Progress notes,
11. IDT meeting minutes,
12. Comprehensive Individual Assessment (CIA), and
13. LOC Abstracts.

7.3.2.3 Proposed Budget Levels and Suggested Dollar Amounts for Adults

Proposed Budget Levels (PBLs) are written descriptions of seven levels of support needs (See [Table 1 Proposed Budget Levels](#)). Linked to each PBL are Suggested Budget Amounts based on LCAs and typical service options. (See [Table 2 Suggested Dollar Amounts](#).) The PBL does not limit the request for services and does not require that the budget be developed within a set dollar or service amount. PBLs and Suggested Dollar Amounts may be subject to change based on legislative appropriations, policy decisions or other circumstances affecting rates and services. The process to identify a PBL and Suggested Dollar Amount is as follows:

1. The CM guides the IDT in person-centered thinking.
2. The IDT must first engage in PCP and ISP development and then engage in budget development.
3. The IDT makes determination of which PBL best describes the person based on history, assessments, and support needs.
4. The IDT uses both the PBL and Suggested Dollar Amounts to guide understanding of what a typical budget amount may look like.
5. The CM leads the IDT in ISP development. Visions are developed and Desired Outcomes are identified before identifying DD Waiver service types and service amounts to include on the individual budget.
6. The budget submitted by the CM must focus on the individual needs of the person.
7. The requested services and proposed budget are not in any way limited by the PBL.

7.4 Budget Submission Process

The CM is responsible for timely submission of the ISP, budget worksheet (BWS), and supporting documentation to the OR. To avoid any disruption or delays in approval of clinically justified services, all DD Waiver Provider Agencies on a BWS are responsible for working with the CM to assure accuracy and completeness of the submission. The process for adult and child budget submission includes the following steps:

Chapter 7: Available Services and Individual Budget Development

1. The CM leads the IDT in ISP development. Visions are developed, and Desired Outcomes are identified. Only afterwards are DD Waiver service types and amounts identified.
2. The CM develops the BWS with the person, their guardian, if applicable, and with the IDT adhering to the following principles:
 - a. The desires, needs, and expressed wishes of the person are at the center of the budget development process.
 - b. The budget development process is directed by the person, is person-centered and is not dictated by the CM or a DD Waiver Provider Agency.
3. At least 48 hours or two business days prior to the submission of a packet to the OR, CMs send the BWS via SComms to the IDT and Provider Agencies for review.
4. Within 48 hours or two business days of receiving the BWS, DD Waiver Provider Agencies on the budget must verify and confirm the accuracy of service codes and modifiers, units, and start dates which were agreed upon.
5. The CM submits the ISP, BWS, and any required and supporting documentation to the OR to determine clinical justification.
6. Submissions must be at least 45 full calendar days in advance of an ISP expiration or 30 calendar days in advance of a service revision. For 30 and 45-day timelines, the measure is made by date of the month (e.g., June 30 is 30 days prior to July 30).
 - b. An imminent review waives the submission deadlines under specified circumstances. The case manager works with the OR for non JCMs and with DDS Statewide Case Management Coordinator for JCMs and indicates the type of submission as: 3-day; 5-day; or Imminent Review-Crisis Supports.
 - c. Imminent Review are acceptable under the following criteria:
 - i. Significant life changes (i.e., change in living situation or change in medical condition),
 - ii. Newly identified Aspiration Risk without Clinicians on IDT to provide collaborative assessment or plan development,
 - iii. Risk of significant harm to self or others; loss or death of a significant person to the individual,
 - iv. A serious accident, illness, injury, or hospitalization,
 - v. Loss of a job or being at risk of losing a job;
 - vi. Sudden relocation,
 - vii. Situations where it has been determined that the individual is a victim of abuse, neglect, or exploitation,
 - viii. Criminal justice involvement (arrest, incarceration, release, etc.),
 - ix. Expedited allocation,
 - x. Risk of loss of services,
 - xi. Risk of provider crisis if PA not provided, or

Chapter 7: Available Services and Individual Budget Development

- xii. Other situations that warrant urgent changes to protect the best interest of the individual, including loss of services or being at risk of losing services.
8. Federal requirements do not allow waiver services to be provided if not in the person-centered plan. The CM is required to notify and collaborate with the appropriate Regional Office Case Management Coordinator when special circumstances arise that affected submissions prior to service start dates. Retroactive review will only be considered if request is made to the Regional Office CM Coordinator following all required protocol including but not limited to:
- a. Requests made no later than 90 calendar days from the planned start date of the service;
 - b. Submissions of documentation and required forms to support individual choice and planning was conducted prior to the service start date; and
 - c. Letter of Explanation from both the Case Management Agency and applicable provider agency on Agency letterhead containing: Name, DOB, reason for error, and what will be put in place to prevent a retroactive request in the future. Letters must be on agency letterhead, with director's signature.

Chapter 8: Case Management

8.1 General Definition and Intent of Case Management Services

Case Management services are person-centered and intended to support people to pursue their desired life outcomes while gaining independence and access to needed services and supports. The essential elements of Case Management include activities related to advocacy, assessment, planning, linking, and monitoring. DD Waiver CMs also play an important role in allocation, annual medical and financial recertification, record keeping, and budget approvals. CMs must maintain a current and thorough working knowledge of the DD Service Standards and community resources. In addition to paid supports, Case Management services also emphasize and promote the use of natural and generic supports to address a person's assessed needs.

8.2 Scope

DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services. In general, the CM's scope of practice is to:

1. promote self-advocacy and advocate on behalf of the person;
2. facilitate and monitor the allocation and annual recertification processes as well as transitions as described in [Chapter 9: Transitions](#);
3. participate in specific assessment activities related to annual LOC determination and PCP;
4. link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community;
5. organize and facilitate the PCP process and ISP development in accordance with the DD Waiver Service Standards as described in [Chapter 4: Person-Centered Planning](#) and [Chapter 6: Individual Service Plan \(ISP\)](#);
6. submit the ISP and the Waiver Budget Worksheet (BWS) and any other required documents to TPA Contractor(s), as outlined in [Chapter 7: Available Services and Individual Budget Development](#);
7. monitor the ISP implementation including service delivery, coordination of other supports, and health and safety assurances as described in the ISP; and
8. maintain a complete record for each person in services, as specified in [Chapter 20: Provider Documentation and Client Records](#) and [Appendix A Client File Matrix](#).

8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services

A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to:

1. Operating under the Employment First Principle and facilitating employment decisions based on informed choice by:

- a. verifying that people who express an interest in work or who have employment related desired outcome(s) in their ISP have a current PCA, a career development plan or a self-employment plan, or a community based situational assessment as needed;
 - b. updating the Work/Education/Volunteer section of the ISP and relevant Desired Outcomes and Action Plans;
 - c. monitoring to determine if related assessments are available to IDT members prior to any planning meetings; and
 - d. documenting Employment First in the ISP as described in [Chapter 6.6.3.4 Documenting Employment First in the ISP](#).
2. Address needs for Guardianship when indicated;
 3. Obtain assistance from the Regional Office Nurse, Bureau of Behavioral Services or Clinical Services Bureau for access to technical assistance and consultation when needed
 4. Monitoring to determine if reasonable accommodations are made including access to internet services to support assistive technology and remote personal supports.
 5. Using PCP which aids people to advocate for themselves, as needed and when appropriate.
 6. Notifying the DDSD Regional Office, through the RORA process, if supports are unavailable.
 7. Documenting through ISP meeting minutes, contact notes, or DDSD issued forms like DCP form that decisions made by the person and/or the guardian are based on the completion of required elements of informed choice as outlined in [Chapter 4.2 Informed Choice](#).
 8. Educating other healthcare and DD Waiver Provider Agencies in recognizing and respecting the needs, strengths, and goals of the person.
 9. Facilitating IDT meetings in a manner that promotes conflict free service and support coordination as described in [Chapter 4.5 Conflict-Free Service and Support Coordination](#).
 10. Ensuring that a discussion on individualized Meaningful Day activities occurs in the ISP meeting and is reflected in the ISP.
 11. Ensuring that a discussions of non-disability specific options and actions to increase self-determination occurs in the planning process, before development of the annual budget, and is documented in IDT meeting minutes, contact notes, or relevant DDSD issued forms and templates.
 12. Reviewing the HCBS Consumer Rights and Freedoms with the person and guardian as applicable, at least annually and in a form/format most understandable by the person. (See [Appendix C HCBS Consumer Rights and Freedoms](#).)

13. Confirming acknowledgement of the HCBS Consumer Rights and Freedoms with signatures of the person and guardian, if applicable.
14. Reviewing the ISP Addendum A at least annually to discuss: Individual Client Rights, Client Complaint Procedure, the Dispute Resolution Process, and ANE reporting, with the person and guardian as applicable and in a form/format most understandable by the person.
15. Confirming acknowledgement of the receipt Addendum A with signatures of the person and guardian, if applicable.
16. Support the person's, health care decision maker's or guardian's decisions related to Do not Resuscitate, Do not Intubate or other advanced directives.
17. Leading the SFOC process as described in [Chapter 4.4.2 Annual Review of SFOC](#) including specific responsibilities to:
 - a. obtain a current SFOC form that includes all qualified service Provider Agencies offering services in the applicable region;
 - b. present the SFOC form, for each service, to the person or authorized representative for selection of DD Waiver Provider Agencies;
 - c. review rights and responsibilities with the recipients and guardians at least annually;
 - d. review the person's right to change Provider Agencies and/or the types of services received at least annually;
 - e. contact the Provider Agency, within 5 business days, after a SFOC is signed; and
 - f. follow all requirements detailed in [Chapter 9: Transitions](#) for any changes to Provider Agencies or service types.

[8.2.2 Initial Allocation and Annual Recertification](#)

Although CMs are dependent on other DD Waiver Provider Agencies, upon people in services, and upon guardians to complete various activities, CMs have specific requirements to support and monitor a person's initial allocation and annual recertification. For Initial Allocations, the CM bills up to 20 hours (one time only) to facilitate the process for determining financial and medical eligibility within 90 calendar days of the date that the Case Management Provider Agency was selected. [Chapter 1.7 Medical and Financial Eligibility](#) lists the CM requirements for this process.

[8.2.3 Facilitating Level of Care \(LOC\) Determinations and Other Assessment Activities](#)

The CM ensures that an initial evaluation for the LOC is complete, and that all participants are reevaluated for a LOC at least annually. CMs are also responsible for completing assessments related to LOC determinations and for obtaining other assessments to inform the service planning process. The assessment tasks of the CM include, but are not limited to:

1. Completing, compiling, and/or obtaining the elements of the Long-Term Care Assessment Abstract packet to include:

- a. a Long-Term Care Assessment Abstract form (MAD 378);
 - b. Client Individual Assessment (CIA);
 - c. a current History and Physical;
 - d. a copy of the Allocation Letter (initial submission only); and
 - e. for children, a norm-referenced assessment.
2. Timely submission of a completed LOC packet for review and approval by the TPA contractor including:
- a. responding to the TPA contractor within specified timelines when the Long-Term Care Assessment Abstract packet is returned for corrections or additional information;
 - b. submitting complete packets, no later than 30 calendar days prior to the LOC expiration date for annual redeterminations;
 - c. seeking assistance from the DDS Regional Office related to any barriers to timely submission; and
 - d. facilitating re-admission to the DD Waiver for people who have been hospitalized or who have received care in another institutional setting for more than three calendar days (upon the third midnight), which includes collaborating with the MCO Care Coordinator to resolve any problems with coordinating a safe discharge.
3. Obtaining assessments from DD Waiver Provider Agencies within the specified required timelines.
4. Meeting with the person and guardian, prior to the ISP meeting, to review the current assessment information.
5. Leading the DCP as described in [Chapter 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process](#) to determine appropriate action.

[8.2.4 Linking](#)

CMs must be familiar with the available resources within the community of the person and to link people and families to resources that will assist in achievement of the person's vision. CM requirements include:

1. talking with the person about their wishes and preferences to create a foundation for providing advocacy on his or her behalf;
2. collaborating with the assigned MCO Care Coordinator to assure access to needed healthcare services, medications, medical equipment, and healthcare supplies;
3. communicating with the IDT, especially with the person, guardian, healthcare decision makers and family members as appropriate, to proactively plan for health outcomes and supports needed and desired by the person;

4. effectively using the Case Management agency's list of generic community resources for the person to:
 - a. assist IDT members in exploring publicly funded programs, community resources available to all citizens, and natural supports within the person's community; and
 - b. facilitate discussion of all paid and unpaid resources including options for supports from non-waiver-related programs and non-disability specific options.

8.2.5 Person-centered Planning and the ISP

The CM is responsible for leading the PCP process and ensuring the ISP addresses all the person's needs as determined by any assessments and personal goals, either through DD Waiver services or other means. The CM ensures the ISP is updated or revised at least annually or when warranted by changes in the person's needs and desires. Requirements include:

1. preparing for the annual ISP meeting and subsequent meetings to discuss revisions as described in [Chapter 6: Individual Service Plan \(ISP\)](#);
2. ensuring the ISP is developed through a PCP process in accordance with the rules governing ISP development [7.26.5 NMAC];
3. meeting with the person and guardian prior to the ISP meeting to review current assessment information, prepare for the meeting, create a plan to facilitate or co-facilitate the meeting if the person wishes, and to facilitate greater informed participation; during the meeting with the guardian it is important the CM ask the guardian to communicate any medical, behavioral or psychiatric information as part of an individual's routine medical or psychiatric care.
4. ensuring ongoing assessment and identification of the person's strengths, needs and preferences and sharing results with IDT members to guide plan development;
5. ensuring assessments are used and discussed to inform the planning process;
6. notifying all IDT members of the annual ISP meeting at least 21 calendar days before the meeting;
7. convening an annual meeting of IDT members that includes individuals chosen by the person in services and who have the best information regarding progress during the past year, and who know the individual best;
8. documenting participation of IDT members occurred through IDT meeting minutes, ISP signature pages, and or contact notes;
9. completing all requirements as described in [Chapter 9 Transitions](#) for people who change CM Provider Agencies, other service Provider Agencies, or who transfer between waivers; and
10. completing the [Chapter 6 DDS ISP Template](#) through the planning process in response to what the IDT members learn from and about the person and as described in [Chapter 6 Individual Service Plan \(ISP\)](#).

8.2.6 Development and Timely Submission of Budgets to the Appropriate Third Parties

CMs are responsible for completing or gathering all documents necessary to obtain an approved budget for DD waiver services. CMs are required to honor the timelines and the process related to individual budget development as outlined in [Chapter 7 Available Services and Individual Budget Development](#). CMs are required to:

1. use the appropriate forms and follow current instructions issued by DDS to submit an ISP and budget for approval;
2. complete required trainings on budget submission process as determined by DDS;
3. work with the respective DDS Regional Office for approval of a special review when a retroactive approval is needed;
4. provide a letter of justification for Regional Office approval of any special instructions and complete remediation activities required by the Regional Office if a pattern of untimely submissions is identified; and
5. register for and use the TPA required portals to submit LOC packets and budgets.

8.2.7 Monitoring and Evaluating Service Delivery

The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements:

1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit.
2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence.
3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received.
4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults (including JCMs) living in the community.
5. For non-JCMs, face-to-face visits must occur as follows:
 - a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS.
 - b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility.
 - c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service.

- d. The CM considers preferences of the person when scheduling face-to face-visits in advance.
 - e. Face-to-face visits may be unannounced depending on the purpose of the monitoring.
6. The CM must monitor at least quarterly:
 - a. that all applicable current HCPs (including applicable CARMP), MERPs, Health Passport, PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites.
 - b. The content of each plan is to be reviewed for accuracy and discrepancies.
 - c. that applicable MERPs and/or BCIPs are in place in the residence and at the day services location(s) for those who have chronic medical condition(s) with potential for life threatening complications, or for individuals with behavioral challenge(s) that pose a potential for harm to themselves or others. MERP's are determined by the e-chat and the BCIPs are determined by the critical behavioral needs as assessed by the BSC in collaboration with the IDT.
 - d. a printed copy of Current Health Passport is required to be at all service delivery sites.
7. When risk of significant harm is identified, the CM follows the standards outlined in [Chapter 18 Incident Management System](#).
8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in [Chapter 18 Incident Management System](#).
9. If there are concerns regarding the health or safety of the person during monitoring or assessment activities, the CM immediately notifies appropriate supervisory personnel within the DD Waiver Provider Agency and documents the concern. In situations where the concern is not urgent, the DD Waiver Provider Agency is allowed up to 15 business days to remediate or develop an acceptable plan of remediation.
10. If the CMs reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed upon period of time, the CM shall use the RORA process detailed in [Chapter 19 Provider Reporting Requirements](#).
11. The CM conducts an online review in the Therap system to ensure that the e-CHAT and *Health Passport* are current: quarterly and after each hospitalization or major health event.
12. The CM must use all available data sources to monitor for trends and issues and to determine appropriate follow up action, including prior monthly site visit forms, IQR Findings , annual QMB Surveys, GER in Therap, DDS quality assurance (QA) activities including ISP QA, and any other data provided by DOH.

13. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal monthly in preparation for site visits. The CM uses the information to have informed discussions with the person/guardian about high or low utilization and to follow up with any action that may be needed to assure services are provided as outlined in the ISP with respect to: quantity, frequency and duration. Follow up action may include, but not be limited to:
 - a. documenting extraordinary circumstances;
 - b. convening the IDT to submit a revision to the ISP and budget as necessary;
 - c. working with the provider to align service provision with ISP and using the RORA process if there is no resolution from the provider; and
 - d. reviewing the SFOC process with the person and guardian, if applicable.
14. The CM will ensure Living Supports, CIHS, CCS, and CIE are delivered in accordance with CMS Setting Requirements described in [Chapter 2.1 CMS Final Rule: Home and Community-Based Services \(HCBS\) Settings Requirements](#). If additional support is needed, the CM notifies the DDS Regional Office through the RORA process.
15. Case Management site visit must be documented in the DDS published case note template in Therap and must be complete and submitted in Therap by the last day of the month in which the visit was completed.

8.2.8 Maintaining a Complete Client Record

The CM is required to maintain documentation for each person supported according to the following requirements:

1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable.
2. CMs will provide complete copies of the ISP to the respective DDS Regional Offices 14 calendar days prior to the start of the new ISP.
3. The case file must contain the documents identified in [Appendix A: Client File Matrix](#).
4. All pages of the documents must include the person's name and the date the document was prepared.

8.3 Agency Requirements

Case Management Provider Agencies shall establish and maintain separate financial reporting and accounting activities that are in accordance with state requirements. Case Management Provider Agencies shall have an established automated data system for financial and program reporting purposes.

8.3.1 CM Qualifications and Training Requirements

1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency and ongoing annual training as specified in the [Chapter 17 Training Requirements](#).
2. Case Management Provider Agencies must have professional development requirements in place to assure that all CMs engage in continuing education, DDSD trainings, professional skill building activities, and remediate any performance issues.
3. Case Management Provider Agencies and their staff/sub-contractors must adhere to all requirements communicated to them by DDSD, including participation in the Therap system, attendance at mandatory meetings and trainings, and participation in technical assistance sessions.
4. Case Management Provider Agencies and their staff/subcontractors must adhere to all training requirements to use secure and web-based systems to transfer information as required by the TPA. (This includes the TPA Web Portal and Secure CISCO system).
5. The CM Code of Ethics must be followed by all CMs employed by or subcontracting with the agency and supporting documentation must be placed in CM personnel files.
6. CMs, whether subcontracting or employed by a Provider Agency, shall meet the following requirements, and possess the following qualifications:
 - a. be a licensed social worker, as defined by the NM Board of Social Work Examiners; or
 - b. be a licensed registered nurse as defined by the NM Board of Nursing; or
 - c. have a Bachelor's or Master's degree in social work, psychology, counseling, nursing, special education, or closely related field; and
 - d. have one-year clinical experience, related to the target population, working in any of the following settings:
 - i. home health or community health program,
 - ii. hospital,
 - iii. private practice,
 - iv. publicly funded institution or long-term care program,
 - v. mental health program,
 - vi. community based social service program, or
 - vii. other programs addressing the needs of special populations, e.g., school.
 - e. or have a minimum of 6 years of direct experience related to the delivery of social services to people with disabilities.
7. CMs, whether subcontracting or employed by a Provider Agency, shall have a working knowledge of the health and social resources available within a region.
8. Case Management Provider Agencies must convey all information received from DDSD and relevant to service delivery to their employees/subcontractors in a timely manner.

9. Case Management Provider Agency Directors are required to participate in quarterly face-to-face Statewide Case Management Meetings. Exceptions to this requirement, such as coverage by another staff member or supervisor, may be granted by the DDSD Statewide Case Management Coordinator based on circumstances and individual needs.

8.3.2 Programmatic Requirements

1. Case Management Provider Agencies shall have an established system for tracking key steps and timelines in establishing medical eligibility, monitoring financial eligibility, service planning, budget approval and distribution of records to IDT Members.
2. Case Management Agencies shall maintain at least one office. This office is also required to maintain the following for business operations:
 - a. a 24-hour local telephone answering system, which indicates regular office hours and expected response time by the end of the following business day or within 48 hours in routine, non-critical situations;
 - b. confidential voicemail indicating the expected response time in accordance with these standards when CMs use their home office or cell number as primary contact for the individuals on their caseload;
 - c. an operational fax machine or electronic fax system that complies with HIPAA;
 - d. internet and e-mail access, including use of secure e-mail systems for every CM employed or subcontracted.
 - e. storage of records for each person supported by the Provider Agency consistent with [Chapter 20 Provider Documentation and Client Records](#);
 - f. a meeting room that can accommodate IDT meetings comfortably;
 - g. an area where a CM is able meet privately; and
 - h. a separate physical space and entrance when the office is connected to a residence.
 - i. Meets ADA accessibility requirements
 - j. CM Agency is responsible for ensuring a private location in each Region that does not have an office. This private location must meet ADA accessibility requirements and can be used for private meetings.

8.3.3 Conflict of Interest

Case Management Agencies are required to mitigate real or perceived conflict of interest issues by adhering to, at minimum, the requirements described in [Chapter 16.6 Conflict of Interest](#). CMs are agents responsible for the development of the ISP and as such must also adhere to the following:

1. Case Management Agency owners and their employed or contracted CMs must not:

- a. Be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported. Following formal authorization from DDS, a CM may provide Family Living services or respite to their own family member.
 - b. Have material financial interest in any entity that is paid to provide DD Waiver or Mi Via services on the secondary freedom of choice or in the person-centered plan. A material financial interest is defined as anyone who has, directly or indirectly, any actual or potential ownership, investment, or compensation arrangement.
 - c. Make financial or health related decisions for people on their caseload.
 - d. Be related by blood or affinity to any DD Waiver service provider for individuals on their caseload. Provider Agencies are identified as Provider Agencies of LCAs, Community Inclusion services, Mi Via consultants, Mi Via vendors, BSC's and therapists.
2. A Case Management Provider Agency may not be a Provider Agency for any other DD Waiver service.
 3. A Case Management Provider Agency must disclose to, both DDS and to people supported by their agency, any familial relationships between the agency's employees/subcontracting CMs and employees or subcontractors of Provider Agencies of other DD Waiver services.
 4. A CM or Director of a Case Management Provider Agency may not serve on the Board of Directors of any DD (HCBS) Waiver Provider Agency.
 5. Case Management Provider Agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.
 6. A Case Management Provider Agency may not provide guardianship services to an individual receiving case management services from that same agency. A CM will not provide training to staff of DD Waiver Provider Agencies except when:
 - a. They are certified to deliver the course by the DDS Training Unit.
 - b. They offer training as an open session to staff from multiple agencies through the <http://trainnewmexico.com/>, paid on a fee per participant basis.
 - c. They are not paid via exclusive arrangements with specific Provider Agencies.
 - d. They are providing IST on a topic that:
 - i. they are qualified to train;
 - ii. is related to a person on their caseload;
 - iii. is part of their case management duties; and
 - iv. that is not reimbursed to the CM under separate payment from the Provider Agency (e.g., review of individual preferences or other aspects of the ISP).

8.3.4 Caseload Levels

The Case Management Provider Agency shall hire and retain sufficient CMs to adequately provide service to the agency's DD Waiver client population. Caseload assignments by the agency must adhere to the following requirements:

1. The Case Management Provider Agency shall assign caseloads in such a way as to assure adequate coverage for each person in services, using an average of 30 DD Waiver cases per CM across the agency.
2. CM Caseload is not to exceed more than 50 individuals across DD Waiver, Supports Waiver, Medically Fragile, and Mi Via-
3. Caseloads with children may be weighted proportionally, based upon the number of months of service provided per year (e.g., 4 months of Case Management service = $\frac{1}{3}$ case; 6 months of Case Management service = $\frac{1}{2}$ case).
4. The Case Management Provider Agency must ensure a colleague or supervisor performs essential duties during the CM's absence, including mandated face-to-face visits.
5. The Case Management Agency must provide ongoing supervision and mentoring which includes regular evaluations of caseload levels and of each CM's ability to meet service requirements within the assigned caseload level.

Chapter 9: Transitions

Individuals may choose to change services, provider agencies, waiver programs, or even withdraw altogether from waiver services. Although a resumption of services may ultimately occur, individuals may also be discharged, have services suspended, or be terminated from the DD Waiver under various circumstances. In any of these circumstances, appropriate planning must occur, and information must be provided to facilitate a smooth transition and informed choices. The CM plays a critical role in all types of transitions.

9.1 Change in Case Management Agency

If a person or guardian selects a different case management agency, the following steps must be taken to ensure that critical issues affecting the person's health and safety do not get lost and a complete exchange of information and documentation occurs.

1. The person or guardian has the responsibility to contact their local DDS Regional Office to complete the CM Agency Change form selecting the new Case Management Agency.
2. When the new Case Management Agency and DDS receive the CM Agency Change form, file transfers must be completed within 30 days.
3. The transferring Case Management Agency contacts the receiving Case Management Agency to schedule a transition meeting.
4. The transferring Case Management Agency must also inform the DDS Regional Office(s) of the date and time of the transition meeting. This ensures that the Regional Office(s) are aware of the change and can be available to provide technical assistance as needed.
5. The person and/or guardian should be notified in writing of the date and time of the meeting and should be encouraged to attend, if possible.
6. The transition meeting should occur in person between the two case management agencies, but, if necessary, can be held via teleconference.
7. A DDS Regional Office staff may be requested to attend the transition meeting.
8. The transferring Case Management Agency:
 - a. makes the provider changes on the BWS and ISP;
 - b. submits a revision budget with the end date for their agency and a start date for the receiving agency using the current submission process (e.g., to CORE for non-JCM, TPA for Jackson Class members).
 - c. revises and submits any budgets starting within 30 calendar days of the transition.
9. The receiving Case Management Agency completes a CIU form, as applicable and described in [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#)
10. In situations when the LOC or the ISP is in the process of approval, the transferring Case Management Agency is responsible for completing the process and providing a copy of the approved LOC and/or ISP to the receiving Case Management Agency.

11. If there are issues preventing a smooth transfer, the receiving Case Management Agency has the authority to refuse the file, reject the transfer date, and/or request another transition meeting be convened. The receiving Case Management Agency also contacts its DDSD Regional Office to assist in coordinating a transition meeting.

9.2 Changes in Service Provider Agencies

When a CM is notified that an individual or guardian wishes to change Provider Agencies, the CM should inquire about the reason for the request and attempt to resolve any issues or concerns with the person and/or guardian and the Provider Agency prior to a change. If issues cannot be resolved or the person or guardian simply wish to access the SFOC, transition activities are initiated. The transition requirements are as follows:

1. The CM provides the person or guardian, when applicable, with SFOC forms when a desire to change one or more of the existing Provider Agencies is expressed.
2. The CM provides information about the different Provider Agencies so that the person and guardian, when applicable, can make an informed choice.
3. Once the SFOC form(s) are signed by the person or guardian and returned to the CM, the CM is responsible for:
 - a. notifying affected agencies, (by providing the current and the new agency selected, a copy of the signed SFOC);
 - b. scheduling a transition meeting with the person and guardian when applicable, the current Provider Agency, the new Provider Agency (including nursing and financial representatives), therapy providers, and BSC provider etc. within two weeks of the completion of the SFOC form(s); and
 - c. facilitating the transition meeting, which should occur in person, but, if necessary, can occur via teleconference.
4. The current Provider Agency is responsible for continuing the person's services and supports (that include health and safety) until the transition to the new Provider Agency is complete.
5. If therapists or other team members are not present for the transition meeting, the CM should ensure that they are made aware of the change in Provider Agencies and the transition dates.
6. Prior to the transition date, the CM is responsible for completing and submitting a budget revision as described in [Chapter 7 Available Services and Individual Budget Development](#).
7. The CM completes a CIU form, as applicable and described in [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#)
8. The CM makes the provider changes in Therap, if applicable, and as described in [Chapter 9.11.1 Sharing Records in Therap](#) .

9.3 Out of Home Placement

OOHP is defined as the following:

- a. acute hospital admission for medical or mental health needs;
- b. admission to nursing home, rehabilitation center or sub-acute hospital; or
- c. admission to jail/detention center.

When a person has OOHP the following are required:

1. Provider Agencies must notify case manager immediately of any hospital admission or out of home placement.
2. Provider Agencies must speak with guardian to ensure any medical, behavioral, or psychiatric information is provided to the OOHP upon admission as part of an individual's routine medical or psychiatric care;
3. Provider Agencies must ensure that information on mobility, comfort, safety, and sensory items and/or any durable medical equipment is current in the Individual Data Form (IDF, the e-CHAT, and medication history and document this according to [Appendix B GER Requirements](#)
4. Living Supports Provider Agencies must communicate the need for existing Assistive Technology (AT inventory), adaptive equipment and supports to the out-of-home provider or placement and offer the person's existing AT devices to the out-of-home provider or placement.
5. Upon discharge and to ensure a safe and smooth transition back to the person's home, the Living Supports Provider Agency must check with the guardian as well as the OOHP and promptly update the IDF, *Medical Information Section Adaptive Equipment* portion or other relevant healthcare records to include the healthcare and adaptive supports that the person received from the out-of-home provider.

9.4 Withdrawal from DD Waiver

If a person withdraws from the DD Waiver, the CM must inform the person and guardian, when applicable, of the consequences.

When a person and/or guardian withdraws from DD Waiver services, either by the display of their behavior or by stating the desire to withdraw, the CM is required to:

1. Contact the person and guardian, when applicable, to discuss the issues and the unwillingness of the person to accept services.
2. Document that the person and guardian, when applicable, made an informed decision to discontinue DD Waiver services and that the following was discussed:
 - a. how the person's action(s) will affect their DD Waiver status;
 - b. the length of the waiting list should the person re-apply for the DD Waiver; and

- c. acknowledgement that the person and guardian, when applicable, understands the consequences of their actions.
3. Provide the person and guardian, when applicable, with a copy of the above documentation that includes their signature.
4. Provide the person and guardian, when applicable, with the following specific information about waiver eligibility when a move out of state occurs:
 - a. The waiver is not reciprocal from state to state.
 - b. The person's status on the DD Waiver is only active for 60 days from the date they withdraw.
5. Provide referral or contact information, if possible, for the departments that administer the comparable HCBS waivers in the new state.
6. Notify the Provider Agencies of record and ISD of the recommendation for withdrawal from the DD Waiver services. (It is the responsibility of ISD to formalize the closure of the case.)
7. Complete a CIU form, as applicable and described in [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#)
8. As standard of practice budget needs to be closed out based on budget submission process.

9.5 Discharge from Services

If a Provider Agency identifies a person who is at risk of being discharged or requests a discharge from a DD Waiver service, the Provider Agency must notify the local DDSD Regional Office. The following requirements must be met to ensure safe discharge:

1. The Provider Agency must provide the DDSD Regional Office with 30 (calendar) day written notice of their intent to discharge the person. The notice must:
 - a. state why the Provider Agency can no longer ensure the person's health and safety; and
 - b. include the efforts made to ensure health and safety.
2. The local DDSD Regional Office approves or denies the discharge request made by the Provider Agency.
3. If the discharge request is approved, the Provider agency must send a written 30 (calendar) day notice of discharge to the individual and guardian stating the reason for the discharge.
4. A transition meeting must be scheduled by the CM and completed as described in [Chapter 9.10 Transition Meeting](#), unless precluded by circumstances posing a danger to the health, safety, or welfare of the person and/or others prior to discharge.

5. When alternative arrangements are made prior to completing a transition planning meeting because of the immediate needs of the person in crisis, the transition planning meeting must still occur after the resolution of the crisis.
6. Every effort shall be made to transition the person into a setting that meets their choice and needs.
7. A written transition plan is developed to meet the identified needs. This may include arrangements for the person and guardian, when applicable, to visit alternative settings and plan for assistance with a move.
8. Provider Agencies will not discharge a person until transition activities (as listed in this chapter) occur and all avenues have been pursued to keep the person in the current services. Transitions should take place at the first of the month, whenever possible.

9.6 Suspension of Services

Suspension of services is a temporary interruption of authorized waiver services, for a period not to exceed 90 consecutive days. If the person is suspended from services, the suspension relates to all DD Waiver services. If a Provider Agency identifies a person who is at risk of being suspended from services or requests a suspension from a DD Waiver service, the Provider Agency must notify the DDS Regional Office, the individual's guardian, and the Case Manager. The following requirements must be met to ensure that a suspension of services is appropriate:

1. The Provider Agency must provide the DDS Regional Office and CM with written notice of their intent to suspend the person. The notice must:
 - a. State why the Provider Agency is considering suspension,
 - b. The cause for the suspension,
 - c. The length of time for the suspension, and
 - d. Efforts made to avoid suspension.
2. Causes for a suspension may include, but are not limited to:
 - a. The health and welfare of the person is jeopardized or cannot be assured, e.g., a person who abuses substances and refuses to accept treatment or Improvement or deterioration in the health or functional status of the person results in they no longer meeting medical LOC.
 - b. The person no longer meets financial eligibility requirements.
 - c. The person/guardian is repeatedly non-compliant with Addendum A of the ISP, Client Rights and Responsibilities.
 - d. The person is institutionalized for short or long-term care in a hospital, nursing facility, rehabilitation center, or law enforcement/corrections facility.
 - e. The person takes a leave of absence for a vacation (in or out of state) exceeding 90 consecutive days.

In the event of a suspension of services, the CM is responsible for:

1. providing information to the person should the person care to appeal the decision;
2. notifying the Provider Agencies of any interruption of services by phone, immediately (within one business day);
3. notifying the DDSD Regional Office within five working days of the suspension; and
4. notifying ISD office immediately (within one working day) about the recommendation for suspension of services and the specific reason for the recommendation. This can be initiated by phone with the identified ISD worker (no messages) and followed by completion of a CIU form as described in [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#).

9.7 Termination from DD Waiver

If a person is terminated from waiver services, the CM is responsible for providing information and support should the person decide to appeal the decision. The following requirements apply to terminations from the DD Waiver:

1. An individual may be terminated from services through the DD Waiver under the following circumstances:
 - a. Any of the circumstances listed under the Suspension of Services that last 90 consecutive days or more.
 - b. The person has died.
 - c. The person has not received an authorized service longer than 90 consecutive days.
 - d. The whereabouts of the person is unknown after 90 consecutive days.
 - e. The person becomes financially ineligible.
 - f. The person becomes medically ineligible.
 - g. The health and safety of the person is jeopardized or cannot be assured.
 - h. There is documentation of the person/guardian's repeated violations of Addendum A of the ISP: Client Rights and Responsibilities.
 - i. There are documented instances of verbal, physical, sexual, or psychological abuse of service provider employees and/or DDSD employees by the person and/or the person's family, representative or primary caregiver.
2. Termination from services follows the procedures below:
 - a. The CM initiates termination of services only after DDSD is contacted.
 - b. The person's IDT meets to try to resolve issues and attempt to prevent termination of services, if possible.
 - c. When termination of services is finalized, the CM notifies the following entities, in writing, within five working days:

- i. DDS;D;
 - ii. the local ISD office by completion of a CIU form as described in [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#);
 - iii. the TPA (i.e., the Medicaid TPA and OR).
- d. Once termination of services has been finalized, the person's file may be archived by the CM, but must be made available to DOH upon request.

9.8 Resumption of Services

When a person who was previously determined eligible for and participated in the DD Waiver program has their case closed in accordance with HSD rules due to the person's inpatient hospitalization, other clinical treatment, or incarceration that extended past 90 consecutive days, the person may return to the DD Waiver program upon completion of such treatment. This is resumption of services, in which the person utilizes the same unduplicated waiver allocation. A resumption of services must be approved by the Division Director or their designee. DD Waiver Provider Agencies may not assume the approval of a resumption of services and must work with DDS;D Regional Office related to individual circumstances.

9.9 Waiver Transfers

A DD Waiver participant and/or legal representative may choose to transfer to or from another waiver program by contacting the DDS;D to initiate a waiver change. If a person wants to switch waivers within the first 30 calendar days of allocation, and no medical or financial eligibility has begun, the transfer is permitted. Waiver transfers are not allowed when the expiration of the person's LOC is within 90 calendar days or less. If the participant has already begun the eligibility or annual recertification process, the person must meet medical and financial eligibility before they may request a transfer. Waiver transfers require the following steps:

1. A Waiver Change Form (WCF) is completed by the person and/or legal representative and returned to the local DDS;D Regional Office.
2. Once DDS;D staff receive the WCF, it is forwarded by DDS;D staff to the current DD Waiver CM, Medically Fragile CM, and Mi Via Consultant as relevant.
3. Transfers between waivers should occur within 90 calendar days of receipt of the WCF unless there are circumstances related to the person's services that require more time.
4. Transition meetings must occur within at least 30 calendar days of receipt of the WCF. The receiving agency must schedule the meeting within five days of receipt of the WCF.
5. The transition meeting must occur, either by phone or in person, and is required to include the person or their legal representative, as well as the Mi Via Consultant or Medically Fragile Case Manager and DD Waiver CM who attend in person.

Transition Meeting

The transition meeting is required for all scenarios described in this chapter. The transition meeting must include the discussion and sharing of critical clinical issues that need immediate follow up as well as historical information regarding the person. It is important for provider

agencies to communicate with guardians to share with the Interdisciplinary Team Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. The CM is required to complete the DDSD Individual Transition Plan (ITP) and to distribute it to IDT members within five days of the transition meeting. The need for cross-training should be identified during the transition meeting.

The information in the ITP must include, but is not limited to:

1. documentation regarding the discussion of the current ISP;
2. the LCA, including staffing levels, staffing requirements, substitute care needs, IST needs, environmental modification, assistive technology, and adaptive equipment needs;
3. a list of personal belongings and how the personal belongings will be transferred;
4. the representative payee and banking or financial issues;
5. safety concerns;
6. leisure, social, or generic community service needs and preferences;
7. communication preferences;
8. diagnosis, medical issues;
9. medication lists;
10. current physician orders and prescriptions for medication;
11. medical or health services;
12. HCPs and any other Waiver related plans;
13. Community Inclusion and employment services and needs;
14. nursing and nutritional needs;
15. therapy needs;
16. psychological or behavioral health needs;
17. decision consultation or team justification documentations
18. dates of the LOC and the ISP term to include documentation regarding the discussion of the medical and financial eligibility expiration dates (Category of Eligibility)
19. any budget revisions in process;
20. any Court Order appointing guardianship and the parameters of authority for the guardian when applicable;
21. the person's Medicaid/Medicare identified MCO;
22. problems identified by the transferring agency that the receiving agency should be aware of; and
23. the agreed upon date of transfer and any proration of units needed.

9.10 Transfer of Documentation

The extent of documents to be transferred depends on the contents of the individual record. The following is an example of what type of documentation should be transferred to the new Provider Agency if applicable to the person:

1. medical documentation (e.g., primary care practitioner/specialist reports that may impact the ISP or LOC, CARMP, MERPs, HCPs, nursing care plans), as applicable and available;
2. evaluations, assessments, and plans (e.g., therapy, vocational, behavioral, and sexual, for example, preliminary risk screening reports);
3. a current Individual Education Plan, Division of Vocational Rehabilitation (DVR) Plan
4. a schedule of appointments;
5. guardianship orders and power of attorney (POA) paperwork;
6. DNR, DNI or Advanced Directives
7. one full year of case notes (narratives) and monthly site visit forms for Case Management transfers;
8. at least six months to a year of documentation from a transferring Provider Agency, including monthly, quarterly reports or semi-annual reports, nursing and/or medical reports, financial records, and any other documents identified during the transition meeting;
9. the Social Security Card, Medicaid and or Medicare card, Birth Certificate, Certificate of Indian Blood, and ID Card;
10. the ISP, ISP revisions, and associated plans;
11. IDT meeting minutes and correspondence;
12. Transdisciplinary Evaluation and Support Clinic (TEASC) Evaluations;
13. Psychosexual Evaluations;
14. Vocational assessments and Person-Centered Assessments, or results of any personal planning sessions facilitated with the individual within the past three years;
15. Career Development Plans;
16. Allocation letter; and
17. Any other pertinent information.

9.10.1 Sharing Records in Therap

When applicable, records in Therap must be shared prior to Provider Agency transfers. Requirements for sharing records in Therap are:

1. The CM shares the current Individual Data Form (IDF) with the new Provider Agency.
2. The receiving Provider Agency accepts a referral from the CM to access the electronic record following the Therap referral procedures.

3. The discharging Provider Agency provides a complete medical record for the past year, including any paper documents (via hard copy or fax) and documents contained in Therap via SComm. The record must be delivered prior to the transition meeting.
4. The person may not be discharged and transferred to the new Provider Agency until the record transfer is complete.

9.10.2 Letter of Transfer and Receipt

When a person changes Waivers or Case Management Agencies, the transferring Case Management agency retains their original documents. Copies are sent to the receiving Case Management or consultant agency. Representatives of both agencies must sign a Letter of Transfer and Receipt for the records transfer. The record and Letter of Transfer and Receipt must be made available to the DDSD upon request. The Letter of Transfer and Receipt must document:

1. the effective date of the transition;
2. the documents that are transferred;
3. any missing documents; and
4. issues that need immediate follow-up.

Section II DD Waiver Services

Chapter 10: Living Care Arrangements (LCA)

10.1 Introduction

Living Care Arrangements (LCA) are available to adults 18 and older and are based on individual preferences, needs, and clinical justification for the requested service. Five models of LCAs are available. There are two types of Customized In-Home Supports and three types of Living Supports as described below:

1. Customized In-Home Supports (Independent Living) is living in one's own home with some assistance at home and in the community. The amount of support needed is individualized, intermittent, and varies.
2. Customized In-Home Supports (Family/Friends) is living with family or friends with some assistance at home and in the community. The amount of support needed is individualized, intermittent, and varies.
3. Living Supports - Family Living is living with family or with a host family which provides coverage and direct support up to 24 hours a day, 7 days a week.
4. Living Supports - Supported Living is living with others in a home where an agency provides staff coverage, direct support, some nursing care, and nutritional counseling as needed for up to 24 hours a day, 7 days a week.
5. Living Supports - Intensive Medical Living Services (IMLS) is living with others in a home where an agency provides staff coverage 24 hours a day, 7 days a week with daily nursing care and visits, weekly RN visits, and nutritional counseling.

10.2 Settings Requirements in LCAs

All people have the right to choose where they live. Provider Agencies must facilitate individual choice and ensure that any LCA is chosen by the person and is integrated in and supports full access to the community. People should be given choices among all living options, including non-disability specific settings, such as personal homes, apartments or other rental options and shared living situations with non-disabled people. Provider Agencies should ensure people have opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS services. Provider Agencies must work to ensure the LCA meets CMS setting requirements and does not have the effect of isolating people from the broader community, especially if the service or setting is intended for group home living. This includes ensuring:

1. People are informed of their rights at least annually.
2. People are supported to learn and exercise their rights.
3. Each person has a lease or other legally enforceable agreement.
4. People are provided advance information about all costs including room and board, if paid to the provider.

5. People retain the right to have utilities/phone in their own names.
6. Individual needs and preferences are respected regarding housemates.
7. People choose how to decorate their room and residence based on their own personal preferences, within the lease or other agreement.
8. People have their own bed and the right to share a bedroom.
9. People have the right to own personal property.
10. People have the right to pursue adult relationships, both intimate and platonic.
11. People have the right to privacy in the home i.e., Units have lockable entrance doors, with the person and appropriate staff having keys to doors as needed.
12. Toilets, tubs/showers provide for privacy and are designed or adapted for the safe provision of personal care.
13. People have privacy in bedrooms with ability to lock bedroom doors, with the person and appropriate staff having keys to doors as needed .
14. People have free use of all common space in their residence, while respecting other's privacy, personal possessions, and individual interests.
15. People have general control over when, if, and to where they move, unless precluded by a situation which presents an immediate risk to the person or others in the home.
16. People have the right to assume risk. (Dignity of Risk is balanced with the person's ability to assume responsibility for that risk and a reasonable assurance of health and safety.)
17. People have access to food at any time or with an HRC review when food has a potential to be a danger.
18. People have freedom and support to control their schedules and activities.
19. People may have visitors at any time they choose.
20. The setting is physically accessible to the person.
21. People have access to internet services to support their technology needs.

10.3 Living Supports (Family Living, Supported Living and Intensive Medical Living Services)

Living Supports are intended for people 18 years of age and older who need residential habilitation to assure their health and safety. There are three models of service included within Living Supports:

1. Supported Living,
2. Family Living, and
3. Intensive Medical Living Services (IMLS).

10.3.1 Coverage

All of the models of service in Living Supports (Supported Living, Family Living, and IMLS) must be available 24 hours per day, 365 days a year. The time when a person is employed, at school, visiting family, utilizing other natural supports as identified in the ISP or participating in Customized Community Supports (CCS) or Community Integrated Employment (CIE) is excluded. CCS and CIE services are not intended to supplant the responsibility of Living Supports.

Twenty-four (24) hour care must be provided when non-routine changes to a person's daily schedule are required such as:

1. during illness, or recovery from illness, accidents, or hospitalizations;
2. in the event of emergencies, natural disasters, and/or a pandemic;
3. if the person works or accesses CCS during non-traditional hours (e.g., outside of weekdays from 9 am to 3 pm or 5pm);
4. on weekends and holidays; and
5. when the person chooses to stay home.

10.3.2 Supporting Technology

Agencies must have a plan to support the technology needs of an individual. The plan must include the following: include:

1. Technology is used to facilitate the DSP's role in ensuring health, well-being and privacy of the people supported.
2. DSP support individuals to learn and use their own or the agency's technology as part of natural supports rather than as an extra paid support.
3. The agency builds fair and equitable cost sharing for Wi-Fi/ internet services into rental and utility agreements.
4. The agency supports telehealth, remote monitoring, and/ or family/friend contact on various platforms or by using various devices. Remote personal support is provided according to a person's ISP and choice.
5. The agency supports access to, and increased use of technology devices as specified in a person's ISP.
6. Support is provided in the event of a system problem such as loss of electricity or connectivity;

7. Technology support is provided to ensure that:
 - a. technology and technology devices are maintained to operate in good working condition; and
 - b. DSP have access to training and/or technical assistance to use the technology, data, and internet needed to support people with telephonic/telehealth consultation.
 - c. Accessibility to technology supports and devices from product/internet services and/or provider agency internal IT supports.

10.3.3 Nursing and Nutritional Supports

Annual nursing assessments are required for all people receiving any of the Living Supports (Supported Living, Family Living, IMLS). Nursing assessments are required to determine the appropriate level of nursing and other supports needed within the Living Supports.

Funding for nursing services is already bundled into the Supported Living and IMLS reimbursement rates. In Family Living, nursing supports must be accessed separately by requesting units for Adult Nursing Services (ANS) on the budget.

A supported living, family living, and intensive medical living provider agency must employ or subcontract with:

1. at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals.
2. at least one licensed RN; employ or subcontract with at least one additional nurse for on call services, and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

For nutrition the IDT must have a discussion annually at the person's ISP meeting, and thereafter as needed, about the person's clinical needs for a nutritional assessment. Nutritional counseling may be part of a person's array of supports bundled in LS or Family Living if recommended by the IDT and clinically needed. Additionally, nutritional counseling must be part of a person's array of supports whenever any of the following health conditions are present or newly emerge: enteral (G or J tube) feedings; weight issues (underweight, overweight, unplanned weight loss or gain); risk or presence of skin breakdown or wounds; moderate or high risk for aspiration; metabolic or endocrine disorders or other complex medical or nutritional needs including heart, kidney, liver, Crohn's or Celiac Disease, or complex allergies.

After the Registered Dietician or Licensed Nutritionist completes the assessment and identifies any needed services, the IDT will decide whether to continue with Nutritional Counseling services.

10.3.4 Nursing Staffing and On-call Nursing

A Registered Nurse (RN) licensed by the State of New Mexico must be an employee or a sub-contractor of Provider Agencies of Living Supports. An LPN may not provide service without an RN supervisor. The RN must provide face-to-face supervision of LPNs, CNAs and DSP who have been delegated nursing tasks as required by the New Mexico Nurse Practice Act and these service standards. Living Supports Provider Agencies must assure on-call nursing coverage according to requirements detailed in [Chapter 13.2.4 Nursing Monitoring and Oversight Requirements](#) and [Chapter 13.2.6 On-Call Nursing](#).

10.3.5 Medication Assessment and Delivery

Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD AWMD training;
2. the nursing and DSP functions identified in the [Chapter 13.3 Adult Nursing Services](#);
3. all Board of Pharmacy regulations as noted in [Chapter 16.5 Board of Pharmacy](#); and
4. documentation requirements in a Medication Administration Record (MAR) as described in [Chapter 20.6 Medication Administration Record \(MAR\)](#).

10.3.6 Accounting for Individual Funds

Costs for room and board are the responsibility of the person receiving the service and are not funded by the DD Waiver program. Living Supports Provider Agencies must adhere to the following:

1. The Living Supports Provider Agency must produce a monthly accounting of all personal funds managed or used by the agency.
2. A copy of documentation must be provided to the person and or his or her guardian and the DOH upon request.
3. When room and board costs are paid from the person's SSI payment to a Living Supports Provider Agency, the amount charged for room and board must allow the person to retain 20% of their SSI payment each month for personal use.
4. A written agreement must be in place between the person and the Provider Agency that addresses the reasonable amount of discretionary spending money described in 3.

10.3.7 Requirements for Each Residence

Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:

1. has basic utilities, i.e., gas, power, water, telephone, and internet access;
2. supports telehealth, and/ or family/friend contact on various platforms or using various devices;
3. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;

4. has a general-purpose first aid kit;
5. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;
6. has water temperature that does not exceed a safe temperature (110⁰ F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.
7. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP;
8. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;
9. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;
10. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;
11. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed;
12. has the phone number for poison control within line of site of the telephone;
13. has general household appliances, and kitchen and dining utensils;
14. has proper food storage and cleaning supplies;
15. has adequate food for three meals a day and individual preferences; and
16. has at least two bathrooms for residences with more than two residents.
17. Training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation.
18. Has Personal Protective Equipment available, when needed

10.3.8 *Scope of Living Supports (Supported Living, Family Living, and IMLS)*

The scope of all Living Supports (Supported Living, Family Living and IMLS) includes, but is not limited to the following as identified by the IDT and ISP:

1. residential instruction and assistance with Activities of Daily Living (ADL) that support the person to live in the most integrated setting appropriate to need;
2. adaptive skill development, shopping, social skill development, and money management;
3. communication in the language or communication preference of the person, including the use of any specific augmentative communication system utilized by the person;

4. training in and assistance with community integration that include access to and participation in preferred activities;
5. training in and assistance with developing and maintaining social, spiritual, cultural, and individual relationships, to include the development of generic and natural supports of the person's choosing;
6. assistance with accessing training and educational opportunities related to self-advocacy and sexuality;
7. ensuring readily available access to and assistance with use of a person's adaptive equipment, augmentative communication, remote personal support technology (RPST) and assistive technology (AT) devices, including monitoring and support related to maintenance of such equipment and devices to ensure they are in working order;
8. supporting people to learn and use their technology as part of natural supports rather than as an extra support;
9. ensuring timely coordination with a qualified technology provider to assess, install, train participant and staff to use device(s) and implement use;
10. working with the person's informal support system and other IDT members to initiate and maintain meaningful community connections;
11. implementation of and monitoring of the effectiveness of the ISP to achieve Desired Outcomes;
12. ensuring DSP are available to participate in Therapy and/or BSC appointments with the person on a regular basis or as requested;
13. coordination and collaboration with therapists and therapy assistants to receive training on the implementation of WDSIs in accordance with the participatory approach;
14. coordination and collaboration with the BSC to receive training on the implementation of the PBSPs and any other applicable plans;
15. coordination and collaboration with nurses to receive training on the implementation of HCPs, MERPs and CARMPS;
16. AWMD and related monitoring, including skill development activities that potentially lead to the ability for the person to self-administer medication as appropriate;
17. ensuring provision of nutritional counseling, if recommended by the IDT and clinically indicated;
18. assisting the person as needed to attend health related appointments or services and to communicate health needs by utilizing the *Health Passport* and *Physician Consultation* forms;
19. ensuring provider agency speaks with guardian to ensure any medical, behavioral, or psychiatric information is provided as part of an individual's routine medical or psychiatric care; and

20. ensuring that practitioner recommendations are considered, implemented timely, and carried out until discontinued or according to requirements described in [Chapter 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process](#) .

10.3.9 **Living Supports Family Living**

Family Living is intended for people who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living is intended to increase and promote independence and to provide the skills necessary to prepare people to live on their own in a non-residential setting. Family Living is designed to address assessed needs and individually identified outcomes. Services and supports are furnished by a natural or host family member, or companion, who meets requirements and is approved to provide Family Living. Family Living is provided in the person’s home or the home of the Family Living provider. The Provider Agency is responsible for substitute care coverage for the primary caregiver when they are sick or taking time off as needed. People receiving Family Living are required to live in the same residence as the paid DSP.

10.3.9.1 **Family Living Service Requirements**

1. Family Living cannot be provided in conjunction with any other Living Supports (Supported Living or IMLS), Customized In-Home Supports, or Respite.
2. Family Living must not be provided to more than two people receiving state funded services in the same home unless an exception is granted by DDSD.
3. Family Living must be available 365 days per year.

10.3.9.2 **Family Living Agency Requirements**

10.3.9.2.1 **Monitoring and Supervision**

Family Living Provider Agencies must:

1. Provide and document monthly face-to-face consultation in the Family Living home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include:
 - a. reviewing implementation of the person’s ISP, Outcomes, Action Plans, and associated support plans, including HCPs, MERPs, Health Passport, PBSP, CARMP, WDSI;
 - b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and
 - c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members.
2. Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, MERPs, and CARMPs.

10.3.8.2.2 Subcontractor Application and Home Study

Family Living provider agencies must establish a process for approval of Adult Family Living Sub-Contractors and structure for the completion of the Home Study. The Adult Family Living Subcontractor is considered a DSP and is required to meet applicable DSP requirements for provision of the service. The agency's approval process including the application, self - assessment and Home Study must be approved by DDSD when the agency submits its Provider Application through Provider Enrollment Unit. Oversight from DDSD, QMB and IQR may occur.

10.3.8.2.2.1 Self-Assessment and Application

The self-assessment is to be completed by the FL services sub-contractor applicant along with the provider agency's application for employment. The purpose of the application and self-assessment is to identify family culture, communication style and motivations that may assist in participant matching, especially for non-related subcontractors, as well as assure the applicant being aware of fundamental requirements to provide the service.

1. FL provider agencies must review the application for completeness and must include at minimum:
 - a. Homeowner's/renter's insurance (except for homes that cannot typically be insured, such as those on tribal lands.).
 - b. Signed Firearms Safety Assurance.
 - c. Signed Assurance to arrange or provide transportation as required in Standards Ensure all drivers are following Driver Qualifications and Vehicle Requirements found in [Chapter 14 Non- Medical Transportation](#). Local references.
 - d. Signed agreement establishing advance information about cost sharing with the participant related to room and board, including utilities, rent and food.
 - e. Must have an enforceable lease agreement or legally enforceable agreement.
 - f. Signed Assurance of Appendix C: HCBS Rights and Freedoms.
2. FL Provider agencies may develop their own self-assessment template, but it must include at minimum, an assessment of the subcontractor's experience, ability, and willingness to:
 - a. Complete training requirements set forth by DDSD data training.
 - b. Work on a team and implement the ISP and other therapy, healthcare, or behavior support plans.
 - c. Participate in monthly case management monitoring site visits and well as their agency service coordination activities.
 - d. Support participation in unscheduled and scheduled community activities in the same manner as individuals not receiving DD Waiver services.
 - e. Support the provision of services that support community integration and Employment First as applicable.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Living Supports Family Living

- f. Support use of telehealth, Assistive Technology, Remote Personal Support Technology and Environmental Modifications to increase safety and independence.
- g. Document service delivery and communicate SComm and use electronic platforms required by DDS. As listed in [Chapter 20 Secure Communication \(SComm\)](#)
- h. Follow settings requirements listed in [Chapter 10.2 Settings Requirements in LCAs](#)
- i. Be responsible 24 hours/day while providing significant level of direct, or natural support in the family setting.
- j. Establish back-up plan with the FL Provider agency for when FLP is unable to perform duties.
- k. Signed statement of assurance from FLP acknowledging self-assessment.

10.3.9.2.1.1 Home Study

An on-site Home Study is required to be conducted by the Family Living Provider agency initially, annually, and if there are any changes in the home location, household makeup, or other significant event.

1. The agency person conducting the Home Study must have a bachelor's degree in Human Services or related field or be at least 21 years of age, HS Diploma or GED and a minimum of 1-year experience with I/DD.
2. The Home Study must include a health and safety checklist assuring adequate and safe:
 - a. Heating, ventilation, air conditioning cooling;
 - b. Fire safety and Emergency exits within the home;
 - c. Electricity and electrical outlets; and
 - d. Telephone service and access to internet, when possible.
3. The Home Study must include a safety inspection of other possible hazards, including:
 - a. Swimming pools or hot tubs;
 - b. Traffic Issues;
 - c. Water temperature that does not exceed a safe temperature (110⁰ F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.
 - d. Any needed repairs or modifications
4. The home setting must comply with the CMS Final Settings Rule and ensure tenant protections, privacy, and autonomy.
 - a. Family Living settings in Individual, privately-owned homes (privately-owned or rented homes and apartments with family members are presumed to comply with [Chapter 10.2 Settings Requirements in LCAs](#). However, FL Provider agencies

still have an obligation to monitor and educate families on the settings requirements.

- b. Surrogate Family Living Settings where the person lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS to the individual) are considered provider-owned or controlled settings and should be evaluated as such. Any modification of the additional conditions for provider owned or controlled settings must be supported by a specific assessed need and justified in the person-centered service plan.
5. The Home Study must assure:
- a. Privacy is provided in the sleeping area- bedrooms and bathrooms with freedom to furnish and decorate according to personal choice.
 - b. The individual can close and lock the bedroom door unless indicated in the ISP.
 - c. There are no cameras in the bedroom or bathroom.
 - d. The home environment does not isolate the person from other people not receiving DD Waiver service in their local community.
 - e. The setting supports individual comfort, independence, and preferences, such as full access to kitchen, dining, laundry, and comfortable seating in the shared family space.
 - f. The person has unrestricted access without gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the home.
 - g. The home is physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting the person's mobility or if needed there are environmental adaptations or supports such as grab bars, ramps, accessible appliances.
 - h. Family communicates with the person in a manner respecting privacy and individual choice and preferences.
 - i. Signed statement of assurance from FLP acknowledging home study.

10.3.9.2.2 **Substitute Care**

Family Living Provider Agencies must provide or arrange for up to 750 hours of substitute care (or 1000 hours for JCMs) as sick leave or relief for the primary caregiver. Under no circumstances can the Family Living Provider Agency limit how these hours will be used over the course of the ISP year. The agency cannot not limit the total number of substitute care hours used, other than limiting the hours to the maximum amount allowed during an ISP year.

10.3.9.2.3 Adult Nursing Requirements for Family Living

All Family Living Provider Agencies are required to also be an approved ANS Provider Agency to support nursing requirements for people who receive Family Living from their agency. (If desired, Family Living Provider Agencies may decide to be active on the SFOC for ANS to support others in their community who might also need ANS.)

Through their ANS provider agreement, the Family Living Provider Agency must comply with applicable sections of [Chapter 13 Nursing Services](#) including:

1. ensuring annually that up to 12 hours (48 units) of ANS for assessment and consultation services are provided to all people in Family Living;
2. providing required elements of Ongoing Adult Nursing Services (OANS) to JCMs and people in Family Living with surrogate or host families; and
3. providing ongoing Adult Nursing Services (OANS) to people living with biological family members when the service is clinically justified and chosen by the person and family.

10.4 Living Supports-Supported Living

Supported Living is intended to increase and promote independence, and to teach the skills necessary to prepare people to live on their own in a non-residential setting. Supported Living is designed to address assessed needs and individually identified outcomes.

Within the Supported Living model, there are four categories of service: Basic, Moderate, Extensive, and Extraordinary Medical/Behavioral. The four categories are based on the intensity and nature of individual support needs. In addition, the Non-Ambulatory Stipend is available when a person is non-ambulatory. The Non-Ambulatory Stipend assists with funding for added staffing through the night in case an emergency evacuation is needed. Supported Living is provided to two to four people in a home that is leased or owned by the person.

Prior authorization is required from the respective DDS Regional Office for a person to receive this service when living alone. All requests must be made to the local DDS Regional Office via the CM. Supporting documentation must include IDT meeting minutes including an explanation as to why the person cannot safely live alone utilizing CIHS or intermittent DSP support. The ISP must reflect this exceptional living situation.

10.4.1 Supported Living Service Requirements

10.4.1.1 General Requirements

Provider Agencies of Supported Living must adhere to the following requirements:

1. Supported Living cannot be provided in conjunction with any additionally budgeted Living Supports (Family Living and IMLS), CIHS, Respite, separately billed ANS (unless approved to be provided during participation in CCS and or CIE), or Nutritional Counseling.
1. Use of on-call and some remote staffing patterns can be utilized if chosen by the individual and indicated in ISP.
2. Staffing patterns must be adjusted throughout the day to accommodate a person's health and safety, overall support needs, and ISP outcomes.
3. Supported Living Categories must be approved prior to service delivery. Supported Living provided at a higher category cannot be requested unless criteria for the immediately lesser category has been met.
4. Specific staffing ratios (e.g., 1:1 or 2:1) are not strictly required on a daily or hourly basis, but should be based on the approved Supported Living Category, as follows:
 - a. Supported Living Category 1 (Basic Support) routinely accommodates up to 7 hours a week of focused DSP attention and rare nursing services based on the person's needs and ISP. Focused DSP attention may be more or less than 7 hours on a given week, based on the person's needs and ISP.
 - b. Supported Living Category 2 (Moderate Support) routinely accommodates between 8-14 hours a week of focused DSP attention and up to 5 hours monthly

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

of nursing. Focused DSP attention may be more or less than 14 hours on a given week, based on the person's needs and ISP.

- c. Supported Living Category 3 (Extensive Support) routinely accommodates between 15-28 hours a week of focused DSP attention and frequent (up to 10 hours a month) nursing services. Focused DSP attention may be more or less than 28 hours on a given week, based on the person's needs and ISP.
 - d. Supported Living Category 4 (Extraordinary Medical/ Behavioral Support) routinely accommodates the need for more than 28 hours a week of focused individualized DSP attention. Focused DSP attention may be more or less than 28 hours on a given week, based on the person's needs and ISP.
5. An average of five hours of nutritional counseling must be available annually when recommended by the IDT and clinically indicated.
 6. At least one DSP who works directly with the person must be available to attend IDT meetings and additional staff input must also be collected for IDT consideration.
 7. The nurse must attend, in person or by phone, the annual IDT meeting and any other IDT meeting where health issues are on the agenda for anyone with high e-CHAT acuity.

10.4.1.2 Additional Requirements for Supported Living-Category 4 Extraordinary Behavior Support

Supported Living Category 4 Extraordinary Behavior Support is for people with extraordinary behavior support needs. Extraordinary behavior support needs are defined as high frequency disruptive behaviors that pose serious health and safety concerns to self or others (e.g., making risky decisions about one's own health and safety, including problematic choices of friends and/or sexual partners, illicit drug and alcohol abuse) and/or intermittent or chronic destructive behaviors that may or will result in physical harm or injury to self or others (e.g., physical acts that may require stitches or extensive wound care to potentially lethal acts such as stabbing someone). Extraordinary behavioral support needs may also include acts that may have or have caused great emotional harm to self or others (e.g., sexual assault). Individuals engaging in such behaviors may have also experienced intermittent or chronic involvement with the criminal justice system (e.g., detainment or arrest(s) for physically aggressive, sexually inappropriate, or assaultive behavior).

Supported Living – Category 4 Extraordinary Behavior Support must adhere to the following additional requirements:

1. Supported Living Category 4 services may not be utilized, provided, and billed at the same time as Supported Living (Basic, Moderate, Extensive), Supported Living-Non-Ambulator Stipend, IMLS, CIHS, or Respite services.
2. The Supported Living Category 4 Provider Agency must have documentation detailing the level of DSP intervention needed to assure the health and safety of the person and/or to assure the health and safety of others because of the person's extraordinary

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

behavior needs. The documentation must provide evidence that additional DSP had to intervene to secure the health and safety of the person and/or the health and safety of others.

3. The Supported Living Category 4 Provider Agency must have documentation and evidence that the IDT discussed:
 - a. additional means of addressing the extraordinary behavior support needs other than increasing the level of staffing support;
 - b. the reasons why increasing staff is necessary;
 - c. why the current level of staffing is not sufficient; and
 - d. what the IDT has already pursued and exhausted.
4. The additional staffing required to ensure the health and safety of the person and of others must be defined in the health and safety section of the ISP and must be included in a current PBSP.
5. Supported Living Category 4 cannot be provided unless the person also receives services from a BSC. The BSC must address the level of enhanced or additional staffing needed to reduce the risk of harm to self or others in the home or community setting. Specific strategies on how the level of staffing (and, more importantly, DSP intervention) will reduce the likelihood of harm to self and/or others must be addressed in the PBSP, and if indicated the BCIP.
6. DSP must be available to receive timely and an increased level of IST related to extensive behavior plans and must be available for frequent consultation and monitoring from the BSC.
7. DSP must be available for additional training, meetings, and frequent communication with their agency supervisors and the BSC.
8. The BSC must provide the level of oversight and monitoring of DSP necessary to determine the implementation and efficacy of the strategies within the PBSP and BCIP.
9. DSP must implement strategies documented in the PBSP for the extra supports needed each day including enhanced or additional staffing.
10. DSP must implement a plan, developed in collaboration with the BSC and documented in the PBSP, for returning to a typical staffing pattern once the circumstance associated with the increased risk has ended.

10.4.1.3 Additional Requirements for Supported Living Category 4 Extraordinary Medical Support

Supported Living Category 4 Extraordinary Medical Support Needs is for people with extraordinary medical support needs. Extraordinary medical support needs are defined as a chronic physical or medical condition requiring prolonged dependency on medical treatment for which skilled nursing intervention is necessary.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

The person's physical or medical condition may be characterized by one of the following:

- a. life threatening condition characterized by frequent periods of acute exacerbation that requires regular/frequent medical supervision, physician treatment/consultation and which in absence of such medical supervision or physician treatment/consultation would require hospitalization or admission to a nursing home or rehabilitation facility;
- b. administration of specialized treatments that are medically necessary such as suctioning, I.V. medication, injections, wound care for decubitus ulcers, etc.;
- c. dependence on medical technology requiring nursing oversight such as enteral (feeding tube) or parenteral (intravenous tube) nutrition support or continuous oxygen;
- d. administration of specialized treatments that are ordered by a physician or nurse practitioner which will take place over a period of recovery of at least 30 days; or
- e. medical support needs that are extensive but do not meet the clinical criteria for IMLS.

Supported Living – Category 4 Medical Supports must adhere to the following additional requirements:

1. Supported Living Category 4 services may not be utilized, provided, and billed at the same time as Supported Living (Basic, Moderate, Extensive), Supported Living Non-Ambulatory Stipend, IMLS, CIHS, CCS, CIE, or Respite services.
2. The Supported Living Category 4 Provider Agency must have documentation and evidence that the IDT discussed:
 - a. additional means of addressing the extraordinary medical support needs other than increasing the level of staffing support;
 - b. the reasons why increasing staff is necessary;
 - c. why the current level of staffing is not sufficient; and
 - d. what the IDT has already pursued and exhausted.
3. Enhanced or additional staffing is required to implement the applicable HCPs and MERPs to ensure the health and safety of the person.
4. The enhanced or additional staffing hours and how the additional staffing supports relate to implementing HCPs and MERPs must be defined in the health and safety section of the ISP.
5. Supported Living Category 4 for extraordinary medical support cannot be provided unless the person receiving this service receives frequent nursing oversight including at a minimum, monthly nursing assessments documented as follows:
 - a. Monthly nursing notes must include a summary of all visits/contacts related to the physical or medical condition.
 - b. Monthly nursing notes must include a description of the person's current physical/medical status.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

- c. Monthly nursing notes must include the status of any physician's orders (new orders, discontinued orders, etc.), status of laboratory or diagnostic tests, specialist evaluations, medical appointments, medications, treatment, and/or equipment.
 - d. Monthly nursing notes must include the skilled services provided and the person's response to the interventions.
6. The IDT must address the level of enhanced staffing needed to implement HCPs and MERPs. The IDT must also address how the enhanced or additional staffing will reasonably ensure the health and safety of the person, the long-term prognosis for recovery, or what may occur in the absence of enhanced supports must be addressed in the Health and Safety section of the ISP.
7. DSP must be available to receive timely and an increased level of IST related to the HCP and MERPs and must be available for frequent consultation and monitoring from the agency nurse.
8. DSP must implement plan(s), HCPs, and MERPs for the extra supports needed each day including the enhanced staffing.
9. DSP must be available for additional training, meetings, and frequent communication with their agency supervisors and the agency nurse.
10. The agency nurse must provide the level of oversight and monitoring necessary to determine the implementation and efficacy of the strategies within the HCPs and MERPs.
11. The IDT must develop and document in the ISP a plan for returning to a typical staffing pattern once the medical condition requiring increased staffing has ended (i.e., a fade out plan). If the IDT, in collaboration with the agency nurse and treating physician(s), believe a fade out plan is not possible, the IDT must address and document in the ISP the specific medical condition and support needed that will not allow for fading supports.

10.4.1.4 **Non-Ambulatory Stipend**

The Non-Ambulatory Stipend is available to provide additional funding for Supported Living Provider Agencies to ensure a second DSP is available in the home through the night where a non-ambulatory individual resides. The Non-Ambulatory Stipend is used for assistance with emergency evacuation, or some other emergency as needed. Use of the Non-Ambulatory Stipend does not preclude calling emergency services. Requirements for the Non-Ambulatory Stipend are:

1. The Non-Ambulatory Stipend cannot be billed if the provider is already using enhanced staffing for any other person in the home (i.e., Supported Living Category 4) through the night.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

2. Provider Agencies must ensure a second DSP member is in the home through the night when the stipend is approved and used for any person in the home.
3. Provider Agencies must have documentation of the DSP staffing pattern throughout the night.
4. Provider Agencies must coordinate with the appropriate therapist to assure there is an adequate transfer strategy in place for emergency evacuation.
5. Provider Agencies must ensure DSP are trained to competency level in an individualized transfer strategy that is linked to the emergency evacuation plan for the home.

10.4.1.5 Supported Living Agency Requirements

10.4.1.5.1 Monitoring and Supervision

Supported Living Provider Agencies must:

2. Provide and document monthly face-to-face consultation in the Supported Living home, conducted by agency supervisors or internal service coordinators with DSP and the person receiving services on at least a monthly basis to include:
 - a. reviewing implementation of the person's ISP, Outcomes, Action Plans and associated support plans, including HCPs, MERPs, PBSP, CARMP, WDSI;
 - b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapist or BSC; and
 - c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members.
3. Monitor that DSP implement and document progress of the AT inventory, RPST, physician and nurse practitioner orders, therapy, HCPs, PBSP's, BCIP's, PPMP's, RMP's, MERPs, CARMPs.
4. Monitor and document monthly that the devices listed in the WDSIs are available, functioning properly, and are used and communicate issues related to AT or RPST devices to the appropriate therapy consultant or IDT member.
5. Ensure and document the following:
 - a. The person has a Primary Care Practitioner.
 - b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist.
 - c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.
 - d. The person receives a hearing test as recommended by a licensed audiologist.
 - e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Supported Living Service Requirements

6. Agency activities occur as required for follow-up activities to medical appointments (e.g., treatment, visits to specialists, and changes in medication or daily routine).

10.4.1.5.2 Additional Requirements for Each Supported Living Residence

1. Provider Agencies shall assure proper sanitation and infection control measures (including adequate personal protective equipment) consistent with current national standards published by the Centers for Disease Control and Prevention. This includes:
 - a. use of standard precautions;
 - b. specific isolation or cleaning measures for specific illnesses; and/or
 - c. communicable disease policies which ensure that employees, subcontractors, and agency volunteers are not permitted to work with signs/symptoms of communicable disease or infected skin lesions until authorized to do so in writing by a qualified health professional.
2. DDSD does not allow Supported Living Provider Agencies to have a dedicated, provider-only office space or room within the home. Supported Living Provider Agencies shall take the necessary actions to comply with DDSD Service Standards and the NM Board of Pharmacy requirements regarding individual files and secure medication storage without maintaining an agency office in the person's home. Provider office space is only allowed when the following conditions are met:
 - a. The agency and people in the home establish an agreement regarding shared use of office machines and use/purchase of supplies based on the notion that the office is an integral part of the home. The people may not be charged rent for the space used for this purpose.
 - b. People in the home are allowed access to the office space and to be able to use the space for the person's personal needs.
 - c. The office space is set up as a typical "home office" and viewed by individual(s) who receive Supported Living services as an integral part of their home.
 - d. The office may be in a separate dedicated space/room but must not be sectioned off, locked, or otherwise restricted by barriers. The office should be accessible to all individuals living in the home.
 - e. The office space is not used for staff-only activities such as staff meetings, staff breaks, or staff parties that exclude the individual(s) living in the home.

10.4.2 Living Supports-IMLS

IMLS is a Living Supports option for persons with complex medical needs who require intensive, DSP supports as well as nursing care and oversight. This service promotes health and supports each person to acquire, retain, or improve skills necessary to live in the community and prevent institutionalization. IMLS may be provided on a long term or short-term basis. People receiving IMLS must have medical needs assessed at a high acuity level. They require intensive clinical nursing oversight and health management that are provided directly by a RN or LPN and are consistent with the eligibility parameters for IMLS which are issued by DDS and posted on the DOH website, CSB page <https://nmhealth.org/about/dds/pgsv/clinical/>.

IMLS is intended for people with intensive medical support needs. This service does not exclude access to CCS and includes any intermittent nursing or nursing consultation needed by the person to participate in those services. IMLS ensures provision of transportation for all medical appointments, household functions and activities, to and from day services, leisure/recreational activities, and other meaningful community options. IMLS also provides for assistance with social relationships and the provider must assist people to develop and maintain social, cultural, and spiritual relationships of their choosing.

10.4.2.1 Intensive Medical Living Service (IMLS) Requirements

10.4.2.2 General Requirements

1. No more than four people may be supported in a single residence at one time. Such residences may include a mixture of people receiving IMLS and Supported Living.
2. IMLS cannot be provided in conjunction with any additionally budgeted Living Supports (Family Living and Supported Living), CIHS, Respite, separately billed ANS (unless provided in conjunction with CCS or CIE), or Nutritional Counseling.
3. Agency nurses and DSP provide individualized support based upon assessed need. Assessment shall include use of required health-related assessments, eligibility parameters defined by the DDS, other pertinent assessments completed by the nurse, and the nurse's professional judgment.
4. Daily nursing visits are required according to the following:
 - a. A daily, face to face nursing visit must be made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to deliver the required direct nursing care, monitor each person's status, and oversee DSP delivery of health-related care and interventions.
 - b. Face to face nursing visits may not be delegated to DSP or non-licensed staff.
 - c. Although a nurse may be present in the home for extended periods of time based on individual(s) needs, a nurse is not required to be present in the home during periods of time when direct nursing services are not needed.

5. Weekly RN oversight visits and on-call nursing is required according to the following:
 - a. A supervising RN must perform an RN oversight visit at least weekly.
 - b. The RN oversight visit may not be delegated to an LPN or a non-licensed person.
 - c. The supervising RN's oversight visit is performed to:
 - i. monitor the clinical status and needs of the person and the delivery of planned care and services;
 - ii. provide consultation and serve as a resource; and
 - iii. provide oversight of the licensed nurses and DSP.
 - d. The frequency of the RN oversight visit may vary but must be based on the person's condition, the skill level of the DSP, and prudent nursing practice. It is up to the judgment of the supervising RN to determine if a weekly RN oversight visit is adequate or if there is a need to visit more frequently.
 - e. RN oversight visit(s) may replace one or more of the daily nursing visits during each week if all ordered nursing tasks are completed during the RN visit.
6. On-call Nursing must be provided as described in [Chapter 13.2.4 Nursing Monitoring and Oversight Requirements](#) and [Chapter 13.2.6 On-Call Nursing](#).
7. Nursing screening and assessment tools are required according to the following:
 - a. Required nursing screening and assessment tools must be completed, annually between 45 and 14 calendar days prior to the annual ISP meeting and as needed for significant change of medical condition.
 - b. An agency nurse will complete the designated IMLS prior authorization packet prior to admission into IMLS services, and then annually thereafter between 45 and 14 calendar days prior to the annual ISP meeting.
 - c. The nurse will submit the designated IMLS prior authorization packet with date and signature.
8. Nutritional counseling provided in accordance with standards for nutritional counseling found in [Chapter 12.5 Nutritional Counseling](#) must be available as needed, recommended by the IDT, and clinically indicated.
9. Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist).

10.4.2.3 Short-Term IMLS

Short-term IMLS may be provided for up to 90 calendar days. Short-term IMLS may be accessed after a recent hospitalization or a nursing home or rehabilitation facility stay. Short-term IMLS allows time to update health care plans, train staff on new or exacerbated conditions, and to ensure the routine home environment is appropriate to meet the needs of the person. Such short-term placements may occur in a person's usual home if their provider is an approved IMLS provider. IMLS may also be provided on a short-term basis to people with intensive

medical needs who normally live in a Family Living setting, when the family needs a substantial break from providing care. Short-term IMLS placement may range from 4 to 90 consecutive days and shall not exceed 90 days per ISP term. Otherwise, the individual may choose an approved IMLS provider pending transition back to their usual home.

1. The IMLS provider must assure that all relevant IST needed by DSP is provided to ensure health and safety during the short-term stay.
2. Short Term IMLS may not be provided at the same time as ANS, Family Living, or Supported Living.

10.4.2.4 Intensive Medical Living Service (IMLS) Agency Requirements

10.4.2.4.1 General Requirements

1. Provider Agencies must hold an active Provider Agreement as a Supported Living Provider.
2. Each Provider Agency must have capacity to provide at least one short-term placement.

10.4.2.4.2 Monitoring and Supervision

IMLS Provider Agencies must:

1. Supervise medically related supports by a RN. The RN must reside in New Mexico and must be able to be available within one hour.
2. Ensure that every 30 days at least one supervisory visit at the residence will be conducted on each shift. Supervisory visits shall adhere to the following requirements:
 - a. Once per month the visit shall include a face-to-face interview with each person supported.
 - b. Results of these visits shall document in each person's case record the safety of the service, quality of services provided, and extent to which the person's ISP is being implemented.
 - c. The visit shall also ensure and document that AT and/or equipment used are in good working order and being used as outlined in the ISP, HCP and/or WDSI.
 - d. At least one-third of residence visits for each shift shall be unannounced.
3. Arrange regular staff meetings and training sessions as needed to ensure competent implementation of the ISP, HCP, WDSIs, and any behavioral plans as applicable.
4. Provide adequate nursing and DSP staffing to assure adherence to these standards including:
 - a. Delivery of a Quarterly Nursing Report to the IDT that reflects the person's health status and summarizes the significant events that have occurred in the last quarter. This Quarterly Nursing Report should be an electronic Healthcare Report that incorporates data from the electronic health tracking system.
 - b. Appropriate planning and transition of care between one service to another, including creation and delivery of a discharge summary report completed by the

nurse. This summary must include a synopsis of the person's stay that reflects current health status and needs at time of discharge.

- c. Nurse and at least one DSP in attendance at the annual ISP meeting, in person or by phone/teleconference, for each person receiving IMLS. The agency nurse and at least one DSP shall attend all other IDT meetings where health status or health-related interventions are to be discussed. If a nurse is unable to attend an annual or health related ISP meeting due to unavoidable circumstances, the nurse shall provide a written health status update to the IDT.
 - d. Nurse and DSP collaboration and consultation with other IDT members regarding TSS, WDSI, PBSPs, BCIPs, PPMPs, and RMPs, if applicable.
5. Provider Agencies shall assure proper sanitation and infection control measures (including adequate personal protective equipment) consistent with current national standards that are published by the Centers for Disease Control and Prevention. This includes:
- a. use of standard precautions;
 - b. specific isolation or cleaning measures for specific illnesses; and/or
 - c. communicable diseases policies which ensure that employees, subcontractors, and agency volunteers are not permitted to work with signs/symptoms of communicable disease or infected skin lesions until authorized to do so in writing by a qualified health professional.

10.4.2.4.3 Staff Requirements

1. Nurses must have current licensure in compliance with the NM Nurse Practice Act.
2. DSP must meet minimum education requirements detailed in [Chapter 16 Qualified Provider Agencies](#) and have a minimum of one year of experience.
3. The following staffing ratios are required:
 - a. At least one DSP or nurse must remain awake throughout all night shifts. The RN supervisor may identify that additional DSP must be awake based on the needs of the person and skill level of the DSP.
 - b. Twenty-four (24) hour staffing must be adequate to meet the ongoing medical needs of the person receiving IMLS. This staffing may be covered by any combination of DSP, nurse, and supervisory employees.
 - c. When IMLS recipients share a residence with persons receiving other types of Living Supports, at least two employees must be available in the home during all mealtimes as well as when people are being assisted with bathing, preparing for the day and for bed.
 - d. At least two staff members must always be present when two or more people receiving IMLS reside in the same home.

10.5 Customized In-Home Supports (CIHS)

Customized In-Home Supports (CIHS) are intermittent services and/or supports that are individually designed to instruct or enhance home living and community skills and to address health and safety as needed. CIHS provides people the opportunity to design and manage the services and/or supports needed to live in their own home or their family home. CIHS is not a residential service with 24 hours a day, 7-days a week coverage.

CIHS include a combination of instruction and personal support activities provided intermittently when they would normally occur to assist the individual with activities of daily living (ADL), health related supports, meal preparation, household services and money management. Supports also include providing support to acquire, maintain or improve interaction skills in the community

CIHS is intended for people that do not require the amount and intensity of paid direct care support provided under Living Supports services. CIHS consists of two types of living arrangements: Living independently and living with paid or unpaid families or natural supports.

The rate for Customized In-Home Supports does not provide funding for nursing services. People in Customized In-Home Supports that need nursing services can include ANS as a separate service on their budget. To ensure compliance with the NM Nurse Practice Act, unless nursing supports are obtained through a source other than the DD Waiver, ANS must be budgeted if the person cannot self-administer their medication or requires or receives health related supports from DSP who are not related by affinity or consanguinity.

10.5.1 Scope

CIHS aids with the acquisition, improvement, and/or retention of skills to achieve personal outcomes. CIHS enhance the person's ability to live independently in the community as specified in the ISP and associated support plans (e.g. PBSP and WDSI). The scope of CIHS includes, but is not limited to:

2. assistance and instruction with ADL including grooming, bathing, dressing, oral care, eating, transferring, exercise, mobility, and toileting;
3. assistance with the acquisition, restoration, and/or retention of independent living skills such as shopping, banking, money management, and use of public transportation;
4. assistance with social interaction skills and community involvement;
5. assistance with use of the person's adaptive equipment, augmentative communication, RPST, and AT devices, including supports related to maintenance of such equipment and devices to ensure they are in working order;
6. supporting people to learn and use their technology as part of natural supports rather than as an extra paid support;
7. ensuring timely coordination with a qualified technology provider to assess, install, train participant and staff to use device(s) and implement use;
8. Use of on-call and adjusted staffing patterns when remote personal support technology is chosen by the person

9. implementing a Communication Dictionary, AT, AAC, or RPST and communicating any needs or concerns to the appropriate therapist in a timely manner, including replacing batteries and recharging devices as needed to assure function;
10. implementing, tracking progress, and documenting outcomes of healthcare orders, therapy plans, WDSIs, TSS, HCPs, PBSPs, BCIPs, PPMPs, RMPs, MERPs, and CARMPs, as applicable to the person in service;
11. communicating any concerns to the relevant authors of plans; and
12. addressing health and safety as needed to include the following as applicable:
 - a. supporting access to medical or behavioral health services; and
 - b. assisting with medication delivery such as setting up or reminders.
13. supporting access to medical or behavioral health services including telehealth, remote monitoring, and/ or family/friend contact on various platforms or using various devices.; and assisting with medication delivery such as setting up or reminders.

10.5.2 Customized In-Home Supports Service Requirements

10.5.2.1 General Requirements

1. Services shall be available up to 365 days per ISP year. CIHS is not a residential service with 24 hours a day, 7-days a week coverage.
2. CIHS units are used based on needs of the individual and may change depending on individual circumstances during the week.
3. For routine (i.e., more than 21 calendar days a year) need for more than 11 hours per day:
 - a. Paid supports are not considered intermittent, and a residential support should be considered.
 - b. Routinely providing more than 11 hours per day of paid support by the same person who also lives in the home with the participant is considered Family Living model of support.
 - c. A general schedule of hourly support, connection to ISP vision and desired outcomes, and justification that 24/7 residential models will not better serve the individual are required for Regional Office approval to submit a budget averaging more than 11 hours per day.
 - d. Fading of hours must be discussed by the team semiannually including use of technology to support more independence and clinical justification must be provided annually.

DD Waiver Services
Chapter 10: Living Care Arrangements (LCA)
Customized In-Home Supports (CIHS)

4. CIHS may not replace or substitute for CCS or CIE during the day when these support models are better suited during the day to support the person's needs, preferences, and goals.
5. Daily companionship, natural support or and simply overnight presence offered by members of household is not a paid support under CIHS.
6. CIHS are delivered by DSP in the person's own home, family home, or in the community.
7. Costs for room and board are the responsibility of the person receiving the service.
8. CIHS is intended to provide individual support, but CIHS may be provided to more than one person at a time under the following circumstances:
 - a. Roommates (up to three individuals with I/DD) all receive this service and have compatible outcomes for the service in their ISPs; and
 - b. Small groups (no more than three individuals with I/DD) are supported during activities outside the home, such as social events or grocery shopping.
9. CIHS can be provided to a person who has roommates/housemates, including three people in other DDS funded services.
10. CIHS includes responsibility to assist the person to coordinate transportation and use technology as outlined in the person's ISP.

10.5.3 Customized In-Home Supports Agency Requirements

10.5.3.1 Monitoring and Supervision

CIHS Provider Agencies must:

1. Provide and document monthly face-to-face consultation in the home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include:
 - a. reviewing implementation of the person's ISP, Outcomes, Action Plans and associated support plans, including HCPs, MERPs, PBSP, CARMP, WDSI;
 - b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and
 - c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members.
2. Monitor that the DSP implement and document progress of the AT and RPST inventory, physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, MERPs, CARMPs.
3. Monitor DSP use of the state approved EVV system to meet EVV requirements as detailed in [Chapter 21.4 Electronic Visit Verification](#) Services rendered that are not captured in the EVV system and do not have the approval / exception from the state cannot be paid.

Chapter 11: Community Inclusion

11.1 General Scope and Intent of Services

Community Inclusion (CI) is the umbrella term used to describe services in this chapter. In general, CI refers to opportunities for people with I/DD to access and participate in activities and functions of community life. Agencies providing Community Inclusion services should align their mission, vision, or values with providing full access to community inclusion and employment. The DD waiver program offers Customized Community Supports (CCS), which refers to non-paid activities or experiences and Community Integrated Employment (CIE), which refers to paid work experiences or activities to obtain paid work. CCS and CIE services are mandated to be provided in the community to the fullest extent possible. Remote based CCS and CIE supports may be used to enhance service provision, if appropriately planned for during the person-centered planning process.

11.2 Employment First

The DDS adopted an Employment First Policy in 2016 to establish procedures for supporting working age adults to have access to valued employment opportunities as the preferred service in New Mexico. Every person has the right and ability to work given opportunity and access. Access to competitive integrated employment enables the person to engage in community life, control personal resources, increase self-sufficiency, and is a proven method for creating community inclusion, identity, status, and roles. When person centered planning, IDT members must first look to and consider utilizing community and natural supports to assist people to attain their employment goals and Desired Outcomes. As such, supported employment activities are a planning priority for all working age adults. Employment should be the first consideration. The IDT is expected to explore all options to support employment and assist with barrier removal so that the individual can obtain their goal of working. If someone does not choose employment, the decision should be based on informed choice made by the individual, in conjunction with their guardian, as appropriate.

Making an informed choice about employment is an individualized process. The Case Manager, provider and IDT should assist every individual in making an informed choice, which may include implementing opportunities for experiences. All individuals have unique histories, experiences, and backgrounds, which means that some may have limited experiences and will require more information to make a decision about employment, while others may have rich and varied experiences in employment and/or volunteering and can make an informed choice based on that history.

The Individual, guardian and IDT must work together to determine and provide opportunities for activities and experiences that support making an informed choice about employment and clearly document the person's informed decision-making process in the ISP.

1. **Assessment:** The first step in making an informed choice about employment starts with the assessment process. The Person-Centered Assessment (PCA) and minimum requirements are referenced in [Chapter 11.4 Person Centered Assessments \(PCA\) and Career Development Plans](#) below.

2. Experience: The second step in making an informed choice includes offering opportunities to explore new experiences in the community to determine interests, abilities, and assess skills for individuals that have no volunteer or work history. It is the responsibility of the provider to offer and document the outcome of these experiences. The outcome of these experiences must be documented by the CM in the ISP Work, Education and/or Volunteer History section. If new experiences will not be explored, those reasons should be documented in the ISP, as well.
3. Opportunity for Trial Work or Volunteering: The third step in making an informed choice includes offering/providing the person job exploration activities including volunteer options and/or trial work opportunities if the person and guardian are interested. Provider Agencies should assist in accessing these opportunities. These opportunities must be documented by the CM in the ISP in the Work, Education and/or Volunteer History section.
4. Once the first three steps have been fulfilled, then the individual, in conjunction with a legal guardian, if appropriate, can determine whether employment shall be pursued.
5. If employment is the preferred option, then the IDT shall have a discussion of potential impact on the person's benefits and services. This process may require accessing community resources to determine the potential impact. Provider Agencies can assist in providing this information, and the details of the discussion must be documented by the CM in the Work, Education and/or Volunteer History section of the ISP as described in [Chapter 6.6.3.4 Documenting Employment First in the ISP](#).
6. If a person is retired, then this information must be clearly documented in the ISP in the Work, Education and/or Volunteer History section. The reasons for the choice to retire, the retirement date, and other pertinent information should be included in the ISP as described in [Chapter 6.6.3.4 Documenting Employment First in the ISP](#).

11.3 Implementation of a Meaningful Day

The objective of implementing a Meaningful Day is to plan and provide supports to implement the person's definition of their own meaningful day, contained in the ISP. Implementation activities of the person's meaningful day are documented in daily schedules and progress notes.

1. Meaningful Day includes:
 - a. purposeful and meaningful work;
 - b. substantial and sustained opportunity for optimal health;
 - c. self-empowerment;
 - d. personalized relationships;
 - e. skill development and/or maintenance; and
 - f. social, educational, and community inclusion activities that are directly linked to the Vision, Desired Outcomes and Action Plans stated in the person's ISP.

2. Community Life Engagement (CLE) is also sometimes used to refer to “Meaningful Day” or “Adult Habilitation” activities. CLE refers to supporting people in their communities, in non-work activities. Examples of CLE activities may include participating in clubs, classes, or recreational activities in the community; exploring new opportunities and resources, utilizing community mapping; learning new skills to become more independent; volunteering; or retirement activities. Meaningful Day activities should be developed with the four guideposts of CLE in mind¹. The four guideposts of CLE are:
 - a. individualized supports for each person;
 - b. promotion of community membership and contribution;
 - c. use of human and social capital to decrease dependence on paid supports; and
 - d. provision of supports that are outcome-oriented and regularly monitored.
3. The term “day” does not mean activities between 9:00 a.m. to 5:00 p.m. on weekdays.
4. Community Inclusion is not limited to specific hours or days of the week and should be provided in alignment with the individual’s Desired Outcomes.
5. Community Inclusion services cannot be used to replace the responsibility of the Living Supports Provider Agency for a person who receives both services.

11.4 Person Centered Assessments (PCA) and Career Development Plans (CDP)

Agencies who are providing CCS and/or CIE are required to complete a person-centered assessment (PCA). A PCA is a person-centered planning tool that is intended to be used for the service agency to get to know the person whom they are supporting and to help identify the individual needs and strengths to be addressed in the ISP. The PCA should provide the reader with a good sense of who the person is and is a means of sharing what makes an individual unique. The information gathered in a PCA should be used to guide community inclusion services for the individual. Recommended methods for gathering information include paper reviews, interviews with the individual, guardian or anyone who knows the individual well including staff, family members, friends, BSC therapist, school personnel, employers, and providers. Observations in the community, home visits, neighborhood/environmental observations research on community resources, and team input are also reliable means of gathering valuable information. A Career Development Plan (CDP), developed by the CIE Provider Agency with input from the CCS Provider, must be in place for job seekers or those already working to outline the tasks needed to obtain, maintain, or seek advanced opportunities in employment. For those who are employed, the career development plan addresses topics such as a plan to fade paid supports from the worksite or strategies to improve opportunities for career advancement. CCS and CIE Provider Agencies must adhere to the following requirements related to a PCA and Career Development Plan:

1. A PCA should contain, the following major topics, at a minimum:
 - a. information about the person’s background and current status;
 - b. the person’s strengths and interests and how they are known;
 - c. conditions for success to integrate into the community, including conditions

for job success (for those who are working or wish to work); and

- d. support needs for the individual.
2. The agency must involve the individual and describe how they were involved in development of the PCA. A guardian and those who know the person best must also be included in the development of the PCA, as applicable.
3. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated with the most current information, annually. A more extensive update of a PCA must be completed every five years. PCAs completed at the 5-year mark should include a narrative summary of progress toward outcomes from initial development, changes in support needs, major life changes, etc. If there is a significant change in a person's circumstance, a new PCA should be considered because the information in the PCA may no longer be relevant. A significant change may include but is not limited to losing a job, changing a residence or provider, and/or moving to a new region of the state.
4. If a person is receiving more than one type of service from the same provider, one PCA with information about each service is acceptable.
5. PCA's should be signed and dated to demonstrate that the assessment was reviewed and updated with the most current information, at least annually.
6. A career development plan is developed by the CIE provider with input from the CCS provider, as appropriate, and can be a separate document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when.

11.5 Settings Requirements for Non-Residential Settings

All individuals have the right to choose where they receive services.

All Provider Agencies must facilitate individual choice and must ensure that any service provided in an agency-operated facility is a setting chosen by the person and is integrated in, and supports full access to, the community. Provider responsibilities in agency-occupied settings include but are not limited to:

1. Encouraging and allowing visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. It is the responsibility of the Provider Agency to ensure visitors are informed of their responsibilities under HIPAA.
2. Allowing people to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences, or other barriers preventing individuals' entrance to or exit from certain areas should not be used.
3. Ensure the building meets ADA standards and is physically accessible.

4. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable.
5. Ensuring any staff of the DD Waiver Provider Agency do not talk about an individual(s) in the presence of others or in the presence of the individual as if s/he were not present, and that staff address the person directly when discussing the participant or matters concerning the participant.
6. Providing a secure place for the person to store personal belongings.
7. Ensuring people have full access to a dining area with comfortable seating and opportunity to converse with others during break or mealtimes.
8. Affording dignity to the diners, e.g., people are treated age-appropriately and not required to wear bibs.
9. Assisting with arranging for alternative meals and/or private dining if requested.

11.6 Customized Community Supports (CCS)

CCS for adults are designed to assist a person to increase their independence and potentially reduce the amount of paid supports, to establish or strengthen interpersonal relationships, to join social networks, and to participate in typical community life.

CCS are based upon the preferences and choices of each person and designed to measure progress toward Desired Outcomes specified in the ISP. Activities include adaptive skill development, adult educational supports, citizenship skills, communication, social skills, self-advocacy, informed choice, community integration, and relationship building.

Outcomes from this service may include an enhanced capacity for self-determination, development of social networks that allow the person to experience valued social roles while contributing to his or her community and establishing lasting community connections.

11.6.1 Scope of Service

CCS should be provided in the community to the fullest extent possible. Services should lead to participation and integration in the community and support the person to reach his or her personal goals and Desired Outcomes for growth and development.

When planning CCS, the IDT members shall recognize the person's right to make life choices that may include risk. The IDT members shall assess risk on an individual basis and develop or enhance risk mitigation strategies as needed. The assumption of risk shall be balanced with the person's ability to assume responsibility for that risk and a reasonable assurance of health and safety while maintaining compliance with DDS Service Standards and the NM Nurse Practice Act for those with health-related supports.

Individuals who have health related support needs that require nursing services during the provision of CCS, have access to nursing supports in various ways. Nursing supports at various levels are bundled into the CCS Group services and are available for other CCS models of service (CCS-I, CCS-Small Group, Community Inclusion Aide) through coordination with the person's Living Supports provider and/or Adult Nursing Services (ANS) provider.

11.6.2 General Service Requirements for CCS Individual, Small Group and Group

CCS shall be selected and provided based on the interests of the person and Desired Outcomes listed in the ISP. Requirements include:

1. Conducting community-based situational assessments that include exposure to new experiences, discovery activities or other person-centered assessments. The assessment will be used to guide the IDT's planning for exposure to new community-based activities, overcoming barriers to employment and integrating clinical information, assistive technology, behavioral and therapy supports as necessary for the person to be successful in development of their meaningful day and employment.
2. Creating individualized schedules that can be modified easily based on individual needs, preferences, and circumstances and that outline planned activities per day, week and month including date, time, location, and cost of the activity.
3. Skill building activities to support the person's Desired Outcomes, as appropriate.
4. Assisting with skills application activities in typical community settings (e.g., volunteering, banking, or shopping).
5. Providing information regarding a range and variety of employment options.
6. Ensuring that volunteer positions comply with the Fair Labor Standards Act (FLSA) regulations.
7. Providing supports for volunteer activities, offering information, and coaching to community members to support the person's success.
8. Identifying and connecting the person to community resources and options present in the ISP Action Plan.
9. Arranging or providing opportunities (time, information, materials, and other resources) to pursue age-appropriate hobbies, volunteer activities, recreation/leisure activities, and interests with non-disabled peers.
10. Providing opportunities for active individual choice-making during the day, including daily schedules, activities, skill building, and community participation.
11. Providing information pertaining to individual rights and responsibilities in the community.
12. Assisting in the development of self-advocacy skills.
13. Providing support to the person to assume social roles that are valued by both the person and the community.
14. Providing support to the person in becoming actively engaged in community sponsored activities specifically related to the person's interests, as compared to the group and/or agency interests.
15. Assisting with budgeting to pay for adult education activities designed to promote personal growth, development, and community integration as presented in the ISP Action Plan and Outcomes.

16. Providing supports to participate in age-appropriate generic community retirement activities with non-disabled peers.
17. Arranging and assisting the person to participate in community or internet-based classes, including staff time to support the person while in class, in cases where the support needs have been deemed clinically or medically necessary.
18. Providing and training on transportation supports during CCS activities, including the use of public transportation options.
19. For persons with behavioral health needs during CCS:
 - a. assisting with behavioral health stabilization, as needed;
 - b. participating in training for and implementation of PBSPs and other related plans (e.g., BCIPs, RMPs, PPMPs);
 - c. collaborating and communicating with BSCs immediately to discuss any behavioral health issues or concerns and need for additional training.
20. For persons with health needs during CCS:
 - a. receiving training and oversight from a DD Waiver provider nurse acting in accordance with the NM Nurse Practice Act to consistently implement HCPs, including CARMPs, MERPs and practitioner orders;
 - a. providing assistance with and support for medication delivery in compliance with the DDS AWMD training; and
 - b. collaborating and communicating with a DD Waiver provider nurse acting in accordance with the NM Nurse Practice Act to immediately communicate any health issues or concerns.
21. Implementing a Communication Dictionary, AT, AAC, or RPST and communicating any needs or concerns to the appropriate therapist in a timely manner, which includes replacing batteries and recharging devices as needed to assure function.
22. Implementing, tracking progress, and documenting outcomes of healthcare orders, therapy plans, WDSIs, TSS, HCPs, PBSPs, BCIPs, PPMPs, RMPs, MERPs, PBSPs and CARMPs, as applicable to the person in service.
23. Communicating any concerns to the relevant authors of plans.
24. Providing basic assistance needed for personal care and ADL, such as eating, dressing, toileting, and personal hygiene.
25. Assisting with the development of natural support networks that complement or replace paid supports through development of personal relationships/friendships with people who are not disabled and who have similar interests and preferences.
26. Engaging in specific activities needed to successfully implement the person's ISP.
27. Arranging access to age-appropriate adult education opportunities available to the public (e.g., coursework or conferences with non-disabled peers).

28. Brief or intermittent time at an individual's home or in an agency operated building, per individual need, not to exceed a three-hour period for lunch, break, behavioral stabilization, ADLs, and/or change of clothes, no more than 15 hours per week. **This time is not to be used in an agency operated building to attend activities such as birthday parties or seasonal gatherings.**
- a. JCMs may receive CCS in the home up to 30 hours a week to maintain the same level of service received under 2007 DD Waiver Standards.
29. Remote based supports may be implemented to assist the individual to explore the community and online community activities, groups, and resources. Remote based supports must comply with the CCS Scope of work. In addition:
- a. Staff must be trained to support individuals to use remote based supports.
 - b. Remote based supports may only be billed from the start time of the remote based class/session to the end time of the remote based class/session. Agencies may only bill for one location at a time, either remote or in person, not both.
 - c. Agencies may not bill for time used to develop remote based supports or supplies associated with sessions.
 - d. If technical issues occur (i.e., internet outage, power, or connectivity issues) only the hours that the service was provided can be billed.
 - e. Remote based supports must meet accessibility requirements related to both the ADA and the individual's technology availability.
 - f. Providers are responsible for providing remote services on a platform that all individuals can access. An inability for an individual to access remote services is the same as choosing to not provide the service.
 - g. Remote based supports must be person centered and presented in the ISP Action Plan and Outcomes.
 - h. Remote based supports are intended to supplement not supplant community-based services and must not lead to social isolation. Individuals are encouraged to participate in the community to the fullest extent possible in conjunction with the use of remote based supports.**
 - i. IDTs are encouraged to explore AT and RPST to support independence in the community, to the fullest extent possible.

11.6.3 Individual Customized Community Supports (CCS-I)

CCS-I are age appropriate and provided on a one- to-one (1:1) basis. Activities listed in the scope of work are delivered in a manner consistent with the person's ISP and are provided exclusively in the community or as a remote based support, as appropriate. Nursing supports needed during the provision of CCS-I must be planned for in the ISP and coordinated through an ANS provider and/or the Supported Living, Family Living or IMLS Provider Agency as is relevant to the person.

11.6.4 Small Group Customized Community Supports (CCS Small Group)

CCS-Small Group is provided in groups of three or less. Activities listed in the scope of work are delivered in a manner consistent with the person's ISP and are provided exclusively in the community or as a remote based support, as appropriate. CCS Small group may not occur in an agency-operated building.

11.6.5 Customized Community Supports- Group (CCS-Group)

Within the CCS Group model, there are three categories of service: CCS Group Category 1 and CCS- Group Category 2 Extensive Support and CCS- Group- Jackson only. The three categories are based on intensity and nature of individual support needs.

Activities listed in the scope of work are delivered in a manner consistent with the person's ISP and may be provided in the community in an agency-operated building or as a remote based support, as appropriate.

1. Age-appropriate activities are delivered in a manner consistent with the person's ISP and are provided in the community to the fullest extent possible.
2. CCS-Group are not segregated vocational or prevocational activities, e.g., center-based or sheltered work.
3. Staff ratios at a day facility or in the community depend on the approved CCS- Group category:
 - a. CCS-Group Category 1 is not to exceed one-to-six (1:6).
 - b. CCS-Group Category 2 Extensive Support is not to exceed one-to-four (1:4).
 - c. CCS-Group Jackson Only is not to exceed one-to-four (1:4).
 - i. JCMs may receive the CCS-Group Jackson Only service to maintain the same level of Adult Habilitation Medical/Behavioral Outlier services received under the 2007 DD Waiver Standards.
4. For people with health- related support needs, nursing staff and support is required within this model of service according to requirements described in [Chapter 13.2 Part 1 - General Nursing Services Requirements](#).

11.6.6 Community Inclusion Aide

The Community Inclusion Aide provides personal care or behavioral health stabilization services in a community setting for individuals who require assistance with ADLs, health, and behavioral health supports, as needed, and is to be delivered in the community exclusively or as a remote based support, as appropriate. The scope of work includes, but is not limited to, the following:

1. Assisting with mobility, access, and communication within the community;
2. Providing training on transportation supports during Community Inclusion Aide activities which includes the use of public transportation options;
3. Not to be utilized for transportation

4. Assisting with ADLs by assisting with personal care such as eating, meal preparation, and individual personal hygiene;
5. For persons with behavioral health needs:
 - a. assisting with behavioral health stabilization, as needed;
 - b. participating in training for and implementation of PBSPs and other related plans e.g., BCIPs, RMPs, PPMPs;
 - c. collaborating and communicating with BSCs immediately to discuss any behavioral health issues or concerns and need for additional training
6. For persons with health care needs:
 - a. receiving training and oversight by a nurse to implement HCPs including CARMPs, MERPs and implementation of practitioner's orders during CCS;
 - b. aiding with and support for medication delivery in compliance with the DDSD AWMD training; and
 - c. collaborating and communicating with ANS Provider Agencies to immediately communicate any health issues or concerns;
7. implementing a Communication Dictionary, AT, AAC, or RPST and communicating any needs or concerns to the appropriate therapist in a timely manner, which includes replacing batteries and recharging devices as needed to assure function;
8. assisting with implementation of remote based supports.
9. implementing, tracking progress and documenting outcomes of healthcare orders, therapy plans, WDSIs, TSS, HCPs, BCIPs, PPMPs, RMPs, MERPs, PBSPs and CARMPs, as applicable to the person in service; and
10. communicating any concerns to the relevant authors of plans.

11.6.7 Fiscal Management of Adult Education (FMAE)

FMAE allows the individual to designate funds from their ISP budget for registration fees, tuition, fees, and/or related materials associated with in person or virtual classes, lessons or conferences designed to promote personal growth, development, and community integration as determined necessary for the person. Related materials do not include electronics or assistive technology. FMAE is not intended to support coursework toward a college degree. Services available through other federal resources such as Vocational Rehabilitation and Federal Financial Aid should be explored and exhausted for college coursework. CCS agencies serve as the fiscal intermediary to administer the FMAE funds on behalf of the individual. FMAE may not be utilized for CCS Agencies to bill/cover the cost for registration fees, tuition fees or related materials to support individuals in service. This service must be related to a Vision-driven Desired Outcome in the Live, Work, or Develop Relationships/Have Fun area or the Meaningful Day area of the ISP. FMAE is permissible as a stand-alone service on a budget without having another service under CCS on the budget. CCS providers administering FMAE expectations include:

1. processing requests for payments, reviewing of financial documents, and issuing checks to vendors on behalf of the person;
2. establishing an account for each person receiving this service;
3. tracking and accounting for approved expenditures on behalf of the individual; and
4. payments and purchases on behalf of the individual, plus up to a 10% administrative processing fee not to exceed \$550 per ISP year.

11.6.8 Agency Requirements

CCS Provider Agencies must comply with the following requirements:

1. Employ or subcontract with at least one RN for nursing services under CCS-Group.
2. Adhere to /submit the quarterly reporting as described in [Chapter 19.4 Employment First Reporting Requirements](#).

11.7 Community Integrated Employment (CIE)

Community Integrated Employment (CIE) activities support individuals to obtain and maintain employment in the community. Services are individualized to meet the needs, interests and skills of the person that is being supported. Employment services support people in jobs that are in integrated businesses, industries, or government environments.

11.7.1 Scope of Service

CIE is intended to provide supports that result in jobs in the community which increase economic independence, self-reliance, social connections, and the ability to grow within a career.

CIE services are geared to place people with disabilities in employment settings with non-disabled co-workers within the general workforce or assist the person in business ownership. This service may include small group employment. People are supported to explore and seek opportunity for career advancement through growth in wages, hours, experience, promotions and/or movement from group to individual employment. People are provided the opportunity to participate in negotiating their work schedule, break/lunch times, leave and medical benefits with their employer. These activities are to be reflected in individual career development plans.

CIE includes Job Development, Short-term Job Coaching, Job Maintenance, Self-Employment, Intensive Community Integrated Employment (ICIE), and CIE- Group models. All the models may incorporate elements of customized employment, which includes job carving, job restructuring, and negotiated responsibilities. Reasonable accommodations are essential to employment, when needed. A Community Inclusion Aide may be provided to assist individuals with personal care needs related to ADLs in individual community employment settings when natural supports are not available. Services must be provided in a way that does not embarrass, disrespect, or restrict a person from making friendships and co-worker relationships. Natural/peer supports should be explored and encouraged to potentially fade the paid supports. Fading paid supports is most successful when natural/peer supports are in place and stable.

In a group employment setting, the provider determines the job site and is responsible for the day-to-day supervision of the individuals and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with his or her role as employer.

11.7.2 Service Requirements

11.7.2.1 General CIE Requirements

CIE services shall be provided based on the interests of the person and Desired Outcomes listed in the ISP. Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the person's Desired Outcome and the job. Services may include remote based supports if they are appropriate, and person centered. CIE services are not intended to be portrayed as a 2 for 1 employment situation. Individuals should be supported to be as independent as possible, on the job. CIE Staff are expected to support, teach/train and promote independence and are not allowed to complete the job for the individual.

Requirements include:

1. Arranging for, providing, or training on transportation supports during CIE including the use of public transportation (i.e., bus, train, ride share, etc.) options;
2. Accessing services and supports through agencies such as the Division of Vocational Rehabilitation (DVR) and Department of Workforce Solutions (DWS), including attendance at appointments. Individuals who have a change in employment such as, loss of a job, wants a second job, wants to advance and/or transition to other types of employment are required to utilize funding for services available through vocational rehabilitation and special education as mandated in federal regulation.
3. Providing basic assistance needed for personal care and ADL (such as eating, toileting and personal hygiene);
4. For persons with health care needs:
 - a. receiving training and oversight through ANS to implement HCPs and implementation of practitioner's orders occurring during CCS;
 - b. aiding and support with medication delivery in compliance with the DDSD AWMD training; and
 - c. collaborating and communicating with ANS Provider Agencies to immediately communicate any health issues or concerns;
11. Implementing a Communication Dictionary, AT, AAC, or RPST and communicating any needs or concerns to the appropriate therapist in a timely manner, including battery replacement and use of recharging devices as needed to assure function;
12. Implementing, tracking progress and documenting outcomes of healthcare orders, therapy plans, WDSIs, TSS, HCPs, PBSPs, BCIPs, PPMPs, RMPs, MERPs, and CARMPs, as applicable to the person in service;
13. Communicating any concerns to the relevant authors of plans;
14. Ensuring and implementing a system to communicate and minimize any disruption to a person's employment when an individual suffers a "life change" (e.g., hospitalization, significant health status change, relocation to another city, loss of employment); and
15. Attending IDT meetings within ten calendar days of a person's life change to take appropriate actions to minimize a disruption in the person's employment. (See [Chapter 6.5.2 ISP Revisions](#) for more information.)
16. Remote based supports may be implemented to assist the individual in employment. Remote based supports must comply with the CIE Scope of work. In addition:
 - a. Staff must be trained to support individuals to use remote based supports.
 - b. Remote based supports may only be billed from the start time of the remote based class/session to the end time of the remote based class/session. Agencies may only bill for one location at a time, either remote or in person, not both.

- c. Agencies may not bill for time used to develop remote based supports or supplies associated with sessions.
- d. If technical issues occur (i.e., internet outage, power, or connectivity issues) only the hours that the service was provided can be billed.
- e. Remote based supports must meet accessibility requirements related to both the ADA and the individual's technology availability.
- f. Providers are responsible for providing remote services on a platform that all individuals can access. An inability for an individual to access remote services is the same as choosing to not provide the service.
- g. Remote based supports must be person centered and presented in the ISP Action Plan and Outcomes.
- h. **Remote based supports are intended to supplement not supplant necessary employment supports and** must not lead to social isolation. Individuals are encouraged to participate in community integrated employment to the fullest extent possible in conjunction with the use of remote based supports.
- i. IDTs are encouraged to explore AT and RPST to support independence in the employment, to the fullest extent possible.

11.7.2.2 Job Development

Job development services through the DD Waiver can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Requests to utilize the DD Waiver for job development must have prior approval by DDSD.

If job development services cannot be accessed through special education or vocational rehabilitation services as defined above, the following must be provided:

1. Written documentation from the vocational rehabilitation or special education agency on their agency letter head that specifies why services are not otherwise available.
2. The CM must provide a letter of justification addressed to the Supported Employment Lead or Designee to include:
 - a. The number of job development hours to be requested (not to exceed 30 hours/month for more than 6 months);
 - b. Anticipated duration of the service;
 - c. The reason for the job development supports; and,
 - d. Anticipated employment outcome/goal based on the individual's interests, skills and Desired Outcome as defined in the ISP.

- e. Failure to follow partner agency requirements unavailable (i.e., does not want to use these services, missing appointments, etc.) does not constitute justification for services being otherwise unavailable.

Job Development may include, but is not limited to, activities to assist an individual to plan for, explore, and obtain CIE. Staff providing job development and related services must, at a minimum, meet DDS requirements detailed in [Chapter 17: Qualified Provider Agencies](#).

Services include:

1. Conducting community-based situational assessments, discovery activities or other person-centered assessments. The assessment will be used to guide the IDT's planning to identify potential areas of interest, address overcoming barriers to employment and integrating clinical, assistive technology, remote based supports, RPST, and therapy supports necessary for the person to succeed in employment.
2. Promoting career exploration based on interests within various careers through job sampling, trial work experiences, or other assessments as needed.
3. Developing and/or identifying community-based job opportunities that are in line with the person's skills and interests.
4. Developing a résumé (written or visual) that identifies a person's skills and vocational experience.
5. Assisting the person to find jobs that are well-matched to their vocational outcome including negotiating with employers for job customization,
6. Assisting with transportation to and from interviews.
7. Supporting the person in gaining the skills or knowledge to advocate for him/herself in the workplace.
8. Educating the person and IDT on rights and responsibilities related to employment.
9. Arranging for or providing benefits counseling and assisting with reporting.
10. Exploring, facilitating, developing, requesting, and implementing job accommodations and the use of assistive technology to help an individual be successful in job search and employment.
11. Providing job site analysis (matching workplace needs with those of the person).
12. Assisting the person to gain and/or increase job seeking skills training, which include, but are not limited to interviewing skills, résumé writing, and work ethics training.
13. Assisting employers with the Americans with Disabilities Act (ADA) issues, Work Opportunity Tax Credit (WOTC) eligibility, requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies.
14. Utilizing employment resources such as: One-Stop Career Centers, Division of Vocational Rehabilitation Department of Workforce Solutions, Chambers of Commerce, Job

Accommodation Network, Small Business Development Centers, Service Corps of Retired Executives (SCORE), businesses, community agencies, Partners for Employment, or DDSD resources, to achieve employment outcomes.

11.7.2.3 Job Coaching

Job coaching is intended to be used as short-term supports, if needed. In special circumstances only, face to face, short-term job maintenance (job coaching generally lasting up to 3 months) services through the DD Waiver can be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Requests to utilize the DD Waiver for short-term job coaching services must have prior approval by DDSD. If job coaching services cannot be accessed through special education or vocational rehabilitation services as defined above, the following must be provided:

1. Written documentation from the vocational rehabilitation or special education agency on their agency letter head that specifies why services are not otherwise available.
2. The CM must provide a letter of justification addressed to the Supported Employment Lead or Designee to include:
 - a. The number of job coaching hours to be requested (not to exceed 30 hours/month for more than 3 months);
 - j. Anticipated duration of the service;
 - k. The reason for the short-term job coaching; and,
 - l. Employment verification to include:
 - i. Name of Employer;
 - ii. Employment Location;
 - iii. Schedule demonstrating a minimum of 4 hours of work per month;
 - iv. Start date; and
 - v. Wage information,
30. Failure to follow partner agency requirements unavailable (i.e., does not want to use these services, missing appointments, etc.) does not constitute justification for services being otherwise unavailable.

Services include:

1. Conducting work site assessments. The assessments will be used to guide the IDT's planning to identify potential areas of interest, address overcoming barriers to employment and integrating clinical, assistive technology, remote based supports, RPST, and therapy supports necessary for the person to succeed in employment.

2. Providing effective and quality job coaching and on-the-job training as needed to assist the person in maintaining and enhancing skill development.
3. Supporting the person in gaining the skills or knowledge to advocate for him/herself in the workplace.
4. Educating the person and IDT on rights and responsibilities related to employment.
5. Arranging for or providing benefits counseling and assisting with reporting.
6. Exploring, facilitating, developing, requesting, and implementing job accommodations and the use of assistive technology to help an individual be successful in employment.
7. Providing job site and task analysis (i.e., matching workplace needs with those of the person, identifying tasks specific to the position and assisting the individual in mastering those tasks);
8. Maintaining ongoing communication with various levels of the company to assure satisfaction for both the person and the company;
9. Assisting the person with the development of natural supports, remote based supports, and development of plans to fade paid supports, if desired;
10. Assisting the person to communicate and express their needs with supervisors, peers, and co-workers;
11. Supporting the person in gaining the skills or knowledge to advocate for him/herself in the workplace.
12. Advocating for the person to be integrated into the work culture, including attending job-related social functions, interacting with their non-disabled co-workers during lunch or break times as well as full access to employer designated dining or break areas.
13. Assisting the person to gain and/or increase job skills, which include, but are not limited to additional training, fading of supports, and opportunities for career advancement.
14. Assisting employers with the Americans with Disabilities Act (ADA) issues, Work Opportunity Tax Credit (WOTC) eligibility, requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies.
15. Utilizing employment resources such as: One-Stop Career Centers, Division of Vocational Rehabilitation Department of Workforce Solutions, Chambers of Commerce, Job Accommodation Network, Small Business Development Centers, Service Corps of Retired Executives (SCORE), businesses, community agencies, Partners for Employment, or DDS resources, to achieve employment outcomes.

11.7.2.4 Job Maintenance

Job Maintenance is intended to be used as the long-term supports, if needed once funding through vocational rehabilitation or the educational systems have been utilized.

Job Maintenance is provided on a one-to-one ratio. Non-face-to-face activities on behalf of the person may only be provided up to 50% of the billable time. All other CIE services must be conducted with the person present either at the work site or remotely, as appropriate. For an agency to bill for job maintenance the individual must have appropriate employment verification each month (i.e., Name of employer, employment location, schedule demonstrating a minimum of 4 hours of work per month, and wages.) Although the service is billed as a monthly unit, the rate structure is built upon providing a minimum of four hours of service monthly with a maximum of 40 hours per month for CIE Job Maintenance.

The scope of work for job maintenance may include, but is not limited to, the following:

1. Maintaining ongoing communication with various levels of the company to assure satisfaction for both the person and the company;
2. Assessing the need for additional hours of Intensive Community Integrated Employment based on individual need;
3. Educating the person and IDT on rights and responsibilities related to employment.
4. Providing effective and quality job supports and on-the-job training as needed to assist the person in maintaining and enhancing skill development.
5. Arranging for or providing benefits counseling and reporting of wages.
6. Assisting the person with the development of natural supports, remote based supports, and development of plans to fade paid supports, if desired.
7. Assisting the person to communicate and express their needs with supervisors, peers and co-workers.
8. Exploring, facilitating, developing, requesting, and implementing job accommodations and the use of assistive technology to help an individual be successful in employment.
9. Providing job site and task analysis (i.e., matching workplace needs with those of the person, identifying tasks specific to the position and assisting the individual in mastering those tasks);
10. Supporting the person in gaining the skills or knowledge to advocate for him/herself in the workplace.
11. Advocating for the person to be integrated into the work culture, including attending job-related social functions, interacting with their non-disabled co-workers during lunch or break times as well as full access to employer designated dining or break areas.
12. Assisting the person to gain and/or increase job skills, which include, but are not limited to additional training, fading of supports, and opportunities for career advancement.
13. Assisting employers with the Americans with Disabilities Act (ADA) issues, Work Opportunity Tax Credit (WOTC) eligibility, requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies.

14. Utilizing employment resources such as: One-Stop Career Centers, Division of Vocational Rehabilitation, Department of Workforce Solutions, Chambers of Commerce, Job Accommodation Network, Small Business Development Centers, Service Corps of Retired Executives (SCORE), businesses, community agencies, Partners for Employment, or DDS resources, to achieve employment outcomes.

11.7.2.5 CIE- Group

In CIE- Group as many as six individuals work in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers and/or the public must occur. Within the CIE Group model, there are two categories of service: CIE Group Category 1 and CIE- Group Category 2 Extensive Support. The two categories are based on the intensity and nature of individual support needs. The scope of work for CIE- Group may include, but is not limited to, the following:

1. Staff ratios at a non-residential facility or in the community are dependent upon the person's approved category of service:
 - a. CIE Group Category 1 are not to exceed one-to-six (1:6).
 - a. CIE – Group Category 2 – Extensive Support are not to exceed one-to-four (1:4).
2. Participating in the IDT to develop a plan to assist a person who desires to move from group employment to individual employment, including accessing services and supports through agencies such as the Division of Vocational Rehabilitation (DVR) and Department of Workforce Solutions (DWS), including attendance at appointments.
3. Assisting the person to gain and/or increase job skills, which include, but are not limited to additional training, fading of supports, and opportunities for career advancement to individual employment.
4. Exploring, facilitating, developing, requesting, and implementing job accommodations and the use of assistive technology to help an individual be successful in employment;
5. Providing effective job supports and on-the-job training as needed to assist the person in maintaining the job placement and enhancing skill development.
6. Advocating for the person to be integrated into the work culture, including attending job-related social functions and interacting with non-disabled co-workers during lunch or break times, as well as fully accessing employer designated dining or break areas.

11.7.2.6 Self-Employment

Self-employment services through the DD Waiver can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Self-employment services are intended to be used as the long-term supports once funding through vocational rehabilitation or the educational systems have been utilized. Requests to

utilize the DD Waiver for Self-Employment to start a business, must have prior approval by DDS. If self-employment services cannot be accessed through special education or vocational rehabilitation services as defined above, the following must be provided:

1. Written documentation from the vocational rehabilitation or special education agency on their agency letter head that specifies why services are not otherwise available.
2. The CM must provide a letter of justification addressed to the Supported Employment Lead or Designee to include:
3. The number of self-employment hours to be requested related to start up services (not to exceed 30 hours/month for more than 3 months);
4. Start date and anticipated duration of the startup service;
5. The reason for the use of self-employment funds to start a business; and,
6. The following documents:
 - a. Name of Small Business;
 - b. Description of product or service;
 - c. Small business plan;
 - d. Market Analysis; and,
 - e. Business implementation date
7. Failure to follow partner agency requirements does not constitute justification for services being otherwise unavailable (i.e., does not want to use these services, missing appointments, etc.).
8. Self-Employment supports under CIE are Direct Support Professional services only and may not be used to purchase supplies or goods associated with the small business, they can only be used as support services.

When a person elects to start their own business, the CIE Provider supports the person by assisting with the development of a business plan, conducting a market analysis for the product or service, and establishing the infrastructure to support a successful business. Nonface-to-face activities on behalf of the individual may be provided only up to 50% of the billable time. All other CIE services must be conducted with the individual present. Self-employment does not preclude employment in the other models. The scope for Self-employment may include, but is not limited to, the following:

1. completing a market analysis of product/business viability;
2. assisting with and/or utilizing community resources to develop a business plan, a business infrastructure to sustain the business over time and marketing plans;
3. assisting with the development of a business bank account;
4. assisting with obtaining a tax ID or incorporation documents and with completing any other business paperwork required by local and state codes;
5. supporting the person to develop and implement a system for bookkeeping, tax preparation/payment and records management; and

6. providing effective on-the-job training and skill acquisition.
7. utilizing employment resources such as: One-Stop Career Centers, Division of Vocational Rehabilitation, Department of Workforce Solutions, Chambers of Commerce, Job Accommodation Network, Small Business Development Centers, Service Corps of Retired Executives (SCORE), businesses, community agencies, Partners for Employment, or DDS resources, to achieve employment outcomes.

11.7.2.7 Job Aide

The Job Aide provides one-to-one (1:1) personal care services in an individual, community integrated employment setting for people who require assistance with Activities of Daily Living (ADL) during work hours to maintain successful employment as job coaching is reduced. The scope of work includes, but is not limited to, the following:

1. assistance with personal care and ADLs during work hours; and
2. advocating for the person to be integrated into the work culture, including attending job-related social functions and interacting with their non-disabled co-workers during lunch or break times as well as fully accessing employer designated dining or break areas.

11.7.2.8 Intensive CIE

ICIE is designed to provide services for people who are working in an individual, community integrated employment setting and require more than 40 hours of staff supports per month to maintain their employment. The scope of services for ICIE is the same as those outlined in [11.7.2.3 Job Maintenance](#) above.

11.7.3 Agency Requirements

1. Provider Agencies must submit the “quarterly reporting with data related to work and non-work outcomes to DDS quarterly. (See [Chapter 19: Provider Reporting Requirements](#).)
2. CIE Provider Agencies will ensure that services occur in an integrated work setting where the person:
 - a. is paid fairly for the work performed and in accordance with Workforce Innovation and Opportunity Act Workforce (WIOA), the Fair Labor Standards Act and NM Labor Law;
 - b. is treated in a respectful manner, including respect for culture and language;
 - c. shares the same status and has the same wage structure as others performing the same or similar work;
 - d. is presented with opportunities for advancement which are similar to those for employees without disabilities who have similar positions;

DD Waiver Services
Chapter 11: Community Inclusion

- e. assures wages or compensation for work comply with the Fair Labor Standards Act (FLSA) and the Code of Federal Regulations; and
- f. assures provider Medicaid reimbursement is not the source of individual compensation for work.

Chapter 12: Professional and Clinical Services

12.1 General Scope and Intent of Professional Services

Professional and Clinical Services include behavioral and therapeutic services provided by licensed professionals. The services are not covered under the Medicaid State Plan, EPSDT, or bundled into any other DD Waiver service model. Depending on the discipline, professional and clinical services may include assessment, development of related support plans, training of paid and unpaid caregivers to carry out the plan, and monitoring activities. The services are delivered in the person's home or in the community as described in the ISP. This chapter contains requirements for Provider Agencies of the following DD Waiver services: Behavior Support Consultation (BSC), Nutritional Counseling, Therapy Services, and Preliminary Risk Screening and Consultation (PRSC).

12.2 Behavior Support Consultation

12.2.1 *Positive Behavior Support*

Positive Behavior Support (PBS) emphasizes the acquisition and maintenance of positive skills (e.g., building healthy relationships) to increase the person's quality of life—understanding that a natural reduction in other challenging behaviors will follow. Specifically, in PBS the BSC identifies skills and capacities that contribute to a person's ability to experience success and satisfaction in a range of settings. Support includes all efforts to teach, strengthen, and expand positive behaviors. The focus of support is primarily on assisting and guiding the person toward opportunities to pursue the goals that genuinely represent what is most important to the person. An important, but secondary consideration is to understand, anticipate, and minimize or prevent problem behaviors that have general and specific outcomes or functions for the person. The usual function of problem behavior becomes less useful when people are supported effectively and when those responsible for support are given sufficient information and guidance. Problem behavior may be reduced or eliminated when a person is assisted to achieve desired goals in socially desirable ways. Effective support considers changes to the environments, relationships, and activities available to a person rather than exclusively targeting problem behavior.

12.2.2 *Behavioral Support Consultation*

Behavioral Support Consultation (BSC) services are intended to enhance the DD Waiver participant's quality of life by providing PBS as the person works on functional and relational skills. BSC services identify distracting, disruptive, and/or destructive behavior that impacts quality of life and provides specific prevention and intervention strategies to manage and lessen the risks these behaviors present. While other service system settings (e.g., SSE) and generic community settings (e.g., adult continuing education) are also considered and utilized when needed, BSC services do not include individual or group therapy, or any other mental health or behavioral health services that would typically be provided through the Medicaid state plan benefits.

The BSC has the essential responsibility for identifying key aspects of positive behavior and PBS. The BSC leads the continuous discovery of antecedent conditions—the who, what, where and when of all behavior; the why regarding motivation and behavioral function; and generates prevention and intervention strategies. The BSC supports the person's successful achievement of Vision-driven Desired Outcomes. A quality foundation for BSC has several components:

1. assessment of the person and their environment, including barriers to independent functioning;
2. design and testing of strategies to address concerns and build on strengths and skills for independence; and
3. writing and training plans in a way that the person and Direct Support Professional (DSP) can understand and implement them.

12.2.3 Service Requirements

BSC services, including training and monitoring may be delivered in person (face to face), via telehealth/telephonic (remote), or through a combination of methods, based on the task to be completed, and the BSC's assessment of the situation in collaboration with the individual and/or their guardian (if applicable). Unless there is a public health emergency, the BSC may not rely on providing only remote services during the ISP year. BSC services are required to include the following outcomes or activities (at a minimum):

1. guide the person's and the IDT's understanding of contributing factors that currently influence behavior such as: genetic and/or syndromal predispositions, developmental and physiological compromises, traumatic events, co-occurring I/DD and mental illness, communicative intentions, coping strategies, and environmental issues;
2. enhance the person's and the IDT's competency to predict, prevent, intervene with, and potentially reduce behaviors that interfere with quality of life and pursuit of ISP Desired Outcomes, including recommendations regarding needed adaptations to environments in which the person participates;
3. be available for timely discussion and revision of assessments, plans, and semi-annual reports per DOH/DDSD Service Plans for people with I/DD living in the community [7.26.5 NMAC];
4. attend and consult, either in person, via telehealth or by conference call, the annual ISP and any other IDT meeting convened for service planning that have behavioral implications for the person and the provision of BSC services;
5. support effective ISP implementation through timely completion of the PBSA, PBSP, BCIP, PPMP and semi-annual reporting as applicable;
6. develop assessment and plans in compliance with required components outlined in the "Beyond the ABCs" training required of new BSCs;
7. initial and annual re-assessments (i.e., PBSAs) must include face-to-face, in person evaluation unless they are conducted when under a Public Health Emergency or other State or Local Order;
8. support effective implementation of the CARMP by complying with all relevant requirements found in [Chapter 5.5 Aspiration Risk Management](#);
9. develop behavior support strategies to lessen the negative impact of contributing factors to enhance the person's autonomy and self-determination;
10. provide IDT members, including DSP, with training, materials and/or other relevant information needed to successfully implement the PBSP and perform any ongoing data collection or provider reporting required by the PBSP and all other related plans (BCIP, PPMP, or RMP);
11. train staff, and/or an agency designated trainer;

12. collaborate with medical personnel, ancillary therapies, and Provider Agencies of Living Supports (Family Living, Supported Living, IMLS), CIHS, CIE, and CCS to promote coherent and coordinated support efforts, including mutual scheduling of timely training sessions;
13. schedule training in appropriate groupings, when possible, to maximize time efficiency for all participants;
14. train and designate trainers jointly with and according to the following:
 - a. Training will include discussions with the designated trainer and exercises designed by the BSC to demonstrate understanding by DSP.
 - b. After the designated training of DSP, the BSC will follow up with observation of DSP and, if indicated, provide individual or group re-training within 30 calendar days.
 - c. Designation will follow all requirements outlined in [Chapter 17.9 Individual-Specific Training](#).
15. assist relevant DD Waiver Provider Agencies (e.g. Family Living, Supported Living, IMLS, CIHS, CIE, and CCS) to reference relevant portions of the PBSP in the TSS;
16. monitor the person's progress at a frequency determined by the BSC in conjunction with the IDT, in various settings in person or via telehealth when necessary through direct observation, staff interviews and/or data collection;
17. document his or her on-site visit in the agency program log where the visit occurred;
18. attend a HRC meeting, either in person, via telehealth, or by conference call, to answer questions that the HRC may have:
 - a. at the initial presentation of any plan (PBSP, BCIP, PPMP or RMP) containing interventions requiring review;
 - b. at the annual review of any plan(s) if the restriction(s) is (are) applicable; and
 - c. when any substantial changes are made to the restriction(s) that a plan contains;
19. advocate for supports that assure the person is free from aversive, intrusive measures; chemical, mechanical, and non-emergency physical restraint; isolation; incarceration; and abuse, neglect, or exploitation;
20. speak with the individual and their guardian (if applicable) to ensure any medical, behavioral, or psychiatric information is provided as part of an individual's routine medical or psychiatric care;
21. attend psychiatric appointments when the person:
 - a. has a significant change in their psychiatric condition or has a mental health diagnosis not currently well managed, putting the individual at risk for reduced access to community or family affiliation or resources, or increased risk of psychiatric hospitalization or criminal justice involvement;

- b. requires ongoing psychiatric evaluation where specialized data collection and analysis is needed;
- c. is currently in Crisis Supports due to a psychiatric or behavioral issue; or
- d. has been recommended to have a Risk Management Plan because of a Preliminary Risk Screening where psychiatric issues are considered a contributing factor.

12.2.3.1 Fading of BSC Services

On an annual basis, BSCs are required to consider whether BSC services should be faded (this normally occurs during the conduct of the annual assessment (PBSA)). If a designated trainer can train appropriately for a specific portion of the PBSP (or other related plans), then fading should be considered in that area. Information from ongoing monitoring of plan implementation should be used to determine the appropriateness and degree of fading BSC supports. As a part of fading, BSCs may consider if a designated trainer might complete initial training of the PBSP and/or training of portions of the PBSP and related plans when appropriate.

Fading should be considered if:

1. life circumstances are stable for the person, e.g., there have not been any recent moves or life changes such as the introduction of a new roommate.
2. PBSPs and related plans such as BCIPs, CARMPs and PPMPs are being consistently implemented across settings and only require minimal training and monitoring (by the BSC or designated trainers).
3. BSC services across settings are primarily focused on monitoring, observing, and assessing progress.
4. Individual is likely to maintain current level of progress with existing DSP supports if the BSC decreases frequency of visits.

12.2.4 Service Limitations

1. BSC services do not include individual or group therapy, or any other mental health or behavioral health services that would typically be provided through the behavioral health system. DD Waiver services may not replace services available through Medicaid or Medicare behavioral health services but may be provided concurrently.
2. Children and young adults who receive counseling or behavioral health services through their local school may also receive BSC services through the DD Waiver; the focus of their PBSP is limited to home and community, rather than the school setting. No more than five hours of service per year may occur in the school setting for school age children and young adults, only for attending IEP meetings and cross-over training.
3. Individuals must have an initial or annual PBSA that indicates they meet the clinical necessity criteria for ongoing services.

12.2.4.1 Licensure

A mental health professional that wants to provide BSC services must possess one of the following approved by a New Mexico licensing board:

1. An independent practice license as a:
 - a. Psychologist,
 - b. Licensed Clinical Social Worker (LCSW),
 - c. Licensed Independent Social Worker (LISW),
 - d. Licensed Professional Clinical Mental Health Counselor (LPCC),
 - e. Licensed Professional Art Therapist (LPAT),
 - f. Licensed Marriage and Family Therapist (LMFT) or
 - g. Master Degree Psychiatric Nurse.
2. A supervisory-level practice license: Professionals licensed at this level are approved in one-year increments by BBS Bureau Chief, Clinical Director or designee and require direct clinical supervision by an independently licensed mental health professional. These licenses include:
 - a. Mental Health Counselor (LMHC),
 - b. Clinical Mental Health Counselor (LMHC),
 - c. Master Social Worker (LMSW), or
 - d. Psychologist Associate (PA).

12.2.4.2 Clinical Experience with Individuals with I/DD

1. BSCs must have a minimum of one year of clinical experience or history of working with individuals with I/DD.
2. A combination of relevant education, internship, familial, or volunteer experience may be substituted for caseload history or clinical experience in certain exceptional circumstances with prior written agreement from the DDSD.
3. Regardless of current level of licensure (independent or supervisory) professionals without this experience require clinical supervision by an independently licensed BSC for a minimum of one year.

12.2.4.3 Exceptions to Qualifications

1. An academic intern from an accredited university may participate in the provision of BSC services under the clinical supervision of an independently licensed BSC. The academic intern's time is not billable. A copy of the signed academic internship agreement between the university, the clinical supervisor, and the academic intern and a supervision plan must be submitted to the BBS Bureau Chief, Clinical Director, or designee and must not exceed two years. Academic interns may not work with individuals until their internship agreement and supervision plan has been approved by the BBS Chief, Clinical Director, or designee.
2. Professionals with a Master of Arts or Master of Science degree and certified as a Board-Certified Behavior Analyst (BCBA) may provide BSC. Professionals in this category require clinical supervision by an independently licensed mental health professional; the

supervisor and/or contracting agency notifies DDSD/BBS of their supervised status annually.

3. Professionals with a Master's level teaching license working in the DD Waiver Program as a BSC as of November 1, 2012, in good standing, may continue to provide BSC. Professionals in this category require clinical supervision by an independently licensed mental health professional; the supervisor and/or contracting agency notifies DDSD/BBS of their supervised status annually.
4. BSCs who have a supervisory-level license or are in one of the exception categories require a written Supervision Plan. The supervisor is clinically responsible for all services provided by the supervisee(s) and must follow all supervision requirements of their licensure board. Supervisors must assure compliance with those requirements and will consult their licensure board regularly to keep current on supervision requirements for their respective disciplines. In addition, the supervisor and supervisee agree to the following:
 - a. Both supervisor and supervisee will document the clinical and service issues, as well as the review of case progress notes, assessments, and plans that are discussed at each supervision session.
 - b. The supervisor will countersign all assessments, plans and semi-annual reports verifying their clinical review prior to the documentation being provided to teams.
 - c. Documentation of the supervision will be provided to the DDSD semi-annually.

12.2.5 Agency Requirements

BSC agencies and the services that their employees or subcontractors provide are subject to the oversight and monitoring of the DDSD BBS.

1. As of July 1, 2013, each BSC Provider Agencies must employ or subcontract with at least one professional with an independent practice license.
2. BSC Provider Agencies are required to ensure BSC meeting attendance, site visits, and telephone coverage during regular business hours. BSCs are required to provide information to CMs and other pertinent IDT members regarding arrangements for vacations and/or extended absences, when the BSC is not able to respond within 24 hours during regular business hours.

12.2.5.1 Documentation

The BSC Provider Agency must ensure documentation contains all requisite components and meets the following requirements. All documents (except a BSC's progress notes and semi-annual reports) are a billable activity and must be submitted per the person's ISP budget year. BSCs must provide PBSAs to core IDT members at least two weeks prior to the scheduled annual IDT meeting. PBSPs and other plans (BCIP, PPMP) will be provided within 30 calendar days of the start of the annual ISP term, unless noted otherwise below:

1. Positive Behavior Supports Assessment (PBSA): Individual assessments are conducted at minimum on an annual basis, when there has been a change in the status of either the person, or the BSC Provider Agency, or when the new BSC deems it necessary to ensure the assessment accurately reflects current situation and fulfills all requirements.
2. Positive Behavior Supports Plan (PBSP): When BSC services have been authorized based upon PBSA results, the PBSP must be developed and/or revised as needed; when there has been a change in the status of the person or BSC Provider; and is updated at least annually, no later than 30 calendar days of the start of the annual ISP term. PBSPs must contain written strategies for DSP to implement regarding PBS.
3. Revisions required by DDSD: If the DDSD determines that there is a need to revise the PBSA and/or PBSP, the BSC must make the revisions within 30 calendar days. If health and safety issues have been identified by DDSD, an assessment or revised assessment must be completed, the plan revised, and staff trained on the revisions within ten calendar days of notification by DDSD.
4. Behavioral Crisis Intervention Plan (BCIP): When the person's needs episodically exceed the techniques and interventions contained in the PBSP, a BCIP must be developed. The BCIP clearly describes how those supporting the person are to intervene in a behavioral crisis; a BCIP may include more than one behavioral concern requiring crisis intervention. All Direct Support Professional must be trained on the BCIP within ten (10) calendar days of plan development. The BCIP must be reviewed and modified at least annually and in response to changes in the person's status or at the request of the DDSD. If health and safety issues have been identified by DDSD, the plan must be revised and DSP must be trained on the revisions within ten calendar days of notification by DDSD.
5. CARMP, PRN Psychotropic Medication Plan (PPMP), and/or Risk Management Plan (RMP): BSCs develop, train, and monitor these plans when applicable, CARMP development by the BSC occurs in accordance with requirements outlined in [Chapter 5.5 Aspiration Risk Management](#).
6. Semi-Annual Report: The semi-annual report documents progress toward PBSP goals and must be submitted according to timelines detailed in [Chapter 19 Provider Reporting Requirements](#).
7. Progress Notes: Documents all meetings, trainings, client visits, monitoring and all other interactions for which billing is generated; time spent compiling notes is not billable.

12.2.5.2 Requirements for Document Submission

1. The BSC/BSC Agency is responsible for the timely submission to core members of the person's IDT of the following documentation:
 - a. the current PBSA, PBSP, and Semi-Annual Progress Report; and

- b. the BCIP, PPMP, and RMP when applicable.
- 2. The BSC/BSC Agency is responsible for submission to DDSD and/or BBS upon request and within the timeframe and format requested of the following information:
 - a. the current PBSA, PBSP, and Semi-Annual Progress Report;
 - b. the BCIP, PPMP, and RMP, when applicable;
 - c. documentation of the name of the supervisor and all supervision given by the Provider Agency to subcontractors or employees;
 - d. progress notes; and
 - e. documentation of HRC approval for any PBSP, BCIP, PPMP, or RMP that requires HRC review.

12.3 Preliminary Risk Screening and Consultation

Preliminary Risk Screening & Consultation (PRSC) is a part of a comprehensive and collaborative process designed to address continued risk of sexually inappropriate and/or offending behavior in persons who exhibit or have a history of exhibiting risk factors for these types of behaviors. This service is part of a variety of behavior support services (including BSC and Socialization & Sexuality Education) that promotes community safety and reduces the impact of interfering behaviors that compromise the person's quality of life. PRSC is provided by a licensed mental health professional who has been trained and approved as a Risk Evaluator by the BBS and who is engaged in a review process that is continuously guided by clinical and wider system expertise.

12.3.1 *Scope*

1. The PRSC service provides, through a structured risk screening process and related levels of clinical review:
 - a. Identification of individual level and type of risk-related concerns for inappropriate sexual behavior, including:
 - i. conducting a preliminary risk screening either in person (face to face), via telehealth/telephonic (remote), gathering information according to BBS-approved structured risk screening protocol;
 - ii. considering the risk associated with vulnerable others (e.g., related to current roommates or changes in roommates, work or community settings that routinely may contain vulnerable persons, etc.); and
 - iii. determining the periodic need to review risk based on the person's circumstances and clinical expertise within a multi-layered system of clinical review of risk screening and related risk/management strategies.
 - b. Strategies for risk management under the least restrictive supervision conditions, including:
 - i. developing and refining risk management strategies based on the individualized risk profile; and
 - ii. recommending reduction in supervision when clinically indicated
 - c. Technical assistance related to the identification of the management of risk level, including:
 - i. preliminary risk screening and periodic case review;
 - ii. ongoing case consultation with BBS staff, expert consultant(s) or a designee;
 - iii. assistance with a referral to a licensed professional for a Risk Assessment or Psychosexual evaluation if recommended; and
 - iv. assistance to the BSC or IDT when a person requires an RMP.

- d. Drafting of consultation notes and/or preliminary risk screening report.
2. Individuals may not receive BSC services from the Risk Evaluator.
3. The Risk Evaluator is required to:
 - a. engage in activities necessary to collect information and collaborate with expert consultant(s) to complete a preliminary risk screening report, revised report, and/or consultation notes per the BBS-approved templates including recommendations regarding measurable goals and a system of implementation; and
 - b. interface with BBS following completion of a screening or periodic case review in the following ways:
 - i. provide reports and/or consultation notes to BBS and the referring team within 30 calendar days of the preliminary risk screening meeting; and
 - ii. participate in any mandated BBS-sponsored trainings and meetings.

12.3.2 *Service Requirements*

12.3.2.1 *Qualifications for a Risk Evaluator*

This service is provided only by a Risk Evaluator who has first participated in the PRSC process as a trainee, and then as a provisional supervised Risk Evaluator.

Each professional shall provide documentation to BBS of completion of the following qualifications to be considered for provisional provider application approval:

1. a master's or doctoral degree in a counseling or counseling-related field from an accredited college or university;
2. a current independent practice license, through the Board of the New Mexico Regulation and Licensing Department (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners) in a counseling or counseling-related field;
3. at least two years of clinical experience working with individuals with I/DD;
4. at least one year of clinical experience working with individuals with I/DD who have inappropriate sexual behaviors;
5. have demonstrated a willingness to work collaboratively with BBS, consultants, and teams; and
6. have demonstrated a commitment to maintaining competency (through documented reading, conference attendance or training) of best practice in the field of risk screening and management of individuals with I/DD who exhibit sexually inappropriate or offending behavior.

12.3.2.2 *Prerequisite Requirements*

The professional shall provide documentation to BBS of completion of the following activities:

1. completion of pre-requisite training requirements for Risk Evaluators as outlined in 12.3.2.2.3
2. notification in writing of interest in providing the service;
3. participation in an initial interview with BBS or designated BBS consultant to determine whether qualifications have been met to be accepted into pre-requisite training; and
4. participation in at least two screenings with a BBS-approved Risk Evaluator (i.e., reviews information prior to screenings, attends screenings, debriefs, reads, and discusses consultation notes or report with the Risk Evaluator).

12.3.2.2.1 Preliminary Competency Review

After meeting the qualifications and pre-requisite requirements, the professional will complete the provider application for the service and interview with BBS and/or consultants for a preliminary competency review to determine whether a Provisional 12-month Provider Approval will be granted.

12.3.2.2.2 Provisional Approval

If granted Provisional Provider approval, the provisional Risk Evaluator is required to complete the following to become a BBS-approved Risk Evaluator within the first 12 months:

1. facilitate at least four risk screenings with on-site supervision by a BBS-approved Risk Evaluator including case preparation, interview(s), draft consultation notes or report, and feedback to teams;
2. complete at least 20 hours of additional supervised independent training and reading related to risk screening and treatment of individuals with I/DD who exhibit sexually offending behaviors;
3. demonstrate continued ability to work collaboratively with BBS and teams; and
4. participate in a final competency review with BBS to determine whether requirements for full BBS approval in this area have been met.

12.3.2.2.3 Training and Supervision Requirements for BBS-Approved Risk Evaluators

Training and supervision requirements for BBS- approved Risk Evaluators are to:

1. complete training requirements for Risk Evaluators within 30 days and prior to working alone with individuals;
2. Complete training on NMDOH-approved Abuse, Neglect and Exploitation (ANE) Awareness, reporting procedures in accordance with NMAC 7.1.14. ANE Awareness training must be completed within 30 days of hire and prior to working alone with a person in services and according to requirements detailed in Chapter 18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting, then ANE Awareness every year;
3. complete ANE refresher each year and participate in regular, mandatory update trainings at least annually with a BBS-designated trainer; and

4. Complete the DDSD-approved curriculum on Indications of Illness and Injury within 90 days of hire and prior to working alone with a person in service, and
5. participate in mandatory trainings at least annually with the BBS designated trainer for the service.
6. participate in ongoing supervision with a BBS-designated supervisor, which will include a combination of:
 - a. on-site, virtual and telephone contact;
 - b. collaborative review of documents and reports; and
 - c. on-site, virtual, or telephonic co-facilitation of risk screenings.

12.3.3 *Agency Requirements*

The agency providing the PRSC service is required to submit the following to the BBS:

1. documentation that the designated Risk Evaluator has met qualifications and completed all requirements; and
2. assurance that the qualified BBS-approved Risk Evaluator will provide the service personally.

12.4 Therapy Services

DD Waiver Therapy Services are required to be consistent with the Participatory Approach Philosophy and the Collaborative-Consultative service delivery model. This service emphasizes supporting increased participation, independence, and community inclusion in combination with health and safety. Therapy services are provided when indicated to support the achievement of a person's Visions and Desired Outcomes in the ISP and the prioritized areas of need identified through therapeutic assessment.

Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) are skilled therapies recommended by a person's IDT members and subsequent clinical assessment that demonstrates the need for therapy services. Therapy Practitioners may also include Physical Therapy Assistants (PTA) or Certified Occupational Therapy Assistants (COTA) providing services in collaboration with their supervisor.

Individuals on the DD Waiver with rehabilitation/therapy needs related to illness or injury, may receive referrals for Medicaid State Plan (or other medical coverage plans) for acute medically focused therapy, Home Health Therapy or Hospice Services. The DD Waiver Therapist collaborates as needed and shares knowledge about the person to support the delivery of these acute, short term services.

Non-duplicative DD Waiver Therapy Services may be provided concurrently with both Medicaid funded State Plan or other covered therapy services. They may also be provided concurrently with in-home Home Health Therapy and Hospice services. DD Waiver Therapy Services may not be provided concurrently with inpatient Medicaid Services (e.g., hospitalization, long term care or rehabilitation).

12.4.1 Participatory Approach

The "Participatory Approach" is person-centered and asserts that no one is too severely disabled to benefit from assistive technology and other therapy supports that promote participation in life activities. The Participatory Approach rejects the premise that an individual shall be "ready" or demonstrate certain skills before assistive technology can be provided to support function. All therapists are required to consider the Participatory Approach during assessment, treatment planning, and treatment implementation. Services provided using the Participatory Approach are person centered:

1. Therapy Services are required to be based upon each person's needs, tolerance for activity, preferences, and abilities.
2. Therapy Services are required to be designed to support functional participation and self-advocacy in fulfilling roles with family, friends, the community, and members of common interest groups.
3. Interventions will be determined by the person, whether his or her preferences are expressed independently, with assistive devices or interpreted by others and according to culturally appropriate and age-appropriate values.

4. Services provided using the Participatory Approach are required to integrate therapy strategies into daily life.
5. The therapist shall develop strategies to support activities of daily life through development of WDSIs addressing a variety of topics including health and safety needs. The WDSIs are utilized by DSP during routine activities, and by IDT-members to create TSS that further integrate therapy strategies into the ISP and the individual's daily life as needed.

12.4.2 Collaborative- Consultative Model

The Collaborative-Consultative therapy service delivery model is required to be followed by therapists providing therapy under the DD Waiver. The role of the therapist is to design and train supportive/adaptive strategies through direct collaboration with the person, DSP and other members of the IDT. Purposes for collaboration and consultation include the following:

1. to ensure that therapy provided under the NM DD Waiver is of the highest quality and professionally appropriate;
2. to coordinate therapy interventions and ensure consistent approaches;
3. to share information as it pertains to the person receiving services;
4. to perform specialty evaluations such as aspiration risk management; and
5. to provide crossover training and to respond to special requests for assistance.

12.4.3 Delivery of Therapy Services/Service Setting

All therapy practitioners are required to provide interventions according to their NM Licensure Acts. Therapists supervising therapy assistants are responsible for providing the appropriate quality and frequency of supervision to ensure safe and effective therapy service delivery.

1. Therapy services must be delivered in settings where the person lives their life. This includes home and community settings. Visits may not occur exclusively in only one setting using one modality.
2. Therapists may use their expertise with a specific modality to deliver therapy services (e.g., pool, horses, dogs, gymnasium). However, that one modality or site may not be exclusive to other sites and delivery of services in all life settings including customized community supports, as appropriate and agreed upon by the individual, guardian, therapist, and respective provider.
3. Therapy services must involve training of those who work directly with the individual across settings to follow through with recommended activities and strategies.
4. Therapy services, including training and monitoring may be delivered in person (face to face), via telehealth (remote), or through a combination of both methods, based on the task to be completed, the condition of the individual and the therapist's assessment of the situation. Unless there is a public health emergency, the therapist may not rely on providing only remote services during the ISP year.

5. Therapy services may be delivered in the community setting. The therapy intervention plan must address any routine delivery of service that involves seeing the individual at a community site. One on one services may be delivered during community services and training and integration of any WDSIs may occur. Therapy visits should be integrated into the individual's daily routine. The therapist may take the individual to a different location. Discussion about locations for delivery of therapy services, including scheduling, should occur with the individual, the IDT, and the guardian. Communication with Provider Agencies is critical to assure collaboration and smooth planning.
6. Visits to employment sites should not occur unless they are in direct alignment with an employment related reasonable accommodation that has first been approved by the individual, guardian, and employer.

12.4.4 *Physical Therapy*

12.4.4.1 *Qualifications*

1. A physical therapist, or a physical therapy assistant, licensed by the New Mexico Regulation and Licensing Department (NMRLD), may provide billable physical therapy services in accordance with the American Physical Therapy Association's scope of practice.
2. A physical therapist providing services under the DD Waiver shall follow supervision provisions of New Mexico's Physical Therapy licensure standards.
3. A student physical therapist or a student physical therapist assistant may provide billable physical therapy services if a formal academic intern agreement is signed by the therapy Provider Agency and the university and 100% direct on-site supervision is provided for evaluation and treatment services by a licensed physical therapist or physical therapy assistant who is an approved DD Waiver therapist.

12.4.4.2 *Scope*

1. Physical therapy is a skilled licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions, or injuries.
2. A licensed Physical Therapy Assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist in accordance with the PT Licensing Act.

12.4.5 *Occupational Therapy*

12.4.5.1 *Qualifications*

1. An Occupational Therapy Practitioner (OT) or Certified Occupational Therapy Assistant (COTA) with a current and active license issued by the NMRLD may provide billable occupational therapy services in accordance with the current NM OT Licensing Board/OT Practice Act and applicable American Occupational Therapy Association (AOTA) guidance documents.
2. A Level II Student Intern from an AOTA accredited university may provide billable services on behalf of an occupational therapy Provider Agency if a formal academic intern agreement is signed by the Therapy Provider Agency and the student's university. An OT Student must receive 100% direct on-site supervision during client evaluation and treatment by a DD Waiver OT (for OT students) or a DD Waiver OT and OTA as applicable (for OTA students). The supervising OT shall review and approve all support services such as non-direct Assistive Technology services. The supervising OT shall review and sign all therapy related reports/documentation completed by the Level II Student Intern.
3. An Occupational Therapy Aide/Technician or a Level I Student Intern is not permitted to provide billable occupational therapy services to DD Waiver participant.

12.4.5.2 *Scope*

1. Occupational Therapy is a skilled licensed therapy service involving the use of everyday life activities (occupations) for evaluation, treatment, and management of functional limitations. Occupational Therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.
2. Occupational Therapy services typically include:
 - a. evaluation and customized treatment programs to improve one's ability to engage in daily activities;
 - b. evaluation and treatment for enhancement of performance skills;
 - c. health and wellness promotion;
 - d. environmental access and assistive technology evaluation and treatment;
 - e. training and consultation to family members, Direct Support Professional, and others as indicated; and
 - f. training and consultation to family members, Direct Support Professional and others as indicated.

3. Occupational Therapy Assistants (COTAs) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT and in accordance with the current NM OT Licensing Act.

12.4.6 *Speech-Language Pathology*

12.4.6.1 *Qualifications*

1. A Speech Language Pathologist (SLP), licensed by the NMRLD, may provide billable speech-language pathology services in accordance with the American Speech-Language-Hearing Association (ASHA) scope of practice.
2. A clinical fellow with clinical fellow licensure issued by the NMRLD may provide billable speech-language pathology services with supervisory experiences as detailed in their Clinical Fellowship Plan accepted by ASHA:
 - a. A copy of the clinical fellow temporary license shall be submitted to the DDS Provider Enrollment Unit (PEU) as with other required provider application materials at the time that the clinical fellow is employed by an agency.
 - b. The clinical fellowship supervisor shall be knowledgeable about current clinical best practices with the I/DD population and these DD Waiver Therapy Standards. All services provided are required to be within the ASHA scope of practice.
 - c. The approval to provide services shall be obtained prior to the initiation of therapy services by the clinical fellow. Proof of permanent New Mexico Speech-Language Pathology licensure shall be submitted to PEU within 18 months or at the successful completion of the Clinical Fellowship Plan, whichever occurs first.
3. A graduate student intern from an ASHA accredited university may provide billable services in cooperation with a speech language pathology Provider Agency:
 - a. If a formal academic intern agreement is signed by the Therapy Provider Agency and the university and 100% direct, on-site supervision is provided for evaluation and treatment services by a licensed speech-language pathologist who is an approved DD Waiver Therapy Service Provider Agency.
 - b. All required clinical documentation is signed by the student intern and the supervising DD Waiver speech-language pathologist.
 - c. The academic intern agreement is approved annually for a term of one year.
 - d. The approval to work as an intern is granted for no more than two (2) one-year terms for any individual.
4. An Apprentice in Speech Language Therapy is not permitted to provide billable speech therapy services to DD Waiver participants.

12.4.6.2 *Scope*

Speech-Language Pathology Service, also known as Speech Therapy, is a skilled licensed therapy service, provided by a Speech-Language Pathologist. Speech Therapy involves the non-medical

application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensorimotor competencies. Speech-Language Pathology services are also used when a person requires the use of an augmentative and alternative communication system and/or strategies.

12.4.7 *Service Requirements*

12.4.7.1 Client Ratio and Co-Treatment for OT, PT and SLP

1. Therapists provide individual therapy using a therapist-to-client ratio of one therapist to one DD Waiver participant (1:1 ratio). This may include collaboration with multiple DSP, for the period of the therapy service.
2. Therapists may provide co-treatment when there is a functional and/or clinical need for more than one therapy discipline to meet during a session to address the needs of one individual. This treatment is utilized when multiple areas of expertise are required to meet ISP Visions, Desired Outcomes and Action Plans.
3. Co-treatment is utilized for a limited time, for a specific objective and identified in the Therapy Intervention Plan, when anticipated. It may include collaboration with one or more family members and/or DSP.

12.4.7.2 IDT Participation

Therapists support the individual in achieving their ISP visions, Desired Outcomes and Action Plans through the following requirements:

1. Therapists participate in annual and any ARM related IDT meetings in person (face to face), via telehealth (remote) based on health and safety needs at the time of the meeting.
2. Therapists are required to participate in additional IDT meetings when the agenda contains issues relevant to their specific therapy disciplines.
3. Therapy services, including training and monitoring may be delivered in person (face to face), via telehealth (remote) or a combination of both methods, based on the task to be completed, the condition of the individual and the therapist's assessment of the situation. Unless there is a public health emergency, the therapist may not rely on providing only remote services during the ISP year.
4. If real-time participation at the IDT is not possible, the therapist will:
 - a. inform the CM before the meeting regarding their absence and provide input relevant to the topic of the meeting;
 - b. submit applicable therapy reports and other required documentation that would support the IDT's discussion of the issue prior to the meeting;
 - c. contact the CM after the meeting for a summary to determine assignments the IDT members may have requested of the therapist; and
 - d. submit additional relevant documentation to the IDT within required timelines.

5. Therapists provide clinical expertise to all members of the IDT as needed. Therapists are required to contribute expertise to support the person's achievement of Visions, Desired Outcomes and Action Plans as identified in the ISP.

12.4.7.3 Assistive Technology (AT) Services, Remote Personal Support Technology (RPST) and Environmental Modifications

Therapists support the person to access and utilize AT, RPST and Environmental Modifications through the following requirements:

1. Therapists are required to be or become familiar with AT and RPST related to that therapist's practice area and used or needed by individuals on that therapist's caseload.
2. Therapists are required to provide a current AT Inventory to each Living Supports and CCS site where AT is used, for each person using AT related to that therapist's scope of service.
3. Therapists are required to initiate or update the AT Inventory annually, by the 190th day following the person's ISP effective date, so that it accurately identifies the assistive technology currently in use by the individual and related to that therapist's scope of service.
4. Therapists are required to maintain professional documentation related to the delivery of services related to AT, RPST and Environmental Modifications. (Refer to [Chapter 14 Other Services](#) for more information about these services.)
5. Therapists must respond to requests to perform in-home evaluations and make recommendations for environmental modifications, as appropriate.

12.4.7.4 Aspiration Risk Management Supports (ARM)

Therapists support the person in minimizing aspiration risk, identifying signs of illness, and obtaining prompt medical treatment through the following requirements. Therapists are required to follow all applicable activities related to ARM as described in [Chapter 5.5 Aspiration Risk Management](#).

12.4.7.5 Collaboration and Consultation

DD Waiver therapists collaborate and consult with a variety of IDT members and others to support the identified needs of the person. This includes members of the IDT; Primary Care Practitioners; medical specialists; other clinical professionals and a Provider Agency personnel. These activities include but are not limited to:

1. Collaborating with IDT members and Provider Agency personnel regarding therapy needs, seeking input for assessment, development, and implementation of the Therapy Intervention Plan and WDSIs.
2. Attending specialized medical or employment related appointments to obtain clinical information related to therapy services and provide input as clinically indicated.
3. Communicating concerns about the person's condition and the implementation of plans to the appropriate agency staff in a timely manner.

4. Collaborating with agencies on the IDT, when requested, to schedule appropriate training and support regarding WDSI implementation in sessions that are mutually beneficial and maximize time efficiency for all participants. Scheduling additional one to one training may be needed to ensure competence for strategies that could impact health and safety.
5. Communicating to ensure that therapy appointments occur as scheduled and DSP are available to participate in therapy sessions, as requested.
6. Communicating with Living supports and CI agencies regarding new or existing DSP that require training; status of assistive technology (through use of the Assistive Technology Inventory monitoring process); significant change in condition; and/or other issues that affect therapy.
7. Collaborating and communicating with fellow DD Waiver therapists regarding the needs of the person supported.
8. Collaborating with therapists delivering services through Medicaid State Plan or other insurance funded medical rehabilitation services to share knowledge about the person that supports the delivery of those services. Non-duplicative DD Waiver therapy services may be delivered concurrent with medical rehabilitation services, but not concurrently with inpatient services.
9. Consulting and collaborating with DD Waiver agency staff and with Home Health and Hospice providers preceding or during in-home care; verifying that DD Waiver therapy services may be delivered concurrent with Home Health and in-home Hospice care.
10. Seeking consultation from DDSD Clinical Services Bureau, Bureau of Behavioral Support, Regional Offices, and others as needed.

12.4.7.6 **Skilled Treatment/Individual Therapy**

Therapists may provide direct skilled treatment to individuals whose assessment results indicate interventions that may be applied only by a licensed therapist. Direct skilled treatment requirements include:

1. Skilled treatment services may be used on a limited basis to treat a specific clinical diagnosis and/or condition.
2. Treatment of specific conditions are clinically related to a person's I/DD.
3. Skilled treatment services may not be delegated or included in a WDSI.
4. Skilled treatment services are required to be provided in conjunction with the Collaborative-Consultation Model of service delivery.
5. The outcome of the skilled therapy should be applicable to the person's life in all settings. When additional follow-up support by the family or DSP is needed, the therapist will create a WDSI, provide training, and indicate the desired settings for implementation.

12.4.7.7 **Training of IDT Members by Therapists**

1. Training frequency is required at least annually according to the individual ISP term on all WDSIs. Training may occur more frequently, as needed, according to the therapist's judgment or as requested by family, DSP, or IDT.
2. Therapists may, according to their clinical judgment, designate an agency staff to provide ongoing training of DSP in their agency following verification of competence by the therapist. The designee must agree to be a designated trainer and the IST Designation Record Form must be completed and submitted to the designee's personnel file. Trainer designation should be specified in the IST section of the ISP under "who provides the training" as "therapist or designee".
3. In some instances, therapists may provide targeted assessment and brief intervention for targeted needs. The therapist may develop WDSI as part of these services. After initial training the therapist may, according to their clinical judgment, transfer training and monitoring responsibilities to another therapist on the team or to the Living Supports and/or Community Inclusion agency.
4. The individual should be present during training sessions whenever appropriate. The presence of the person is necessary for effective training of such programs as the CARMP.

12.4.7.8 **Monitoring Services**

Therapists are required to monitor and measure the effectiveness of therapy activities listed in this chapter. Monitoring can include a variety of approaches such as observation, data collection and interview as well as "hands-on" intervention to assess the effectiveness of strategies.

1. Therapists are required to monitor and report on the progress of the person toward the achievement of therapeutic goals and objectives including those that relate to specific visions and desired outcomes in the ISP.
2. Therapists are required to monitor the implementation of WDSIs to determine the need for additional training, effectiveness of the WDSI, and readiness for fading.
3. Therapists may transfer monitoring to another IDT member after short-term targeted intervention. This is upon the discretion and consensus of the IDT.
4. Therapists are required to monitor the effectiveness of their skilled therapy interventions. Therapists are required to monitor, any AT or RPST devices related to that therapist's scope of practice to ensure devices are available, functioning properly, and are effective in the settings of intended use.

12.4.7.9 Fading of Therapy Services

1. On an annual basis, therapists are required to consider whether therapy services should be faded. Fading may occur for each aspect of service provision at a time. If a designated trainer can train appropriately for a specific WDSI and/or CARMP, then fading should be considered in that area.
2. Information from ongoing monitoring of WDSI implementation should be used to determine the appropriateness and degree of fading for each WDSI.
 - a. As a part of fading, therapists may consider if a designated trainer might complete WDSI and/or CARMP training when appropriate. Fading may occur for each aspect of service provision at a time
 - b. Fading should be considered if:
 - i. life circumstances are stable, there have not been any recent moves or life changes.
 - ii. WDSIs are being consistently implemented across settings and only require minimal training and monitoring (by therapist or designated trainers).
 - iii. therapy services across settings are primarily focused on monitoring, observing, and assessing progress.
 - iv. Individual is likely to maintain current level with existing DSP supports if the therapist eliminates or decreases frequency of visits.

12.4.7.10 Transitioning Therapy Services

Therapists and Therapy Provider Agencies are required to conduct an orderly and smooth transition of therapy services to a new therapy provider when necessary.

1. The therapist must follow the requirements described in [Chapter 9 Transitions](#)
2. The therapist must complete the following during a transition of services:
 - a. The therapist is required to provide a written transition of therapy notice to the CM and the person/guardian at least 30 calendar days prior to the anticipated transition or as soon as possible due to unforeseen circumstances.
 - b. The therapist is required to complete and distribute a Discontinuation of Therapy Services report (See [Chapter 12.4.7 Discontinuation of Therapy Services Report](#)) and provide the new therapist with copies of the current therapy intervention plan, evaluation reports and other relevant therapy documentation created during the past 12 months.
3. When needed, the transitioning therapist may collaborate with the new therapist during the initial visit. CM and therapist should discuss budget revision dates prior to submission.

4. When therapy is initiated by a new provider, it is the responsibility of the new therapist to review the previous evaluation and determine if another assessment with accompanying evaluation report will be completed or if therapy can proceed with the original information.

12.4.7.11 Discontinuation of Therapy Services

It is required that therapies delivered according to the Collaborative-Consultative Model be discontinued when fading has been successful, there are no other services recommended by the therapist and no additional services are requested by the IDT or additional therapy services are not authorized.

When discontinuation of a specific therapy services is being considered the following actions are required:

1. Discontinuation of the therapy service will be discussed by the full IDT prior to exiting of that service. The therapist should provide factual information about why discontinuation of therapy is appropriate at this time and what structure are or can be put in place to support the individual.
2. When the IDT determines that a therapy will be discontinued, the following will occur:
 - a. The IDT is required to consider integrating appropriate strategies and/or WDSIs developed by the therapist into the ISP, TSS and/or transferring the training and monitoring responsibilities to another entity (i.e. different therapy provider, as appropriate; supervisor at the Living Supports and/or CI agency).
 - b. Strategies and/or WDSIs developed by the therapist will no longer be identified with the therapist's name but may be integrated into the ISP as described above. Short-term therapy because of targeted evaluation/intervention for a specific IDT request for consultation is not subject to this requirement (such as for Environmental Modifications, new wheelchair or RRPST.).
 - c. The therapist is required to complete and distribute a Discontinuation of Therapy Service Report.
 - d. A therapy service that is discontinued may be re-initiated only when the IDT provides a clearly documented rationale regarding the renewed need for the service that meets established clinical criteria for prior authorization. The rationale may include loss of function since discharge using the last evaluation report and a new evaluation to support that determination; the introduction of a new Action Plan that requires additional therapeutic support; or a current evaluation report that states the need for specific services not currently available on the IDT.

12.4.7.12 Therapy Documentation

Therapists create, provide, distribute, and retain all needed documentation for individuals on their caseload through the following requirements.

12.4.7.12.1 General Documentation Requirements

1. All reports must be titled as to the type of required report or description of report content, if not a standard required report.
2. Reports must have a heading that includes the following at a minimum: client name, client date of birth, last 4 numbers of client SS#, CM name and agency, date of report, and date(s) of service. If service is a span of time, indicate start and end date of service period that report covers;
3. Subsequent pages must have client name, report title, report date and page number.
4. Each report must end with licensed therapist's signature (handwritten or electronic); professional credentials, date of signature, name of Provider Agency and contact phone number.

12.4.7.12.2 Initial Therapy Evaluation and Assessments

Evaluations are initiated at the request of the IDT and may be comprehensive or focused on a targeted area. The evaluation is an assessment of the person's status, functional skills and needs. Assessments are required to be individualized, functionally based, as well as to consider functional environments.

1. Initial and Targeted Therapy Evaluation Reports:
 - a. An Initial or targeted Therapy Evaluation Report is required when a new therapy service is initiated and will contain:
 - i. referral information;
 - ii. relevant background medical and social history;
 - iii. relevant information from consultation with IDT;
 - iv. relevant diagnoses;
 - v. assessment tools;
 - vi. processes used and results;
 - vii. interpretation of assessment data;
 - viii. recommendations regarding referral to other services if applicable; and
 - ix. recommendations regarding the need for services and any areas of focus for that therapy discipline's intervention.
6. Timeline and Distribution:
 - a. The initial assessment must be completed within 30 calendar days following the approved budget.
 - b. The completed Initial Therapy Evaluation Report, with therapy recommendations regarding the person's therapy support needs, must be distributed to the

complete IDT. The total time from budget approval to report distribution shall be within 44 calendar days. The completed Targeted Therapy Evaluation report, with therapy recommendations regarding the person's therapy support needs, must be completed and distributed to the IDT. The total time from budget approval to report distribution shall be within 44 days.

12.4.7.12.3 Annual Therapy Re-Evaluation Report

Therapists are responsible for conducting an annual re-assessment and writing an Annual Therapy Re-Evaluation Report for individuals recommended to receive continued ongoing therapy services.

1. The Annual Therapy Re-Evaluation Report shall contain:
 - a. The status of any therapy related interventions in the person's living or day activities during the prior year.
 - b. The status of any therapy related recommendations generated by entities outside of the IDT.
 - c. The functional status and progress of the person in all areas addressed in therapy during the prior year. For individuals at moderate or high risk for aspiration and an ongoing CARMP, this includes an ARM re-evaluation.
 - d. Status of, and recommendations regarding, continuation, modification, or discontinuation of current therapy goal(s) and objective(s) in comparison to established baselines. This includes WDSIs, DSP training, RRPST and AT.
 - e. Assessment tools/processes used, and the results obtained for any pertinent areas traditionally addressed by that therapy discipline.
 - f. The Annual Therapy Re-Evaluation Report does not contain new/proposed therapy goals or objectives.
2. Timeline and Distribution: The Annual Therapy Re-Evaluation Report must be distributed by the therapist to the person/guardian and an IDT member from each service provider that appears on the budget, no more than 45 days and no less than 14-calendar days prior to the annual IDT meeting.

12.4.7.12.4 External Consultation Reports

External consultation reports such as video fluoroscopy and specialty clinics reports should be retained in agency files and referenced as needed in the Therapist's documentation.

12.4.7.12.5 Therapy Documentation Form (TDF)

The TDF combines the Therapy Intervention Plan (TIP), the Semi-Annual Review, and the budget worksheet.

1. The TDF is required for initial and ongoing therapy intervention. The TDF itself contains instructions for completion. There is also an associated instruction sheet to the TDF that

contains detailed information. The therapist must follow the instructions and complete each required section of the TDF:

- a. The TIP section should be revised during the ISP cycle if there is a significant change in the person's status that requires significant changes to therapy services.
- b. If there is a change in therapists, the TIP should be reviewed and be modified as needed.
- c. If the TIP must be revised, the revision must be submitted and processed by the case manager through the established budget revision process.

12.4.7.12.6 Written Direct Support Instructions (WDSI)

Therapists are required to develop Written Direct Support Instructions (WDSIs) for all areas in which DSP need guidance to incorporate these therapy instructions into the person's daily life routines and targeted activities. WDSIs may be developed to support the person with health, safety, ISP visions and desired outcomes and/or increased participation/independence in daily routines. Therapists must use professional judgment to determine which strategies are appropriate and safe for DSP to implement. These strategies do not include skilled therapy services.

1. WDSIs become the basis for training sessions with DSP/team members and are an outline of the areas for training. WDSIs are prioritized and developed gradually based on therapy assessment, the person's needs and preferences, as well as interactive trials of various strategies with the person, the therapist and DSP/team members to determine the effectiveness of the proposed strategies.
2. Therapists are required to develop at least one WDSI within the first six months of receiving an initial therapy budget for ongoing intervention with an individual. Additional WDSIs shall be developed for all appropriate areas as described above and according to the Therapy Intervention Plan and discipline-specific needs.
3. WDSIs shall be developed with user-friendly language that is easily understood by those implementing the instructions. The use of bullet lists, diagrams and photos are good strategies for effective WDSIs. Multiple areas of instruction should not be combined into one global WDSI.
4. Each WDSI must contain:
 - a. A distinct title that describes the individual area of instruction;
 - b. The name of the individual;
 - c. The most recent date the plan was developed, reviewed, or revised;
 - d. An outline of strategies that are to be carried out by the DSP;
 - e. Information regarding the frequency or under what circumstances the strategies should be implemented; and
 - f. The name and credentials of the author and contact information for the author.

5. Timeline and Distribution:

- a. New WDSIs are due, following strategy development and before expected DSP/IDT member implementation.
- b. Ongoing, continued or maintenance WDSIs should be reviewed and revised as needed and redistributed at least annually after development of a new TDF and at least 2 -weeks prior to the ISP effective date for a new ISP cycle. All WDSIs shall be distributed to the CM, to all IDT members and to all agencies where the instructions will be implemented.
- c. Annual retraining of ongoing (continued or maintenance) WDSIs should be completed within 30 calendar days following the ISP effective date.
- d. WDSIs may be revised as needed within the ISP annual cycle. When the WDSI is revised, re-distribution and re-training of DSP/IDT members are necessary.

12.4.7.12.7 Discontinuation of Therapy Services Report

A Discontinuation of Therapy Services Report is required when any ongoing therapy service is stopped, during or at the end of an ISP service cycle.

1. The Discontinuation of Therapy Services Report shall contain:

- a. Date that the provider's therapy services were discontinued;
- b. reason for discontinuation of therapy services delivered by the current therapy provider;
- c. the status of most recent therapy goals;
- d. recommendations from the current therapy provider regarding therapy;
- e. use of assistive technology;
- f. implementation of specific therapy strategies;
- g. other services that may be needed; and
- h. the status of the current budget including the balance of units, by billing code, which have not been used by the discharging therapist.

2. Timeline and Distribution:

The Discontinuation of Therapy Services Report shall be distributed to all IDT members at the time due. If services are discontinued the Discontinuation of Therapy Services Report is due within 14-calendar days following the end of services.

12.4.7.13 Therapy Agency Requirements

Therapy Provider Agencies are required to establish and maintain separate financial reporting and accounting activities that are in accordance with state Medicaid requirements.

Therapy Provider Agencies are required to have an established automated data system for financial reporting purposes. Secured internet access is required to access the Medicaid billing system. Therapy Provider Agencies may be selected for an in person or remote CSB-Therapy Quality Review. The Provider Agency will receive a written report. The Agency Director will sign acknowledging receipt.

12.5 Nutritional Counseling

Nutritional Counseling Services (NCS) Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan and menu services that supports the person to attain or maintain the highest practicable level of health.

Nutritional Counseling Services are already available and bundled into the reimbursement rates for the recipients of DD Waiver Family Living, Supported Living and IMLS.

Nutritional Counseling Services provided by the DD Waiver are in addition to, and shall not duplicate, nutritional or dietary services allowed in the person's Medicaid state plan benefit, or other funding source.

12.5.1 *Scope*

The scope of nutritional counseling includes the following activities to:

1. perform assessment/evaluation of individual nutritional needs annually or as needed due to a change of condition;
2. develop a nutritional plan, train DSP as needed, and revise plans annually or as warranted by change of condition;
3. participate in collaborative assessment for people who are identified at moderate or high risk for aspiration ([Chapter 5.5.2 Collaborative Aspiration Risk Assessment](#));
4. train relevant DSP to implement appropriate section of the CARMP;
5. monitor the nutrition portion of the CARMP a minimum of four times a year, revise and retrain as necessary;
6. participate in IDT meetings as needed; communicate information; share documentation and provide training and consultation to IDT members, DSP, and other relevant parties on the person's nutritional needs and implementation of the plan;
7. educate the person to manage their own dietary needs via counseling and other nutritional interventions; and
8. monitor the effectiveness of nutritional plan, adjusting plan content and strategies as indicated.
9. Serve as an active member of the IDT and address overall nutritional needs, diet, tube feeding, weight loss or gain, wounds, and a variety complex medical or behavioral conditions that have or may impact the persons overall health.

12.5.2 *Qualifications*

Nutritional counseling may be provided by a registered dietician (RD) or licensed nutritionist (LD). This service may be delivered in person or via telehealth.

12.5.3 *Service Requirements*

Nutritional Counseling may be provided in the same setting and at the same time as another service except for Supported Living, Family Living or IMLS.

1. Nutritional Counseling involves the following service requirements to:
 - a. ISP meetings as needed when nutritional issues are on the agenda;
 - b. collaborate with physicians, nursing, and IDTs as needed regarding the nutritional needs of persons with enteral (G or J tube) feedings; weight issues or complex medical nutritional needs to support health and safety;
 - c. provide Nutritional Counseling in a manner consistent within professional scope of practice and within the established code of conduct; and
 - d. provide the Nutritional Counseling individually, not with a group of recipients.
3. Nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's Medicaid state plan benefit, or other funding source.
4. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Nutritional counseling cannot be billed as a separate service during the hours of living supports.

12.5.4 *Agency Requirements*

1. The Nutritional Counseling Provider Agency must assure that employees or contractors submit:
 - a. any evaluation or assessments once completed;
 - b. the nutritional plan and a semi-annual report to IDT members which must:
 - i. summarize progress toward nutritional goals outlined in the nutritional plan including the CARMP; and
 - ii. address the extent to which nutritional interventions are successful in supporting the person's health (e.g., impact on constipation, weight, or disease management).
2. The Nutritional Counseling Provider Agency must assure that employees or contractors delivering this service maintain relevant licensure or certification requirements with the State of New Mexico Licensing Board, and act within their recognized professional code of conduct from American Association of Nutrition and Dietetics.
3. The Nutritional Counseling Provider Agency must maintain adequate staffing to meet the nutritional needs of the people in service.

4. The Nutritional Counseling Provider Agency must provide for coverage or reassignment of contractors or employees experiencing significant illness or vacation.

Chapter 13: Nursing Services

This chapter contains standards for the delivery of nursing services that support the health and safety of persons on the DD Waiver.

The Nursing Services Chapter is divided into three sections.

Sections 13.1 and 13.2 provide an overview of the nurse's role and address the general requirements that are applicable for all nursing supports in the DD Waiver whether providing nursing through a bundled model in Supported Living (SL), Intensive Medical Living Services (IMLS), Customized Community Supports Group (CCS-G) or nursing that is separately budgeted through Adult Nursing Services (ANS).

Section 13.3 addresses specific Adult Nursing Services (ANS) requirements. Although all Family Living Provider Agencies are required to be ANS Provider Agencies, delivering nursing through ANS is not limited to Family Living Provider Agencies. Any nurse or health organization may contract to be an ANS provider for DDSD. The ANS section of this chapter includes information regarding situations for which ANS are required and gives general guidance to all ANS Provider Agencies. The scope of Adult Nursing Services includes:

- a. Nursing Assessment and Consultation provides 12 hours or 48 units of nursing time each ISP year for initial basic and some ongoing supports. For more information refer to [Chapter 13.3.1 Nursing Assessment and Consultation Services](#).
- b. Ongoing Adult Nursing Services (OANS) if selected or required, must go through prior authorization based on the requested nursing supports. For more information see [Chapter 13.3.2 Ongoing Adult Nursing Services \(OANS\)](#).

13.1 Overview of The Nurse's Role in The DD Waiver and Larger Health Care System

Routine medical and healthcare services are accessed through the person's Medicaid State Plan benefits and through Medicare and/or private insurance for persons who have these additional types of insurance coverage. DD Waiver health related services are specifically designed to support the person in the community setting and complement but may not duplicate those medical or health related services provided by the Medicaid State Plan or other insurance systems.

Nurses play a pivotal role in supporting persons and their guardians or legal Health Care Decision makers within the DD Waiver and are a key link with the larger healthcare system in New Mexico. DD Waiver Nurses identify and support the person's preferences regarding health decisions; support health awareness and self-management of medications and health conditions; assess, plan, monitor and manage health related issues; provide education; and share information among the IDT members including DSP in a variety of settings, and share information with natural supports when requested by individual or guardian.

Nurses also respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver. DD Waiver nurses must contact and consistently collaborate with the person, guardian, IDT members, Direct Support Professionals and all medical and behavioral providers including Medical Providers or Primary Care Practitioners (physicians, nurse practitioners or physician assistants), Specialists, Dentists, and the Medicaid Managed Care Organization (MCO) Care Coordinators. Refer to [Chapter 5.1 Healthcare Coordination](#) for additional details.

13.2 General Nursing Services Requirements and Scope of Services

The following general requirements are applicable for all RNs and LPNs in the DD Waiver. This section represents the scope of nursing services. Refer to [Chapter 10: Living Care Arrangements \(LCA\)](#) for residential provider agency responsibilities related to nursing. Refer to [Chapter 11.6 Customized Community Supports \(CCS\)](#) for agency responsibilities related to nursing.

13.2.1 Licensing, Supervision, and Delivery of Nursing Services

All DD Waiver Nursing services must be provided by a Registered Nurse (RN) or licensed practical nurse (LPN) with a current license in good standing in New Mexico or under the Nurse Licensure Compact (NLC). The Nurse Licensure Compact is an agreement between New Mexico and other states that allows reciprocity for licensed nurses.

1. Nurses and Certified Medication Aides (CMAs) must comply with all aspects of the New Mexico Nursing Practice Act.
 - a. An RN must provide routine supervision and oversight for LPNs, Certified Medication Aides (CMAs), and all direct support professionals (DSP) to whom they have delegated specific nursing tasks.
 - b. An LPN or CMA may not work without the routine supervision and oversight of an RN.
 - c. CMAs may not practice within their scope unless the DD Waiver Agency is also an active Certified Medication Aide Provider in good standing with the New Mexico Board of Nursing.
2. If the minimum routine required face to face visits have been met, nursing services, including DSP training and monitoring of the individual and implementation of all plans, may be delivered in person (face-to-face), via telehealth/remote methods or through a combination of methods, based on the task to be completed, the condition of the individual and the nurse's assessment of the situation. Refer to 13.2.4 for tables of routine required visits.
3. The nurse may provide support or direct oversight of nursing students in accordance with their agency policy and the contract agreement with the school of nursing. The nursing student's time is not billable.

4. Nursing assessments including the e-CHAT should be completed in person when possible although telehealth/remote methods may be used when needed, based on prudent nursing practice and the emergent condition of the person.
The RN and LPN may not exclusively use remote methods of oversight unless under a Public Health Emergency or other State or Local Order.

5. Nurse Delegation:

Delegation is a unique relationship between the nurse and a DSP. Delegation is solely contingent on the discretion of the nurse and their nursing judgment. As such, delegation cannot be mandated by the agency and cannot be transferred between nurses or between direct support staff.

When delegation of specific nursing functions has been granted, the nurse, must:

- a. Train each DSP to skill level competency.
- b. Monitor ongoing staff performance, skill level, and the person's health status.
The frequency of monitoring must be based on the delegated task and assure the individual's health and safety.
- c. Rescind delegation immediately at any time the nurse determines that the DSP is unwilling or unable to safely perform the delegated task.
- d. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office.
- e. If the nurse or DSP are no longer employed by the agency, the delegation relationship is nullified. The Agency Nurses must resume responsibility of formerly delegated tasks.
- f. Delegated nursing tasks, training and monitoring for continued competence can only be provided by the delegating nurse.

13.2.2 Collaboration and the Hierarchy of Responsibility for Nursing Tasks

DD Waiver nursing is a community nursing service and is intended to support the individual across all aspects of their life. Nurses in all DD Waiver settings must routinely and professionally communicate and collaborate with one another. Nurses must also communicate with clinical and non-clinical partners within the Waiver system and throughout the larger health care system as needed for the benefit of the person's health and safety.

1. The Primary Provider Nurse (PPN) within the DD Waiver, is determined by the hierarchy (listed below). The hierarchy flows in descending order and is based on the individual's budgeted services. The PPN hierarchy identifies the primary responsibility for nursing tasks that are listed in other sections of Chapter 13 and other chapters of these Standards.
 - a. Living Supports: Supported Living or Intensive Medical Living Supports (IMLS)

- b. Family Living (via Adult Nursing Services: Refer to [Chapter 13.3 Adult Nursing Services](#))
 - c. Customized Community Supports- Group.
 - d. Adult Nursing Services (ANS): Refer to [Chapter 13.3 Adult Nursing Services](#).
 - i. for persons in Community Supports (CCS-I or CCS- SG) or Employment (CIE) with health-related needs.
 - ii. for persons in Customized In-home Supports (CIHS) if health needs may exist or assessment is desired.
 - iii. for persons in unpaid residential services if assessment is desired and health needs may exist.
2. When persons are supported in multiple DD Waiver settings, nurses must communicate, collaborate, and share information with one another regarding the person to support health and safety in all settings.
3. Only the PPN is required to complete the nursing assessment which includes the ARST, MAAT, and e-CHAT. However, they must take the lead to collaborate with nurses in other settings. The PPN is also responsible for sharing the outcomes of those assessments with the other nurses. Refer to [Chapter 13.2.8 Electronic Nursing Assessment and Planning Process](#).
4. Each nurse providing services must create and train their own Health Care Plans and MERPs pertinent to their location of service and participate in CARMP development. See below and Refer to [Chapter 13.2.9 Planning, Training and Implementation of Health Care Plans and Medical Emergency Response Plans](#).
5. The Comprehensive Aspiration Risk Management Plan (CARMP) is the HCP for aspiration, oral hygiene, and tube feeding. The CARMP is the only HCP that is shared in all service settings. The following communication and collaboration must occur:
 - a. The primary provider nurse collaborates with other nurses on the team to ensure access to “CARMP Draft Questionnaire in Therap” Refer to [Chapter 20.5.6 CARMP Draft in Therap](#) .
 - b. All nurses, despite service setting, must collaborate in CARMP development. Refer to [Chapter 5.5 Aspiration Risk Management](#). Specific details regarding completion of the CARMP and training responsibilities.
 - c. Training will be done by the nurses in their service settings for areas on the CARMP where the nurse is identified as the “Lead Contact.”
6. Discharge Planning
 - a. The nurse will collaborate with the CM and other applicable IDT members (i.e., BSC) to support planned discharges after out of home placement from hospitals,

nursing homes, rehabilitation units/facilities or incarceration. Discharge planning includes but is not limited to the following:

- i. Communication with person, guardian, IDT members and out of home provider as needed.
 - ii. Participation in discharge planning meetings.
 - iii. Requesting copy of the discharge summary paperwork from the person/Guardian to inform the continuation of orders and care.
 - iv. Obtaining any new orders or prescriptions if needed and supporting rapid prior authorization of medications if required.
 - v. Coordinating with the DD Waiver Case Manager and the Discharge Planner or MCO Care Coordinator to assure the Home Health Agency or Durable Medical Equipment (DME) dealer provides all needed medical supplies or DME to the home prior to discharge and provides any training on the devices as needed.
 - vi. Consulting with the person/guardian regarding discharge orders and follow-up appointments.
 - vii. Clarifying any updates to Do Not Resuscitate (DNR) orders or end of life planning as needed.
- b. After discharge from an out of home placement, nurses will complete the following tasks:
- i. The Primary Provider Agency Nurse will:
 1. Implement all new orders.
 2. Complete ARST, MAAT, and e-CHAT.
 3. Communicate with other provider nurses who support the person regarding the discharge, any new orders or information and the results of the assessments.
 4. Collaborate in editing the CARMP as needed.
 - ii. All nurses
 1. will collaborate in updating the CARMP as needed.
 2. will collaborate with other team members such as therapy, RD and BSC as needed.
 3. update the HCPs and MERPs, as needed, in their setting and provide training to all DSP.
 4. collaborate with the BSC and/or BBS in updating the PRN Psychotropic Medication Plans (PPMPs)
 - iii. Refer to [Chapter 13.2.7 Documentation Requirements for all DD Waiver Nurses](#) regarding Discharge Planning and

return from OOHP.

7. Transition or change in DD Waiver Provider Agency
 - a. It is the responsibility of both the current and new DD Waiver Provider Agency nurses to communicate and ensure that safe and appropriate planning takes place.
 - b. For persons with health-related issues, nurses must attend the IDT Transition meetings in person or remotely. It is imperative that the exchange of health-related information, personal preferences, required documentation, training of staff, and moving logistics are addressed including medications, supplies, DME and other health related issues. Refer to [Chapter 9 Transitions](#) and [Chapter 13.2.7 Documentation Requirements for all DD Waiver Nurses](#).
8. When Hospice or Palliative services are initiated or utilized, DD Waiver PPN must attend the IDT meeting to communicate and collaborate with the Hospice or Palliative team to clearly identify the roles and responsibilities of the DD Waiver IDT and Hospice/Palliative agency teams to meet the needs and goals of the individual or guardian.
 - a. When Palliative or Hospice services are initiated, it is a change of condition and the PPN must review and update the ARST, MAAT, and e-CHAT to reflect this change in status.
 - b. All existing HCPs/MERPs must be reviewed and edited as needed by the PPN and other provider nurses and new HCPs and MERPs must be created to reflect this significant change. Integration of any key tasks to be performed by Hospice or Palliative staff should be noted in the plans so that DSP will clearly understand their responsibilities and those of the Hospice or Palliative team.
 - c. HCPs/MERPs must reflect the person's condition including updates to health, pain management or end of life plans (such as "Do Not Resuscitate" (DNR) requests) made by the person/health decision maker/guardian.
 - d. All HCPs and MERPs are intended to support the person's decisions and provide clear guidance to the DSP regarding the steps to take when caring for the person while in hospice or palliative care including who to contact in specific circumstances.
 - e. The DD Waiver Provider Agency nurses are responsible for training the DD Waiver DSP on these plans and helping the DSP to support the wishes of the person and their guardian. Nurses may co-train with hospice nurses, as needed, to provide information and support to the individual, IDT, DSP, or others.
 - f. DD Waiver PPN are responsible for ongoing communication and collaboration with the CM, guardian, MCO care coordinator and others, such as the Regional

Office Nurses or other Division staff, as needed, to address ongoing health and safety needs.

- g. During Hospice services, the DD Waiver Agency Nurse must be contacted by all DSP who are not related by affinity or consanguinity for permission to assist with PRN pain, anti-anxiety medications and all other PRN medications.
 - i. the DD Waiver Agency Nurse should confer with BSC on the IDT (if present) when these medications are initially ordered by the Hospice physician to incorporate behavioral elements in plans if needed.
 - ii. A PPMP and HRC approval are NOT required for pain or anxiety medications ordered by Hospice during end-of-life care.
- h. The DD Waver Agency nurse must communicate and collaborate with the Hospice nurse regarding the person's status and overall response to all routine or PRN medications or treatments that are used. This is needed to assure that medications for comfort, anxiety and pain relief are effective and appropriately used.

13.2.3 General Requirements Related to Orders, Implementation, and Oversight

1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicate with providers regarding the person as needed.
2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued.
 - a. The nurse will contact the ordering or on call practitioner as soon as possible, or within three business days, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties.
 - b. Based on prudent nursing practice, if a nurse determines to hold a practitioner's order, they are required to immediately document the circumstances and rationale for this decision and to notify the ordering or on call practitioner as soon as possible, but no later than the next business day.
 - c. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers. Refer to [Chapter 13.3 Adult Nursing Services](#).
3. DD Waiver nurses may take verbal or telephone orders only in limited circumstances.
 - a. Nurses may take verbal orders about issues that are not related to prescribed medications.
 - b. Nurses may not take any verbal orders for new prescribed medications including over the counter medications.

- c. Nurses may not take any verbal orders for ongoing changes in dose, time, or frequency for current, prescribed medications.
- d. Nurses may take verbal orders regarding the delivery of existing, ordered, prescribed medications. The verbal order is to allow timely medication or modification of doses based on the person's current needs and does not allow the nurse to transmit the order to the pharmacy.
 - i. This is limited to temporary dose modification which could include delaying a dose, holding a dose, or giving an extra dose as ordered by the prescriber.
 - ii. If the medication is related to behavioral symptoms, the nurse must notify the BSC as soon as possible.
- e. All information related to a verbal order must be documented, noted, timed, and dated by the nurse and retained in the individual's record.
 - i. The nurse must clearly document the person's specific clinical circumstances and all contact and phone calls with the ordering practitioner, indicating the date and time of the call and the exact order.
 - ii. The nurse must follow the Provider Agency Pharmacy Manual regarding the timeframe and process for getting the verbal order for existing medications or treatments authorized and signed by the ordering practitioner.
 - iii. If this timeframe is not addressed in the Provider Agency's Pharmacy Manual, then all verbal orders for medication must be signed and dated by the ordering practitioner and returned to the Provider Agency within 10 business days of the date of the verbal order.
 - iv. The procedure for the obtaining the ordering practitioner's signature on the verbal order must follow the Provider Agency's Pharmacy Manual. If this is not addressed in the Manual, then the following methods of documentation must be used:
 - a. The ordering practitioner must sign and date a paper or electronic copy of the order. The Provider Agency nurse and Management team are responsible for obtaining and retaining the order in a timely manner. Refer to 5.iii above.
 - b. All documentation related to a verbal order must be printed, noted, timed, and dated by a nurse and retained in the individual's record

13.2.4 Nursing Monitoring and Oversight Requirements

1. Nurses in all settings must complete routine required visits to monitor the status of the individuals.
 - a. This requires seeing the person face to face; determining their status and needs; monitoring the DSP implementation of HCPs and MERPs and providing or reinforcing training for the DSP or the individual as needed.
 - b. Routine Nursing visits may be provided via telehealth (remote) instead of face-to-face during Public Health or other local emergencies per DDSD, Health Department, or other local orders.
2. The frequency of routine required visits is based on the person’s aspiration risk and acuity levels, complexity of needs, Jackson Class Status, and type of service setting.
3. The location of the routine required nursing visits when supporting the person in:
 - a. Residential settings (SL, SL - Category 4, IMLS and FL) will be in their home.
 - b. CCS-G; CCS-I, CCS-SG or CIE will be in the community program setting or in an office setting.
 - c. CIHS will be in their home.
4. Frequency of routine required nursing visits:

The minimum, face to face visit frequency for non-JCMs are based on the person’s aspiration risk and acuity levels derived from the ARST and the e-CHAT or the Supported Living Category. See Table 1, below and 13.2.4.c.

| Table 1: Minimum Routine Required Nursing Visit Schedule for non-JCMs based on eCHAT Acuity and Aspiration Risk | |
|--|-----------------------------------|
| Acuity and Aspiration Risk Level | Frequency of Nursing Visit |
| Low Acuity | At least annually |
| Moderate Acuity | At least semi-annually |
| High Acuity | At least once per quarter |
| Moderate Aspiration Risk | At least once per quarter |
| High Aspiration Risk | At least monthly |

- a. The minimum face to face visit frequency of routine required nursing visits for JCMs are based on the person’s aspiration risk and acuity levels derived from the RST and the eCHAT or the Supported Living Category. See Table 2, below and 13.2.4.c.

| Table 2: Frequency of Routine Required Nursing Visits for Jackson Class Members (JCM) based on eCHAT Acuity and Aspiration Risk levels | | | |
|---|-------------|-----------------|-------------|
| eCHAT Acuity | | | |
| Aspiration Risk Level | Low | Moderate | High |
| Low | Semi annual | Quarterly | Monthly |
| Moderate | Quarterly | Quarterly | Monthly |
| High | Monthly | Monthly | Monthly |

- b. All individuals who are receiving Supported Living Category 4 services, including Jackson Class Members (JCM) in Category 4, will receive a nursing visit at least monthly. If the person qualifies for a monthly visit for more than one reason, the nurse is not required to do more than one visit.
 - c. The nurse must document the person’s status, services that are needed and delivered to support the person’s extreme or skilled needs. Refer to [Chapter 10.3.4 Additional Requirements for Supported Living Category 4 Extraordinary Medical Support](#).
 - d. Nurses supporting person’s in IMLS will visit each person daily with a weekly RN oversight visit. Refer to [Chapter 10.4.2 Living Supports-IMLS](#).
5. Focus of Routine Required Nursing Visits includes:
- a. Monitoring of the person, the DSP, records etc.
 - b. Provide training and support to the person or family.
 - c. Training, oversight, and monitoring of DSP should be completed in accordance with healthcare provider orders, the HCPs/CARMP/MERPs and prudent nursing practice.
 - d. Monitoring of delegated nursing tasks to assure correct understanding and implementation of the delegated tasks. Refer to [Chapter 13.2.1 Licensing, Supervision, and Delivery of Nursing Services](#).
6. In addition to the routine face to face visits, the nurse may provide additional visits using in person or telehealth/remote visits when deemed necessary to interact with the person, family, or staff based on prudent nursing practice.

13.2.5 Change of Condition

- 1. If the nurse identifies or is notified of any change of condition, the nurse may, based on prudent nursing practice, do the following:
 - a. complete a face-to-face assessment as soon as possible within 60 minutes, or

- b. use telehealth/remote services to visualize the individual and interact with DSPs, and/or
 - c. refer the person for immediate emergency care (Call 911) based on reported condition and prudent nursing practice, or
 - d. advise immediate follow up with urgent care, PCP, or another medical provider if safe and clinically appropriate, and
2. The nurse will document the change of condition and all actions, and all actions taken.'
3. The nurse will communicate with the PCP and with the CM to coordinate an IDT meeting as needed.

13.2.6 On-Call Nursing

1. An on-call nurse is required to be available to DSP in a timely manner. They must be able to respond within 15 minutes by phone and within 60 minutes in-person to assess the person if deemed necessary per prudent nursing practice. The nurse may use telehealth/remote services to visualize the individual and interact with DSPs if this is deemed necessary per prudent nursing practice.
2. Any nurse residing out of state, including nurses who reside in states bordering New Mexico must be physically available within 60 minutes.
3. The on-call nurse is required to make an on-site visit when information provided by DSP indicates, in the nurse's professional judgment, that there is a need for a face-to-face assessment to determine appropriate action.
 - a. The on-call nurse is not obligated to make an onsite visit if, based on prudent nursing practice, they determine the person's condition may be unstable and it is safer and preferable to seek immediate access to emergency services (ER) via 911.
 - b. The nurse may refer to an urgent care if the person's condition warrants and will follow-up.
4. An LPN on duty or on-call must have access to their RN supervisor by phone in case consultation is required. LPN should log or document calls to the RN and the instructions they received. The RN is responsible for oversight of the LPN's actions when on call.
5. On-call nurses, both RN and LPN, are required to document the calls they receive, and the actions they have taken or directed. They must communicate with their agency nursing peers and agency management and follow up as needed on the person's status.

13.2.7 Documentation Requirements for all DD Waiver Nurses

Documentation of all professional nursing activities is required to be timely, accurate and in accordance with these standards, and standards of nursing practice. Refer to [Chapter 20 Provider Documentation and Client Records](#) for all guidance related to Therap.

1. Interactions with healthcare providers, must be documented as soon as possible and no later than one calendar day after the contact, in a signed, legible progress note indicating time, date, reason for the contact, call or visit, the outcome, and any planned next steps.
2. Interactions with the person, guardian, families, IDT members, and DSP are documented as soon as possible or within three calendar days in a signed legible progress note indicating time, date, reason for the contact, call or visit, the outcome, and any planned next steps.
3. Nursing visits conducted to monitor health status should be documented as soon as possible and no later than three calendar days after the visit.
4. Nursing visits conducted to evaluate a change of condition or urgent on-call request must be documented as soon as possible or within one calendar day after the visit or call.
5. Documentation of “on call” work will include date, time, reasons for the call and all actions taken. This may be entered in a legible progress note, log or entered in Therap.
6. Routine Nursing progress notes will contain, as appropriate:
 - a. subjective information including the person’s complaints and symptoms, or information reported by DSP, family, or other team members, and
 - b. objective information including apparent signs, physical examination and assessments including vital signs, weight, and other pertinent data for the given situation,
 - c. the nurse’s assessment of the situation,
 - d. the nurse’s immediate plan that addresses the person’s health issues or needs including all interventions and interactions with medical providers as appropriate,
 - e. any other information significant to the person’s health or situation that should be documented, and
 - f. follow up on any recommendations or orders from healthcare professionals.
7. The nurse must follow all requirements for documentation in Therap. Refer to [Chapter 20.5 Creating and Maintaining Records in Therap](#).
8. Electronic signatures are acceptable with the nurse’s credentials identified.
 - a. A nurse may not allow another person or nurse to use their electronic signature.
 - b. A nurse may not use another person’s or nurse’s electronic signature.
9. Out-of-sequence charting or late entry notes may be used to document information that was missed or not entered in a timely manner. The new entry must be made as soon as possible and must be clearly identified as an “out of sequence” or “late entry” nursing note. The late entry must contain the date and time that the late entry is being

documented and the date, time and a summary of the past events which were not promptly documented.

10. Per the nursing hierarchy, the Primary Provider Nurse will complete the ARST, MAAT, eCHAT and collaborate with DD Waiver nurses in other service settings. See [Collaboration and the Hierarchy of Responsibility for Nursing Tasks](#).
11. Semi Annual and Quarterly Reports to the IDT
 - a. Per the Hierarchy, the PPN will provide the IDT with semi-annual Health Care Reports. This frequency applies to all nursing services except IMLS. (See # 10.d below)
 - b. All Nursing reports must be completed using Health Care Reports in Therap, incorporating data from the Health Tracker, and must include a narrative by the nurse that addresses the person's current health status, all significant changes to date since the last report, and all progress towards planned health-related goals. (Refer to [Chapter 19.5 Semi-Annual Reporting](#)).
 - c. All semi-annual Health Care Reports must reflect the person's status in the period between the last semi-annual report and the annual ISP meeting and then cover the 6 -month time frame that begins with the start of the ISP cycle. Since these reporting periods will not be exactly 6 months apart, the nurse should document all significant events regarding health that have occurred since the previous report.
 - d. For individuals receiving IMLS, the nurse must complete a Quarterly Nursing Report that summarizes the person's health status, significant health or other events that have occurred since the previous Quarterly report and the services they receive. Refer to [Chapter 10 Intensive Medical Living Service \(IMLS\) Requirements](#). One of the Quarterly Nursing reports must be completed no more than 45 – 14 days before the annual ISP Meeting. Since the reporting periods prior to the annual ISP meeting, and other Quarterly reports, may not be exactly 3 months apart, the nurse should document all significant events that have occurred since the previous Quarterly report.
12. Documentation of Discharge Planning from Out of Home Placement
 - a. The nurse will document all activities regarding discharge planning for return to home after an out of home placement from hospital, nursing home, rehab stay or incarceration.
 - b. The nurse will collaborate with the CM to support appropriate discharge planning for safe return from out of home placements. Discharge planning includes the following:
 - i. pre-discharge IDT with hospital or other entity

- ii. consultation with the guardian regarding discharge orders and follow-up appointments
 - iii. coordinating with the MCO, home health or durable medical equipment dealer to obtain needed supplies before the discharge if possible.
 - c. After discharge, the PPN will: implement all new orders, complete the ARST, MAAT, and eCHAT; update all HCPs/CARMP and MERPs as needed, and complete training as needed.
- 13. Documentation of Transition between DD Waivers Agencies
 - a. When a person changes their primary DD Waiver Living Care provider agency, it is the responsibility of both the current and new primary residential providers to develop and implement a transition plan (refer to [Chapter 9.2 Changes in Service Provider Agencies](#) and [Chapter 9.11 Transfer of Documentation](#)) that addresses:
 - i. exchange of health-related information;
 - ii. effective communication of the person's preferences;
 - iii. ensuring the transfer of required documentation; and
 - iv. implementation of appropriate logistics including any AT, RPST, medical equipment and medication.
 - b. The Primary Provider Agency nurse from the discharging DD Waiver agency prepares a discharge summary report and provides it to the CM and the new primary residential provider on the day of discharge, regardless of the individual's length of stay. If the individual is staying in their residence but is transferring from a current CCS or CIE provider to a new agency, the current CCS/CIE nurse will complete the discharge summary and collaborate with the new CCS/CIE agency nurse.
 - i. The summary must contain a synopsis of the person's stay or time with the current provider and reflect their current health status and needs at time of discharge.
 - ii. The current provider nurse must collaborate with the new provider nurse to facilitate a smooth transition of care.
 - iii. Any impact to the person's level of care due to health or functional status changes must be discussed with the CM and the nurse from the new residential agency prior to the discharge.

13.2.8 Electronic Nursing Assessment and Planning Process

The DD Waiver nursing assessment process includes the following DDSD mandated tools: The Aspiration Risk Screening Tool (ARST), the Medication Administration Assessment Tool (MAAT), and the electronic Comprehensive Nursing Assessment Tool (e-CHAT).

Responsibility for these activities is based upon the Nursing Hierarchy listed in [Chapter 13.2.2 Collaboration and the Hierarchy of Responsibility for Nursing Tasks](#). There is an ongoing need for continuous professional communication and collaboration between all nurses on the person's team.

The ARST and MAAT must always be completed before the eCHAT because information from those tools informs the e-CHAT. It is recommended to complete the ARST first since this may impact the MAAT.

13.2.8.1 Medication Administration Assessment Tool (MAAT)

The MAAT is a tool used to determine the individual's needs related to their medications and identifies if this can be done independently or with increasing levels of support. The MAAT tool is aligned with the DDSD Assisting with Medication Delivery (AWMD) program and addresses other means of medication delivery.

1. The MAAT must be completed:
 - a. within 3 business days of admission or transfer to a new agency;
 - b. annually by a licensed nurse, at least 45-14 calendar days before the annual ISP meeting;
 - c. within 3 business days of significant change of condition or when any medication change occurs that may impact the delivery of the medication.
2. After completion of the MAAT, the PPN will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all team members at least 14 calendar days before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. It is not necessary to attach records of current or old medications to this report.
3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented by the CM in the ISP. If the team cannot reach consensus, the Guardian will decide.
4. The options for medication delivery are listed below. After the IDT determines which criteria the person meets, the PPN will obtain needed Primary Care Practitioner orders.

13.2.8.1.1 Self-Administration of Medication

1. If the person has the potential to self-administer medications and only needs additional training and support (which is based on the current MAAT results, the nurse's recommendation and the level of delivery agreed upon by the IDT), the IDT (including the nurse) should coordinate, plan, and provide this training and support.
2. The person and IDT should consider the use of AT or Remote Personal Support Technology (RPST) to support independence with self-administration. Persons and staff

should receive appropriate training as needed to support the person's optimal self-sufficiency.

3. After any needed training with AT or RPST is completed, the nurse will complete another MAAT to determine the level of support needed.
4. All people who self-administer medications in Living Supports must have a current Primary Care Practitioner order to self-administer medication and a current written consent from the Guardian if one is present.
5. Persons receiving CIHS-Independent Living while living with family or friends are not required to have a PCP order or consent to self-administer medications.

13.2.8.1.2 Self-Administration of Medication with Physical Assistance by Staff

1. People with physical challenges that prevent them from completing the process of taking medication independently, but who otherwise meet all criteria for independent self-administration, may receive support in the form of physical assistance from staff. If needed, specific ordered medications may need to be delivered by licensed/certified personnel per the MAAT.
2. All persons in Living Supports must have a current written consent, obtained from the person or guardian/surrogate healthcare decision maker for provision of self-administration of medication with physical assistance and a current Primary Care Practitioner order to self-administer medications with physical assistance by staff.

13.2.8.1.3 Assistance with Medication Delivery by Staff (AWMD)

For people who do not meet the criteria to self-administer medications independently or with physical assistance, trained staff may assist with medication delivery if:

1. Criteria in the MAAT are met.
2. Current written consent has been obtained from the person/guardian/surrogate healthcare decision maker.
3. There is a current Primary Care Practitioner order to receive AWMD by staff.
4. Only AWMD trained staff, in good standing, may support the person with this service.
5. All AWMD trained staff must contact the on-call nurse prior to assisting with a PRN medication of any type.
 - a. Exceptions to this process must comply with the DDS Emergency Medication list as part of a documented MERP with evidence of DSP training to skill level.
6. ALL DSP who are supporting a non-related individual and who assist with routine or PRN medications must have access to an on-call nurse in all service settings.

7. Refer to the Training Chapter for more details see [Chapter 17 Training Requirements](#).

13.2.8.1.4 Medication Delivery by a Nurse (RN, LPN) or Certified Medication Aide (CMA)

1. Nurses must administer medications or treatments for routes that are not addressed under the AWMD training program, unless trained by the nurse (such as enemas) or formally delegated by the nurse (such as specific routes such as a G tube) or the DDSD Emergency Medications. Refer to [Chapter 13.2.11 Medication Administration and Nursing](#).
2. The nurse must administer medications via the following routes:
 - a. Nasogastric Tube (NG Tube)
 - b. Nebulizers that are not premixed
 - c. Intramuscular (IM) and intravenous (IV) medications
3. Nurses must administer any new medication that requires a routine ordered assessment with the delivery of each dose for individuals in residential services until:
 - a. The nurse determines the person's condition is stable; and
 - b. A MERP is in place if deemed necessary by the nurse; and
 - c. DSP, including CMAs, are adequately trained and demonstrate competence on the MERP related to the person's condition, the desired effects of the medication utilized, and the routine ordered assessment with the delivery of each dose.
 - d. The above (a-c) is applicable in all settings except for Related Family Living.
4. A Certified Medication Aide (CMA) Level I or II may administer medications through all routes included in the Certified Medication Aide chapter of the New Mexico Nursing Practice Act.
 - a. CMAs must have a current certificate in good standing and must be supervised or directed by an RN.
 - b. CMAs may only work for and perform medication administration for a DD Waiver agency that is currently approved by the Board of Nursing as a CMA Provider and functions in accordance with all New Mexico Board of Nursing Rules.
 - c. A Certified Medication Aide Level II may deliver subcutaneous insulin via pen only. CMA Level I may not deliver insulin.
5. Nurses or Certified Medication Aides Level I or II may administer medication through a gastrostomy, or jejunostomy tube (G or J or G/J tube). The nurse may choose to formally delegate this task to DSP. Refer to [Chapter 13.2.1 Licensing, Supervision, and Delivery of Nursing Services](#).

13.2.8.2 [Aspiration Risk Management Screening Tool \(ARST\)](#)

A licensed nurse completes the Aspiration Risk Management Screening tool (ARST) and takes actions as detailed in [Chapter 5.5 Aspiration Risk Management](#). The ARST is completed:

1. annually at least 45-14 calendar days before the annual ISP meeting
2. within 3 business days of transfer to a new agency
3. within 3 business days of significant change of condition, or
4. after any hospitalization or hospitalization for aspiration pneumonia event.

13.2.8.3 [The Electronic Comprehensive Health Assessment Tool \(e-CHAT\)](#)

1. The e-CHAT is a nursing assessment. It may only be completed by a nurse, and may not be completed by, or delegated to a non-licensed person.
2. Nursing assessments including the e-CHAT should be completed in person when possible although telehealth/remote methods may be used when needed, based on prudent nursing practice and the condition of the person.
3. The nurse must see the person face-to-face to complete the nursing assessment. Use of remote technology may occur during a public health emergency.
4. Only the Primary Provider Nurse (PPN) is required to complete an assessment which includes the ARST, MAAT, and eCHAT in collaboration with other nurses.
5. The PPN must take the lead to communicate with nurses in other settings to gain information to complete the eCHAT assessment. This is critical if nurses in other settings are more familiar with the person.
6. Additional information may be gathered from the family/guardian, members of the IDT and other sources.
7. An e-CHAT is required for all persons in FL, SL, IMLS, or CCS-Group.
 - a. The hierarchy in [Chapter 13.2.2 Collaboration and the Hierarchy of Responsibility for Nursing Tasks](#) identifies the Primary Provider Nurse (PPN) who is responsible to complete the assessment.
 - b. All other DD Waiver recipients may obtain an e-CHAT if required, needed, or desired by adding Adult Nursing Services (ANS) hours to their budget for assessment and consultation regarding available ongoing services. Refer to [Chapter 13.3.1 Nursing Assessment and Consultation Services](#).
8. Prior to starting a new eCHAT, the nurse must review, update, and consider all diagnoses, medications, treatments, and overall status of the person.
 - a. Refer to the Therap website for the specific sequence of steps that need to be taken.
9. The nurse is required to use a new eCHAT template and must always indicate the date and reason for the eCHAT before proceeding. This includes admission, annual assessment, change of condition, hospitalization and hospitalization related to aspiration pneumonia.

10. The nurse is required to complete all the e-CHAT assessment questions in every section. No areas may be skipped. The nurse must add any additional pertinent information in all comment sections.
11. LPNs may contribute to but may not complete or approve the e-CHAT. If an LPN completes the ARST and MAAT and contributes to the e-CHAT, the RN is required to review, edit if needed, and approve the e-CHAT within three business days.
12. Non-nurses may not complete or approve the e-CHAT.
 - a. Non-nurses may only enter data into the e-CHAT from a printed, paper version of the e-CHAT that has been completed, signed, and dated by an RN. Data entry must occur within three business days of completion by the RN.
 - i. The RN is required to review the entire electronic document and then electronically approve the e-CHAT within three business days after data entry.
 - ii. The original paper version of the e-CHAT, signed and dated by the RN, must be retained in the agency file.
13. The final comment section in the eCHAT must be completed. This section must contain:
 - a. Additional narrative notes regarding any health-related issues that were not previously captured or that need additional explanation.
 - b. A brief summary of the person's overall status and, for persons with established plans, their progress toward achieving care plan goals.
14. When completed, the PPN must share the eCHAT with nurses in all other DD Waiver service settings.
15. Based upon the nursing assessment, each nurse is responsible for creating and training healthcare plans and MERPs pertinent to their service setting. The nurses will base these decisions on their knowledge of the person's response to and needs during their services. Refer to [Chapter 13.2.9 Planning, Training and Implementation of Health Care Plans and Medical Emergency Response Plans](#).
16. Each nurse is required to create HCPs that address all areas identified as "required" (indicated by "R" in the HCP column) in the most current e-CHAT Summary Report.
 - a. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. If Aspiration is triggered in the eCHAT, the CARMP is the health care plan and may not be combined with other plans. Refer to [Chapter 5.5 Aspiration Risk Management](#). When the CARMP is in place, no other plans related to aspiration risk management should be created.
 - b. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The

nurse may also create other HCP plans that the nurse determines are warranted in their settings.

17. The narrative section of the e-CHAT Summary Report may be used to note any desired additional information related to care planning, and may be used to document when persons, or guardians, who reside with biological Family Living providers opt out of Ongoing Adult Nursing Services. These notes will indicate in the eCHAT the reason why the nurse did not proceed with plans that are required or were to be considered based on the e-CHAT.
18. Entry and approval of an ARST, MAAT, and e-CHAT in Therap is required to be completed:
 - a. within three business days of admission or transfer to a new Provider Agency, or two weeks following the initial ISP or transition meeting, whichever comes first;
 - b. at least 14 calendar days but no more than 45 calendar days prior to the annual ISP meeting;
 - c. within three business days of a significant change of health status or change of condition; or
 - d. within three business days of return from any out of home placement (OOHP) including hospitalization, long term care, rehab/sub-acute admission, or incarceration.

13.2.9 Planning, Training and Implementation of Health Care Plans and Medical Emergency Response Plans

13.2.9.1 Health Care Plans (HCP)

Health Care Plans are created to provide guidance for the Direct Support Professionals (DSP) to support health related issues. Approaches that are specific to nurses may also be incorporated into the HCP. Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs.

1. The Primary Provider Agency nurse (PPN) is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs that the nurse determines are warranted.
2. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans

- must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.
3. HCPs must include a statement of the person's health conditions, problems or needs and must list measurable goals intended to be achieved through implementation of the HCP.
 - a. Problems/Needs statement may be based upon supports needed for the person to maintain a current health-related strength, ability, or skill or to remediate, minimize or manage existing health conditions.
 - b. Goals must be measurable and may have an achievement, maintenance, or palliative focus.
 4. Interventions that may prevent a medical emergency must be addressed in each HCP to support the response actions identified in the corresponding MERP.
 5. HCPs and goals should be revised when:
 - a. a person's needs or problems change;
 - b. the goal has been met;
 - c. there is potential to attain a new or additional goal;
 - d. a maintenance or palliative goal is no longer appropriate;
 - e. the person no longer requires supports to attain the goal.
 6. Interventions or strategies described in the plan must be personalized to reflect the person's unique needs, non-verbal or assisted communication, known behavioral communication cues, must provide guidance to the DSP, and must be designed to support successful interactions.
 7. To access timely treatment, HCPs shall include person-specific subtle or atypical signs of illness and/or pain for prompt identification and notification.
 8. Some interventions on the HCP may be carried out by DSP, family, or other team members, while other interventions may be carried out exclusively by an agency nurse.
 - a. Persons responsible for each intervention or strategy must be specified in the plan by discipline and/or title.
 - b. Interventions or strategies must be written in plain language that is easily understood by the person responsible for implementation.
 - c. Specific Interventions to prevent emergencies should be written into the HCP.
 9. If HCP are printed, assure that the person's name and date of birth are on the HCP and on each paper page. The HCP must be signed by the author electronically or by hand.
 10. After receiving the eCHAT and eCHAT summary report from the PPN, the nurses in other service areas must create, train, and monitor their own HCPs and MERPs. The plans must be specific to their service area. For CARMP guidance, refer to #16 and #17 below.
 11. Each HCP and MERP must be reviewed, developed, or revised as needed within three

business days of hospital or rehabilitation discharge or change of medical condition. The review must be documented in Therap under Plans.

12. ALL HCPs and MERPs, (all providers) must be entered in or attached to the “*Individual Care Plan module*” in Therap. The nurse should indicate the setting in the name of the plan.
 13. The following applies to Primary Providers only:
 - a. HCP and MERPs must be linked to the e-CHAT Summary Sheet and updated as plans are created, reviewed, or revised.
 - b. Dates for HCPs and MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created, reviewed, or revised.
 14. Each HCP and MERP must be reviewed semi-annually for all settings and quarterly in IMLS to determine if it is needed and if it is effective. Plans should be revised as needed. One of these reviews should occur 45-14 days prior to the annual ISP meeting. After review and discussion at the IDT additional HCP/MERP edits may be needed.
 15. The CARMP must be developed and revised in “*CARMP Draft in Questionnaire in Therap*”, refer to [Chapter 20.5.6 CARMP Draft in Therap](#) and [Chapter 5.5 Aspiration Risk Management](#). After the CARMP is finalized by the CM the PPN downloads the CARMP and attaches it to the “*Individual Care Plan module*” in Therap.
 16. The CARMP is the designated HCP for Aspiration Risk Management. It includes many clinical elements pertinent to the person such as feeding tubes and oral hygiene. Once the CARMP is developed, interim aspiration plans must be removed, and no other aspiration related health care plans should be in place. (See [Chapter 5.5 Aspiration Risk Management](#)).
 17. CARMP’s, HCPs created or revised by an LPN must have RN review and approval as indicated by review date and signature.
 18. When PRN psychoactive medications are ordered, the Nurse must collaborate with the BSC or the BBS to create a PRN Psychotropic Medication Plan (PPMP).
 19. When Hospice or Palliative care services are utilized, DD Waiver Provider Agency nurses must develop new or edit existing HCPs and MERPs to reflect the person’s condition and desires. Plans must clearly indicate steps that DSP need to take, such as contacting the DD Waiver nurse for PRN approval and who to contact first when health conditions change.
- 13.2.9.2 [Medical Emergency Response Plan \(MERP\)](#)
1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions automatically triggered and marked with an "R" in the e-CHAT summary report. The agency nurse should use their clinical judgment and input from

- the Interdisciplinary Team (IDT) to determine whether issues shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.
2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. These include but are not limited to:
 - a. Seizure disorder/epilepsy creating risk for prolonged seizures or status epilepticus;
 - b. Neurological disorders requiring devices or implants such as shunts or vagal nerve stimulator that may have specific directions for use or require intervention if malfunction occurs;
 - c. Cardiac conditions that create risk for heart attack or cardiac failure;
 - d. Asthma or other respiratory disease creating risk for respiratory distress or failure;
 - e. Diabetes mellitus creating risk for diabetic coma from very high or very low blood sugar;
 - f. Risk for sepsis due to use of high dose steroids, cancer chemotherapy, removal of spleen, certain immune disorders, or presence of an indwelling urinary or IV catheter;
 - g. Risk for aspiration creating risk for aspiration pneumonia; acute respiratory distress or sepsis;
 - h. Gastrointestinal disorders with history of severe constipation, impaction, bowel obstruction or gastric bleeding;
 - i. Feeding tubes; address risk of tube displacement or blockage
 - j. Severe allergies that are known to result in anaphylactic shock or other severe, life threatening reaction;
 - k. Bleeding risk related to diseases, disorders, or anticoagulant therapy;
 - l. Other conditions based on the nurse's judgment.
 3. The MERP cannot be combined with or replace the HCP. Measures to prevent a life-threatening condition are addressed in the HCP.
 4. Authors of the MERP should encourage family members/guardians to provide input regarding the situation(s) under which a medical emergency may occur and the action steps that the person and/or his/her guardian desire to be taken in a medical emergency. Persons and/or guardians should be given the opportunity to receive training on MERP implementation if desired.
 5. The MERP must be written in clear, jargon-free language and include at a minimum the following information:

- a. A brief and simple description of the condition or illness and the most likely, anticipated life-threatening complications that might occur.
 - b. How those complications may appear to an observer.
 - c. Clear, jargon free, step-by-step instructions regarding the actions to be taken by DSP and/or others to intervene in the emergency, including criteria for when to call 911 directly.
 - d. List of emergency contacts with phone numbers.
 - e. A reference to whether the person has advance directives or not, and if so, where the advance directives are in the home (if pertinent to the MERP).
 - f. The MERP template in Therap may be used.
6. The nurse is not required to create a MERP for persons in respite services. In this setting, families are responsible for sharing a copy of all instructions regarding emergency plans with the Respite Provider Agency at their discretion.
 7. Based on the frequency and outcome of medical emergencies, the nurse may identify the need to revise the person's HCP or the MERPs.
 - a. The MERP must be reviewed by the agency nurse or other author for needed revisions at least 45-14 days prior to the annual ISP meeting.
 8. During the annual meeting, the IDT discusses the continued need for each condition listed in the MERPs and whether the current plan(s) need(s) to be. If the emergency response involves delivery of a PRN medication, non-related DSP (not related by affinity or consanguinity) must contact the agency nurse and receive approval before the medication is given.
 - a. The only exceptions to contacting the agency nurse before delivery of a PRN is if the person has a severe condition that requires prompt delivery of medication in an emergency. This may only include the specific approved emergency medications as listed on the DOH-DDSD - Clinical Service Website.
 - b. Refer to [Chapter 13.2.11 Medication Administration and Nursing](#). Refer to [Chapter 13.2.9.3 Training and Implementation of HCPs and MERPs](#).
 9. The administration of the emergency medication requires a physician order and should be listed on the MAR.
 10. MERPs must be linked in the eCHAT summary report and attached in the "*Individual Health Care Plan*" module in Therap and must be available in all service settings.
 11. Dates for MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created, reviewed, or revised.
 12. Revisions authored by an LPN must have RN review and approval as indicated by electronic review date and signature denoting approval.

13.2.9.3 Training and Implementation of HCPs and MERPs

1. RNs and LPNs are required to provide Individual Specific Training (IST) about HCPs/CARMP and MERPs to all DSP and all others listed on the IST section of the ISP.
2. This training should be clearly titled, and include an overview of the plans, what steps to take and return demonstration of understanding if deemed necessary by the nurse.
3. The individual or their Guardian determines whether natural supports need to be included in training on the HCP or MERP based upon the role of the natural support(s) in the person's life (ex: response to remote personal support technology [RPST]). If so, natural supports may be included in the IST section of the ISP.
4. The agency nurse is required to deliver and document training for DSP regarding the Healthcare Plan interventions/strategies and MERPs that the DSP are responsible to implement. The training document must clearly indicate the topic of the training and the level of competency achieved by each trainee as described in the Training Chapter.
5. If the MERP requires delivery of a medication in an emergency, the nurse may determine if the DSP must call them first for permission or if the medication may be delivered prior to calling the nurse. The nurse must follow those medications or treatments on the current, approved DDSD Emergency Medications List.
 - a. The DSP must be trained by the nurse to skill level on:
 - i. the individual's condition
 - ii. why and when the medication may be needed
 - iii. the delivery of the medication including the exact steps to follow in an emergency
 - iv. contacting 911 and then contacting the nurse.

Refer to [Chapter 13.2.11 Medication Administration and Nursing](#).

13.2.10 Individual-Specific Training

1. Training must be offered at least annually to those routinely supporting the person and as needed (i.e., for updates and changes in condition).
2. The nurse must train all plans for non-related Family Living Providers.
3. The nurse may identify, at their discretion, a willing, designated trainer to train some or all basic healthcare strategies. This does not apply to any delegated nursing tasks.
 - a. After completing training and demonstrating expertise in training other DSP, the designated trainer is then responsible for training other DSP on those sections of the HCP/CARMP and/or MERP that have been agreed upon.
 - b. The designated trainer must be indicated by name on the HCP/CARMP or MERP and those sections that they are deemed competent to train and have been agreed upon.

4. For delegated nursing tasks or nursing functions, the delegating nurse is required to provide training to skill level and monitoring for continued competence. Training a delegated task cannot be shared or transferred to another DSP. Refer to [Chapter 13.2.1 Licensing, Supervision, and Delivery of Nursing Services](#).
5. The agency nurse is required to document all training, clearly indicating the topic of training, and the level of competency achieved by each trainee as described in [Chapter 17.9 Individual-Specific Training](#).
6. The nurse will document the following information on the training roster for DSP:
 - a. the HCP/CARMP and MERPs by name/title of plan, delegation, and
 - b. a brief summary of the content that was covered.
 - c. Plans should be attached to the training roster.
7. Nurses will monitor the implementation of HCP and MERPs during routine visits and will retrain as needed to support proper delivery of care.
8. Nurses will communicate any concerns with DSP's implementation of plans to the Living Supports or Community Inclusion agencies for resolution of issues.
9. Related Family Living provider subcontractors (related by affinity or consanguinity) who have arranged for HCP/MERPs to be developed by the primary care practitioner or a medical specialist, are responsible for working with that author to obtain reviews and any needed revisions no later than two weeks prior to the annual ISP meeting.

[13.2.11 Medication Administration and Nursing](#)

Nurses are required to:

1. Assure that accurate medications are listed in Therap based on current medical provider's orders.
2. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations, including the requirement for all agencies to have Pharmacy Consultant and a Pharmacy Manual to guide internal procedures.
3. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects.
4. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed.
5. Administer any new medication that requires a routine ordered assessment with the delivery of each dose, for individuals in residential services until:
 - a. The nurse determines the person's condition is stable; and
 - b. A MERP is in place if deemed necessary by the nurse; and
 - c. DSP, including CMAs, are adequately trained and demonstrate competence on the MERP related to the person's condition, the desired effects of the

- medication utilized, and the routine ordered assessment with the delivery of each dose.
- d. The above is applicable in all settings except for individuals residing with and receiving supports from their Related Family Living Providers.
6. Monitor the MAR and treatment records at least monthly for accuracy. The nurse must review for PRN use and errors. The monitoring must be documented. The documentation may be captured within the electronic MAR system or in a nursing progress note if no electronic MAR system is active.
 7. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies.
 8. Respond to calls at any time from agency staff or family members who seek advice or assistance regarding medication issues.
 9. Assure that all orders for PRN medications or treatments have:
 - a. clear instructions for use; and
 - b. observable signs/symptoms or circumstances in which the medication is to be used or withheld.
 10. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness.
 11. Assure documentation of the response to and effectiveness of the PRN medication is on the MAR and in routine progress notes from the DSP and from Nursing when PRN medications are used. All documentation be dated, timed, and address the following:
 - a. DSP must contact the agency nurse *prior* to assisting with medication to inform the nurse what is occurring and obtain approval to assist with delivery of the PRN. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the current approved DDSD Emergency Medications List and the DOH-DDSD-Clinical Services Website.
 - b. The DSP must inform the nurse of the results of the PRN, and both must document what occurred and what was reported.
 12. Monitor and document the person's response and the effectiveness of their medication regime as part of the e-CHAT.
 13. Document any observed or reported signs of allergic reaction or adverse medication effects or side effects and provide needed follow up and supports including accessing appropriate medical treatment and communicating with the ordering practitioner.
 14. Know where medication information from the prescribing pharmacy is kept online, in the home, and community inclusion service locations.
 15. Support the DSP awareness of the expected desired outcomes from medications.

16. Support the person's increased independence and participation taking their medications independently if possible.
17. Collaborate with agency supervisors to investigate and correct medication errors and missing medications as needed.
18. Follow up on Pharmacy Consultant reports as needed and participate in the agency Quality Improvement process.

13.2.12 Medication Administration by Certified Personnel

A Certified Medication Aide (CMA) Level I or II, may administer medications through all routes included in the Certified Medication Aide chapter of the New Mexico Nursing Practice Act. CMAs must have a current certificate in good standing and be supervised/directed by an RN. CMAs may only work for and perform medication administration for a DD Waiver agency that is currently approved by the Board of Nursing, as a CMA Provider and functions in accordance with all New Mexico Board of Nursing Rules.

13.3 Adult Nursing Services

Adult Nursing Services (ANS) may be added to the individual's budget to deliver nursing services in specific residential and non-residential settings.

These budgeted nursing services are part of the ISP and are intended to support the highest possible level of health, functioning and independence for persons, age 21 years and older who:

1. reside in a Family Living setting; or
2. receive Customized In-Home Supports; or
3. may benefit from or require ANS but who do not receive Living Supports; or
4. may benefit from or require ANS during participation in CCS-I or CCS-Small Group and/or CIE.

ANS are also available for young adults, age 18 through 20, who reside in Family Living, and are at aspiration risk and who need ARM supports. Refer to [Chapter 5.5 Aspiration Risk Management](#).

13.3.1 Nursing Assessment and Consultation Services

This core nursing service provides hours for the delivery of specific, limited nursing services. This includes an initial and annual comprehensive health assessment (eCHAT), consultation from the nurse to the person or guardian, development, and training of interim plans.

This activity is required for all participants in Family Living, including young adults from age 18 through 20, and is available to all persons in the service settings listed above. This annual assessment is required even if a Family Living Provider related by affinity and consanguinity has opted to not receive any ongoing nursing services.

No Prior Authorization is needed for this service. An assessment (including ARST, MAAT and e-CHAT) is completed. Based on identified health needs, potential ongoing services are identified, and plans developed.

1. Nursing Assessment and Consultation is the first step in determining the person's health needs and possible eligibility for additional services. It provides 12 hours or 48 units of nursing time each ISP year to provide the following services:
 - a. The nurse completes an initial and annual electronic Nursing Assessments in Therap including the ARST; the MAAT and eCHAT and any other assessments identified as relevant per prudent nurse practice. This includes review of existing health related information from practitioners. After the assessment is complete, the nurse will review the ANS eligibility parameters and identify any Ongoing Adult Nursing Services (OANS) for which the person may qualify.
 - b. The nurse meets with the person, guardian, CM, and as requested, with the IDT regarding the results of the above assessment and resulting recommendations including a discussion of plans that are required or could be considered and any indicated need for Ongoing Adult Nursing Services (OANS). Prior Authorization for OANS will then be initiated based on the services that are selected or that are required. See [Chapter 13.3.2 Ongoing Adult Nursing Services \(OANS\)](#) below.
 - c. The nurse may develop and train any needed interim HCPs, PPMPs, or MERPs pending authorization of selected OANS.
 - d. Under Nursing Assessment and Consultation Services, the nurse may also provide consultation regarding health-related issues, as requested by the person, family/guardian, or IDT. If OANS is not selected, the consultation may not exceed the remaining balance of the 12 hours budgeted for initial/annual Nursing Assessment and Consultation Services and the hours needed for the assessment process for the next ISP cycle.
 - e. If the person is hospitalized or experiences a significant change of condition, the nurse may request an additional eight (8) hours or thirty-two (32) units. These additional hours are used to: attend hospital discharge meetings or related IDT meetings; update assessments, care plans or MERPs to reflect the person's changed health status; create any needed interim plans; conduct training with family/DSP on these changes as needed; complete the Ongoing Adult Nursing parameters tool; and meet with the person or guardian and prepare prior authorization requests for OANS if desired by the person or his/her guardian.
2. Nursing Assessment and Consultation is optional for persons who receive CIHS, CIE, CCS-I or CCS-Small Group. However,
 - a. This service must be budgeted when the person has health needs that trigger HCPs, a CARMP or MERPs. This will allow non-related DSP to be trained to safely support the person during those hours of service.
 - b. This service must be budgeted for those persons whose non-related DSP are

AWMD-trained and who assist with medication or PRN medications during these services.

3. The Annual Nursing Assessment and Consultation is a required service for young adults and adults who reside in Family Living with either non-related or related Family Living providers:
 - a. Persons in Family Living with non-related or host families must access required components of OANS as described below in 13.3.2, Ongoing Adult Nursing Services.
 - b. If the person receives Family Living from a family member related by affinity or consanguinity, and the person or guardian determine that OANS as described in these standards are not desired, the family will provide any needed health supports or interventions based on guidance from the person's healthcare providers.
 - i. The FL provider who is related by affinity or consanguinity, may contact the nurse for support as needed for health-related issues.
 - ii. The nurse is not required to provide ongoing nursing monitoring unless Ongoing Adult Nursing Services are selected.
 - c. The related Family Living Provider is responsible for sharing all information with substitute care providers. However, if the substitute care provider is not related by affinity or consanguinity, then pertinent OANS must be added to assure that needed nursing oversight is provided.

13.3.2 *Ongoing Adult Nursing Services (OANS)*

Ongoing Adult Nursing Services (OANS) are an array of services that are available to young adults and adults who require supports for specific chronic or acute health conditions. OANS may only begin after the Nursing Assessment and Consultation has been completed and the budget for additional ongoing ANS has been submitted and approved. The ANS Provider Agency nurse completes the designated ANS parameter tool to determine needed ongoing nursing hours. This includes any additional required information supporting the need for this service.

Several elements of OANS are required if the person is a JCM; resides with non-related or host Family Living providers; or receives health related supports that require training and oversight by nursing in CCS-I, CCS-small group, CIE, or CIHS.

OANS includes delivering nursing services that meet health needs described in the following categories which are described below: Healthcare Planning and Coordination, Aspiration Risk Management, Medication Oversight, Nurse Delegation, Medication Administration by a Licensed Nurse, and Coordination of Complex Conditions.

The ANS Parameter Tool identifies general categories of need and the possible number of hours per week/month that may be needed to deliver those supports. Nurses will review the overall results of the tool and then identify a logical total number of hours to request for budgeting.

13.3.2.1 Healthcare Planning and Coordination

Provision of Healthcare Planning and Coordination is required in Family Living with non-related or host families and if the person is a JCM residing with either a related or non-related Family Living provider. It is optional for all other eligible persons. In addition:

1. If the person resides with biological family (by affinity or consanguinity) and it is determined that Healthcare Planning and Coordination is not a desired service, the family provides any needed health supports or interventions based on guidance from the person's healthcare providers.
2. If the person participates in CCS, CIHS and CIE and has a need for health-related supports from DSP this service must be budgeted to provide training and oversight by a nurse. The nurse must address the development, training, monitoring, and revision as needed, of HCPs and MERPs which are labeled as "required" in the e-CHAT and additional HCPs and MERPs labeled as "consider" in the e-CHAT and which the nurse recommends.
3. Frequency of nursing monitoring is based on the person's needs, assessed risk, and prudent nursing practice. Refer to [Chapter 13.2.4 Nursing Monitoring and Oversight Requirements](#).
4. The nurse participates in the annual ISP meeting and other IDT meetings with health issues on the agenda.
5. The nurse provides response/consultation, as needed, for unanticipated health related events. The nurse relies on prudent nursing practice to determine if a face-to-face assessment is warranted or if urgent or emergent care is needed.
6. The nurse provides a semi-annual nursing report to the IDT, no later than 45-14 days prior to the annual ISP meeting, the nurse completes and distributes a nursing report regarding the person's status and outcomes of HCPs and MERPs implemented during the year. The nurse may not bill for the development and distribution of the semi-annual report.
7. The nurse documents all related nursing activities per [Chapter 13.2.7 Documentation Requirements for all DD Waiver Nurses](#).

13.3.2.2 Aspiration Risk Management (ARM)

The nurse is responsible for all nursing activities listed in [Chapter 5.5 Aspiration Risk Management](#). This service is required in Family Living for surrogate/host families and JCMs and is optional in CIHS. ARM Screening is required for all adults and young adults on the DD Waiver who receive Living Supports and CCS-G.

1. Biological Family Living providers who are the Guardian for persons at moderate or high risk, may opt out of ARM supports, after the CARMP has been developed and presented

to the person and guardian. Refer to [Chapter 5.5 Aspiration Risk Management](#) for information about editing or deferring from the CAMRP.

2. If the person resides with biological family (by affinity or consanguinity) and it is determined that ARM is not a desired service, the family will continue to provide any needed health supports or interventions based on guidance from the person's health care providers. However, if the individual is receiving ARM-related therapy services to support the CAMRP, they must also budget nursing hours.

13.3.2.3 Medication Oversight

Medication Oversight by a DD Waiver nurse is required in Family Living when a person lives with a non-related Family Living provider; for all JCMs; and whenever non-related DSP provide AWMD medication supports.

1. The nurse must respond to calls requesting delivery of PRN medications from AWMD trained DSP, non-related Family Living providers.
2. Family Living providers related by affinity or consanguinity (blood, adoption, or marriage) are not required to contact the nurse prior to assisting with delivery of a PRN medication.
3. Medication Oversight is optional if the person lives independently and can self-administer their medication or resides with their related family. If the person resides with their family and it is determined that Medication Oversight is not desired, the family must continue to provide any needed health supports or interventions based on guidance from the Primary Care Practitioner or specialists and all elements of medication administration and oversight are the sole responsibility of the person and their biological family. In addition, for Family Living participants the related family must:
 - a. Communicate at least annually, and as needed, for significant change of condition with the agency nurse regarding the current medications and the person's response to medications for purpose of accurately completing required nursing assessments.
 - b. The agency is not responsible for providing a monthly MAR unless the family requests it and continually communicates all medication changes to the Provider Agency in a timely manner to ensure accuracy of the MAR.
4. Medication Oversight is not optional if substitute care is provided by DSP who are not related.
 - a. A MAR is required for the substitute care provider to use.
 - b. Biological families (by affinity or consanguinity) are encouraged, but not required to use the MAR.
 - c. DSP who are related families (by affinity or consanguinity) must complete AWMD training.

13.3.2.4 Nurse Delegation

1. Nurse delegation must be budgeted if delegation relationships exist or the nurse determines that delegation may be utilized to support the delivery of specific tasks in Family Living with surrogate/host families or when DSP support the individual in CIE, CCS-I or small group, substitute care, respite, or other settings where Adult Nursing is delivered.
2. If the person resides with their biological family (by affinity or consanguinity), delegation of nursing tasks is only relevant if the person receives services from persons who are not related by affinity or consanguinity and the person requires specific nursing functions that may be delegated by a licensed nurse during those services.
 - a. Nurses must ensure compliance with the New Mexico Nurse Practice Act, DDS Standards and relevant agency policies and procedures when delegation of specific nursing functions has been granted. Refer to [Chapter 13.2.1 Licensing, Supervision, and Delivery of Nursing Services](#).

13.3.2.5 Medication Administration by Licensed Nurse

Medication administration by a licensed nurse is allowed under the following circumstances:

1. Routine administration of medication when required by DDS Medication Administration and Assessment tool including documentation and oversight of person's response to those medications:
 - a. As a result of discussion with the Primary Care Practitioner, as needed, and as follow-up to pharmacy consultant reports;
 - b. To respond as needed to a report of changing condition or needs;
 - c. To document all related nursing activities;
 - d. In addition to completion of the required designated Ongoing Adult Nursing eligibility parameters, detailed justification for administration of medication by a nurse must be submitted for prior authorization review to indicate why medication delivery must be carried out by a nurse rather than by a CMA, DSP trained in AWMD, family member, or natural support trained by the family; and
 - e. This service is required in Family Living with surrogate/host families when criteria are met.

13.3.2.6 Coordination of Complex Conditions

In addition to Healthcare Planning and Coordination described above, the nurse will provide ongoing support and resources to the person who has complex medical conditions to support the person and guardian if applicable. This service is required in Family Living for non-related families and all JCMs. It is optional for all others.

The following tasks will be provided as needed:

1. Frequent and ongoing assessment, assuring coordination of health-related services and

- monitoring of the person's complex medical conditions;
2. Communicating with the Primary Care Practitioner and relevant specialists;
 3. Collaborating with the designated Healthcare Coordinator (HCC), Home Health Services, Palliative Care and Hospice staff;
 4. Assessing and monitoring the response to and effectiveness of interventions and adjustment of HCPs and MERPs;
 5. Educating and providing support for the person, guardian, family, and team regarding the implications of the person's condition(s);
 6. Attending condition specific medical appointments;
 7. Performing nursing tasks consistent with practitioner orders for interventions or treatments which the nurse is not electing to delegate;
 8. Responding as needed to a report of changing condition or needs;
 9. Serving as a resource for accessing needed information or supports; and
 10. Documenting all related nursing activities.

13.3.3 Adult Nursing Services Limitations

1. All Ongoing Adult Nursing Services (beyond Nursing Assessment and Consultation) must meet eligibility per the ANS parameter tool, clinical criteria, and prior authorization review.
2. Persons cannot receive ANS during the hours of Supported Living or IMLS since nursing is fully bundled into those services.
3. Medication administration may only be billed at the LPN rate, regardless of whether the medication was administered by an RN, LPN, or CMA.
4. Supported Living, IMLS and CCS-Group nurses are expected to administer specific medications if needed during delivery of that service. Billing separately for Medication Administration by a Licensed Nurse is not allowed.

13.3.4 ANS Service Requirements

1. ANS are provided by RNs or LPNs who are licensed to practice in the state of New Mexico.
2. All ANS providers, including Family Living Providers, must request budgets to include any required services listed above.
3. No Prior Authorization is needed for budgeting up to 12 hours/48 Units of ANS time for the completion and delivery of the Nursing Assessment and Consultation service. If the person is hospitalized or experiences a significant change of condition, the nurse may request an additional eight (8) hours or thirty-two (32) units to complete a reassessment.

4. All ANS providers must assure compliance with [Chapter 13.2 General Nursing Services Requirements](#) and [Chapter 13.3.2 Ongoing Adult Nursing Services \(OANS\)](#).

13.3.5 ANS Agency Requirements

1. All providers of ANS must offer and deliver these services in accordance with applicable sections of the New Mexico Administrative Code and the New Mexico Nurse Practice Act.
2. ANS must be offered and provided by all Family Living providers.
3. All providers of ANS must assure that nurses providing this service hold a current RN or LPN license with the New Mexico State Board of Nursing. LPNs must be supervised by an RN per the New Mexico Nurse Practice Act.
4. All providers of ANS must ensure that nurses providing services for the agency complete the training upon hire or assignment to these services within the timeframes listed in the [Chapter 17: Training Requirements](#).
5. All providers of ANS must designate an RN who is the head nurse for the agency and who is responsible for ongoing supervision of the nursing department.
 - a. The DDS Regional Office must be given contact information and notified when turnover occurs.
 - b. An RN will supervise those services delivered by LPNs and CMAs. Such supervision must include periodic face to face interaction and observation.
6. The RN who is the head nurse for the agency must hold a current New Mexico license; must reside in New Mexico; and if residing in a neighboring state, must be available within 60 minutes.
7. ANS Provider Agencies must:
 - a. assure 24-hour access to an on-call nurse to provide support, consultation or direction to persons and DSP. An LPN may take call but must have an RN backup for consultation as needed.
 - b. Delegation is not necessary if the DSP or Family Living Provider is related to the individual by affinity or consanguinity.
 - c. if CMAs are utilized, maintain compliance with applicable New Mexico Board of Nursing rules.
 - d. Responding to calls requesting delivery of PRN medications from AWMD trained DSP; surrogate or host Family Living providers and CMAs:
 - i. Family Living providers related by affinity or consanguinity are not required to contact the nurse prior to assisting with delivery of a PRN medication.

Chapter 14: Other Services

14.1 Assistive Technology Provider

Assistive Technology (AT) service is intended to increase the individuals physical and communicative participation in functional activities at home and in the community. Items purchased through the AT service assist the individual to meet outcomes outlined in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/ or leisure activities, or increase the individual's safety during participation of the functional activity.

Assistive Technology services allow individuals to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional AT, not covered through the individuals State plan benefits.

The focused use of Assistive Technology (AT) benefits individuals on the waiver program to engage more fully in life through increasing communication, independence, and community access. Increased communication allows the individual to freely express their wishes and supports socialization. AT also supports individuals in the work setting thereby increasing their earning potential and independence. AT services are cost effective because they enable the person to function more independently, which decrease reliance on Direct Support Professional. Administrative fees are allowable within this service.

The use of Assistive Technology (AT) is valuable in supporting individuals with I/DD through a "Participatory Approach" which presumes that all persons, regardless of the degree of disability, can participate in daily activities and achieve individual goals. IDT members and provider agencies utilizing AT must be aware of the individual's current AT devices, support the use of the current devices in desired settings and assist to keep the device in working order.

14.1.1 *Scope*

1. Participants arrange for AT through selection of an AT provider agency that acts as a purchasing agent for the technology or acts as the direct vendor of any AT identified in the ISP.
 - a. When the provider acts as a purchasing agent the approved budget must be inclusive of 15% administrative fee and the agency purchases the items directly. The purchasing agency does not reimburse for purchases made prior to approval of the ISP and budget.
 - b. The AT Purchasing Agent either purchases the needed equipment, pays the vendor or the IDT member purchasing the item .
2. Records are kept demonstrating all activities related to the service and reports are provided as required.

14.1.2 *Service Limitations*

1. AT covered by the person's state plan benefit, Division of Vocational Rehabilitation (DVR), the public schools, or other funding sources shall not be covered by the DD Waiver Budget.
2. AT funding may not be provided for those devices that are routinely denied by existing insurance or other sources. It is the responsibility of the person completing the AT Fund application to also provide proof of denial or attempts to explore funding from other sources that may be available through insurance, the MCO, vocational rehabilitation and/or IDEA if available.
3. The total cost shall not exceed \$500 including the 15% administrative fee per ISP year when applicable.
4. Purchase of batteries to power AT devices is limited to \$50.00 per ISP year.
5. Items used primarily for sensory stimulation shall not be approved.
 - a. Items that incorporate a sensory input component are not to be used primarily for sensory stimulation. The items requested need to be related to a therapist plan/TDF objective or outcome and are shown clinically appropriate for use those results in improvement in functional performance, participation and/or decrease behavioral incidents.
 - b. Clinically appropriate sensory stimulation items that specifically relate to a Vision or Outcome or are included in a Therapy plan to increase functional abilities or decrease behavioral events, may be justified through the AT Fund Application process.
6. Devices, materials, or supplies used primarily during therapy services or directed primarily toward a therapeutic outcome such as increasing range of motion shall not be approved.
7. Educational or business software or equipment shall not be approved since funding is provided by schools or DVR. Software applications or adaptive devices related to supporting the person's functional needs and goals for use in daily life and on iPads/tablets, smartphones, and other similar devices used to increase the person's level of independent functioning can be funded through the AT Fund application process.
8. Purchase of devices (iPads/tablets, smartphones, and other similar devices) used to access remote telehealth services and social/community access may be purchased using AT funds. This may also include mounts, holders, protective case, screen protectors, warranty, etc. Refurbished devices may not be purchased using AT funds. (It is preferred

that new AT devices be purchased. When limited funding is available, a refurbished item can be purchased at the request of the individual/guardian.)

9. Adaptive clothing, footwear or accessories that are specifically designed to support the individual's comfort, social integration and independence may be purchased with AT funding. This does not include funding for incontinence products such as adult diapers, adult pull ups or depends, chux or bed pads.
10. Items intended to prepare a person for a functional activity rather than perform the functional activity shall not be approved. The purchase of items or services that are prohibited by federal, state, or local statutes and standards shall not be authorized or reimbursed.

14.1.3 Service Requirements

1. The AT Purchasing Agent/Provider will only process reviewed and approved AT fund applications.
2. When the provider agency or vendor is the direct provider of the technology, the agency/vendor must:
 - a. Deliver and install, as needed;
 - b. Only provide items as detailed in the approved ISP and AT Fund application
 - c. Provide consultation regarding use;
 - d. Assure functioning and warranties, as applicable;
 - e. Provide training to the participant and other identified supports regarding use of the technology; and
 - f. Not charge an administration fee.
3. When the AT provider acts as a Purchasing Agent, the provider:
 - a. either purchases approved items directly or issues a reimbursement check payable to the person or entity responsible for making the purchase on behalf of the person on the DD Waiver.
 - b. Cannot make a check out to any individual or provider who is not a member of the person's IDT.
 - c. Can only release funds to the IDT member designated on the application and cannot be made out to the individual.
 - d. Must obtain receipts for all items.
4. The AT Provider is required to maintain a complete accounting of all finances used for each person supported by the Provider Agency.
 - a. Complete accounting shall include a primary financial file for each person, which contains receipts for all device(s) and/or materials purchased.

- b. An annual accounting of all finances used per person supported by the agency must be delivered to the respective CMs no more than 45 days and no less than 10 days before the ISP planning meeting.

14.1.4 Agency Requirements

1. The AT Provider must provide the individual or their legal representative and the CM with an annual report of the AT device(s) and/or materials purchased with DD Waiver funds. The annual report shall contain all information from the person's primary financial file.
2. The AT Purchasing Agent must provide routine reports to the DDS designated Bureau as requested.

14.2 Remote Personal Support Technology

Remote Personal Support Technology (RPST) is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides up to twenty-four (24) hour alert, monitoring or remote personal emergency response capability, remote prompting or in-home reminders, or environmental controls for independence using technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one's home, and to ensure the health and safety of the individual in services. Remote Personal Support Technology is available to individuals who may want to live independently in their own homes, may have a demonstrated need for timely response due to health or safety concerns, or may be afforded increased independence from staff supervision in residential services. The use of technology should ease life activities for individuals and their families.

RPST includes development of individualized response plans with the installation of the electronic device or sensors, monthly maintenance, rental, or subscription fees. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through response plans that are developed using natural and/or other paid supports for on-site response. Remote Personal Support Technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved Technology Provider who is the director vendor of the service and approved DD Waiver Provider. The use of RPST supports the health and safety of those individuals who desire independence but may have a demonstrated need for support and timely response due to health or safety concerns. RPST may be part of a plan to increase independence over time. RPST may decrease the need, frequency or intensity of assistance or supervision by on-site staff and may replace some on-site supervision with off-site supervision or supports.

RPST can include an array of monitoring, contacts, interactions, and responses. RPST includes, but is not limited to, supports with or without alert capabilities and or monitoring such as: home sensors, mobility, safety, and health management devices; remote task/event cueing, prompting or interactions; location assistance or monitoring; personal emergency response systems; remote video, audio or other "check in "monitoring systems; and environmental control devices or systems that are associated with a monitoring device/system. This may include "smart" devices for home, day, travel, or mobility that are purchased or obtained by the individual for use in a variety of life settings.

14.2.1 Scope

1. Participants arrange for RPST through selection of an RPST provider agency that acts as a purchasing agent for the technology or acts as the direct vendor of any RPST identified in the ISP.
2. When the provider acts as a purchasing agent the approved budget must be inclusive of 15% administrative fee and the agency purchases the items directly. The purchasing agency does not reimburse for purchases made prior to ISP and budget approval.

DD Waiver Services
Chapter 14: Other Services
Remote Personal Support Technology

3. RPST must support an ISP Vision-driven outcome that reflects a desire to increase or maintain independence in the home or community with limited on-site assistance or supervision by paid staff. Alternatively, support of the ISP may be demonstrated through justification in the Health and Safety Section of the ISP.
4. Remote Personal Support Technology services include:
 - a. installation of electronic devices and education in the use of the devices;
 - b. rental of electronic device;
 - c. maintenance for the electronic device;
 - d. warranty, shipping, and handling fees;
 - e. subscription costs which may include a customized response plan, maintenance costs, remote call center staff response, monitoring fees and some education/training costs;
 - f. daily monitoring and reporting; and
 - g. provision of assistance in response to events identified through monitoring.
4. Both RPST Providers that act as purchasing agents and RPST Providers that monitor and interact with the individual must:
 - a. Be knowledgeable about persons with I/DD and products that may benefit the health, welfare, and independence of those individuals.
 - b. Interact with the individual /family and members of the IDT as needed regarding existing or planned smart home technology if planned or present in the home or residential setting.
 - c. Collaborate with the family and team when trainings or changes to the RSPST system or response plans are needed.
 - d. Maintain record of all inspections, upgrades, maintenance and repairs or replacements of devices.
 - e. Collaborate with the family and team regarding changes to any contract or lease agreements including the return of leased equipment in case of significant decline in condition or death of the individual.

14.2.2 [Service Requirements](#)

1. RPST Provider Agencies that monitor or interact with the individual, agency DSP or natural supports must maintain additional records as indicted below.
 - a. Records must include the person’s identification and provide a detailed log of the date, time, and nature of the interactions with the individual and the outcome of that interaction. These may be electronic or paper records.
 - b. If in person or emergency response is needed, the agency must note all contacts that were made or the results of those contacts.

- c. Upon request, the RPST Provider Agency must submit a copy of the RPST log or documentation of all interactions.
2. The RPST provider may not “up sell” systems that exceed the person’s current needs unless significant changes are clearly medically anticipated by the therapists, BSC’s or nurses based upon the person’s diagnoses and their knowledge of the individual; the system has the lifespan and flexibility to meet those anticipated needs and the individual or guardian are aware of and approve of this plan. Capacity for expansion due to anticipated needs must be accurate, realistic and all costs must be clearly listed and explained in the RPST Proposal.
3. After review of the approved request, RPST Provider will:
 - a. Order, deliver, install, and test all requested electronic devices, apps, sensors, or systems in a timely manner.
 - b. Work with the individual/guardian and the IDT to create the RPST Response Plan that identifies all provided devices and services; their specific uses or tasks and the specific planned response for each device or scenario such as remote reminders, interaction, or cueing; on-site response from local agency DSP or natural supports and emergency health, safety or utility providers as needed.
 - c. Assure that all agency DSP and natural supports indicated as on-site responders have accurate contact information and an identified back up, also with accurate contact information.
 - d. Provide or assure initial and ongoing training and supports for the individual, guardian, DSP or natural supports as needed to become knowledgeable about using and managing the system and reviewing and implementing the details of the RPST Response Plan.
 - e. The RPST provider will attend annual and other any IDT meeting as needed related to RSPT issues or response.
4. The cost of this service shall not exceed \$5000 per ISP year.
5. Reimbursement:
 - a. at cost reimbursement for items in the scope of service when provider is direct vendor of technology.
 - b. at cost plus 15% reimbursement fee when provider acts as a purchasing agent
 - c. not available for in person response through this service
6. When a monitoring service/device indicates that the person with I/DD needs assistance, on-call supports shall be promptly available to assist:
 - a. Response may consist of an on-site visit, remote (i.e., phone or video guidance) to the individual, calling 911, or individuals designated on the individualized

response protocol on behalf of the person, depending upon the requirements of the situation.

- b. On-call supports shall be delivered by staff of participating agencies and/or by call center staff of a monitoring service agency unless a natural support has committed to provide such response when needed.
 - c. Documentation regarding all response to RPST should be routinely reviewed by the remote and in-person agencies to monitor and address any changes in the individual's circumstances, needs or response plans. An RPST provider may request an IDT meeting at any time to address concerns with the system or plans.
7. Non-Waiver funds shall not be permitted to upgrade an existing RPST system that was purchased with waiver funds.
 8. DD Waiver funds may not be used for remote monitoring systems intended to monitor DSP or agency staff.
 9. The device is for the sole use of the individual and may not be routinely used by other family members, DSP, or housemates. Exceptions may include systems that support general environmental control or safety of the household such as thermostats or alarm systems.

14.2.3 Agency Requirements

1. RPST Provider Agencies must assure there is HRC approval when the proposed device and/or system may impact the person's privacy or other rights (See [Chapter 3.3 Human Rights Committee](#) for more information.)
2. RPST Provider Agencies must maintain documentation in the form of a log to include the person's identification on all pages of documents.
3. Receipts for all expenditures for RPST devices/services must be maintained including any estimates that have been received.
4. Upon request, the RPST Provider Agency must submit a copy of the RPST monitoring and response log to the CM, 14 calendar days prior to annual ISP meeting.

14.3 Crisis Supports

14.3.1 *Scope*

Crisis Supports are designed to provide an intensive level of supports by trained staff to a person experiencing a behavioral or medical crisis. Crisis Supports help the person and their support network to stabilize the crisis. Crisis Supports may be provided within the person's home or in an alternate residential setting.

The Crisis Supports provider is required to do the following:

1. provide trained Crisis Response Staff (CRS) to assist in supporting and stabilizing the person's medical or behavioral condition;
2. provide training and mentoring for staff, family members, IDT members and other natural supports to remediate the crisis and minimize or prevent recurrence;
3. arrange, if necessary, for an alternative residential setting and provision of CRS to support the person in that residential setting;
4. deliver Crisis Supports in a way that maintains the person's normal routine to the maximum extent possible;
5. deliver Crisis Supports in a way that maintains the person's human rights to the maximum extent possible;
6. present and receive approval from an HRC for a short-term restriction in the case of a severe health and safety risk;
7. assist in stabilizing and preparing the person to return to their original residence or to move into a new permanent residence because of an amendment to the ISP;
8. consult with IDT members, DSP, and other relevant personnel needed to ensure the implementation of the person's PBSP and ISP; and
9. attend IDT meetings.

14.3.2 *Service Requirements*

Crisis Supports are provided when a person requires crisis intervention as determined through the DDSD-BBS. Crisis Supports are provided under the following circumstances:

1. Referral and prior written authorization are provided by the BBS; level of crisis supports provided are always determined by BBS in consultation with the individual, guardian (if applicable) and the IDT.
2. The timeline does not exceed 90 calendar days, except under extraordinary circumstances, in which case duration and intensity of the crisis intervention is assessed weekly by BBS staff. The duration of this service does not exceed 180 calendar days per ISP year except under extraordinary circumstances and approved by the DDSD Director or designee.
3. Crisis Supports can be delivered in conjunction with Supported Living, Family Living, CIHS or in rare circumstances IMLS. Nursing services during Crisis Supports shall be

delivered by the Crisis Alternative Placement, the Supported Living provider, or the IMLS Provider Agencies or by accessing ANS as determined by the IDT in consultation with BBS during the crisis.

14.3.3 *Service Criteria Location*

All Crisis Supports will conform to the supports needed by the person per their ISP, with accommodations that are consistent with the IDT members' consideration of the crisis event and the person's status.

14.3.3.1 *Crisis Supports in the Person's Residence*

The Crisis Supports Provider Agency will provide CRS to support the person in the person's home when feasible and recommended by the BBS. The Crisis Provider Agency will provide or coordinate support services with the person's approved Living Supports, CIHS, CCS, and CIE Provider Agencies as applicable.

1. CRS may be utilized to augment and mentor existing DSP if a move to a Crisis Supports Provider Agency is determined to be unfeasible.
2. As determined necessary by the BBS, CRS staff may be utilized as the sole support to the person. In this instance, the Provider Agency may not bill for Living Supports if they are not providing staffing support to the person.

14.3.3.2 *Crisis Supports in an Alternate Residential Setting*

The Crisis Supports Provider Agency will provide or coordinate an alternate residential setting, if necessary. In the event a person needs to receive Crisis Supports away from his or her home, the Crisis Supports Provider Agency will arrange to have an alternate setting available. This may be an apartment, a motel, or a bedroom at a different residence. Required arrangements by the Crisis Supports Provider Agency for this contingency include:

1. The Crisis Supports Provider Agency plan for an alternate residential setting must be submitted to DDSD within 30 calendar days of the approval of the agency's provider agreement that includes this service.
2. The Crisis Supports Provider Agency's plan must include primary and secondary arrangements for providing an alternate residential setting.
3. If a change in residence is required beyond a primary and secondary arrangement to assure the health and safety of the person or others, the Crisis Supports Provider Agency shall assist the person, his or her team, and the BBS to secure an alternate residential placement for the person.

14.3.4 *Agency Requirements*

14.3.4.1 *On-call Coverage*

The Crisis Supports Provider Agency will establish an "on-call" system and ensure that sufficient staff is available to respond to relevant crisis calls from BBS on a twenty-four hour/seven day a week basis. ***The initial on-call response to BBS should occur within 30 minutes.*** The Crisis

Supports Provider Agency is required to designate sufficient trained staff to be available in the event of a crisis.

14.3.4.2 IDT Coordination

The Crisis Supports Provider Agency shall work with the person's IDT members, respective DDSD Regional Office and Regional BBS staff to affect a timely transition of services to the selected Crisis Supports Provider Agency. Any permanent change in residence due to a crisis will occur because of an ISP modification reviewed and approved by the person, guardian and the IDT. A change in residence will be based upon the long-term interests of the person. As outlined in [Chapter 6.5.2 ISP Revisions](#), any member of the IDT (including the Crisis Supports Provider Agency) may request an IDT meeting.

14.3.4.3 Required Orientation

The Crisis Supports Provider Agency's upper and middle management, including the Chief Executive Officer(s), agency directors, service coordinators and DSP supervisors, will attend orientation to the crisis response system and the DD Waiver Crisis Supports service. Orientation is conducted by DDSD-BBS staff and addresses the following:

1. elements of crisis response;
2. standards regarding Behavior Support; and
3. reviewing and monitoring process for this crisis service.

14.3.4.4 Staffing Requirements

1. The staff-to-client ratio for this service is, at a minimum, one-to-one (1:1).
2. The agency is responsible for the management and staffing of the crisis, unless an alternative agreement has been reached between the Crisis Supports Provider Agency and the BBS Chief or designee. The BBS Statewide Crisis Coordinator/Administrator, BBS Consultant, BBS Clinical Director, and/or designated BBS staff will be available for consultation and technical assistance on a case-by-case basis.
3. All DSP designated by the agency to be CRS shall have already completed the required DDSD training in accordance with DDSD training requirements for DSP described in [Chapter 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors](#) .
4. CRS shall also complete additional training as described in [Chapter 17.1.1 Additional Training Requirements for Community Integrated Employment Agencies and Staff](#)
5. Designated DSP that have not completed this training may not work alone as the designated CRS for any person in services, but may support the person during the same period with a designated CRS if the support is deemed necessary by the BBS, in conjunction with the IDT.

14.4 Environmental Modification

Environmental Modification includes physical adaptations identified in the person's ISP, which provide direct medical or remedial benefits to the person's physical environment.

Environmental Modification must address the person's disability and enable the person to function with greater health, safety, or independence in their residence. All services shall be provided in accordance with applicable federal, state, and local building codes. Environmental Modification is available to a person of any age and shall be coordinated with the person, guardian, CMs, Provider Agencies, licensed contractors, and members of the IDT.

Environmental modification projects include repairs or modification to existing equipment.

14.4.1 *Scope*

Environmental Modification addresses targeted medical, safety or functional concerns that incorporate the person's specific clinical and functional strengths and needs.

1. Examples of Environmental Modification include the following modifications of the person's physical environment, the accompanying purchases as well as the necessary installation services:
 - a. ramps;
 - b. lifts/elevators;
 - c. porch or stair lifts;
 - d. hydraulic, manual, or other electronic lifts/elevators incorporated into the building structure;
 - e. roll-in showers;
 - f. sink modification;
 - g. bathtub modifications;
 - h. toilet modifications;
 - i. water faucet controls;
 - j. floor urinal and bidet adaptations;
 - k. turnaround space adaptations;
 - l. widening of doorways/hallways;
 - m. specialized accessibility/safety adaptations/additions;
 - n. installation of specialized electronic and plumbing systems to accommodate medical equipment and supplies;
 - o. handrails, door handle adaptations, trapeze, and mobility track systems for home ceilings; or
 - p. automatic door opener/doorbells.
2. Environmental Modifications include environmental controls incorporated into the house infrastructure such as:
 - a. voice, light, and /or motion-activated and electronic devices;

DD Waiver Services
Chapter 14: Other Services
Environmental Modification

- b. modified switches, outlets, or other structural controls for home devices;
 - c. alarm, alert or signaling systems which do not duplicate such systems included with RPST obtained under that separate service;
 - d. fire safety adaptations;
 - e. medically necessary air filtering devices;
 - f. medically necessary heating/cooling adaptations; or
 - g. glass substitutes for windows and doors or other structural safety modifications.
3. Improvements or repairs to the existing home, which do not provide direct medical, safety, or functional benefit to the person or which should be included as part of routine home maintenance, shall not be approved. Such non-covered adaptations, modifications or improvements include:
 - a. carpeting except for repairs to carpet needed due to permitted modification, e.g., repair to carpet in a door widening;
 - b. roof repair;
 - c. furnace replacement;
 - d. remodeling bare rooms;
 - e. other general household repairs;
 - f. vehicle modifications; and
 - g. outdoor fences.
4. No duplicate environmental modifications shall be approved. For example, if the person has a safe and usable ramp, a replacement ramp shall not be approved.
5. Environmental modifications cannot be used to fund new residential construction, even if the new dwelling is designed to accommodate the needs of individuals with I/DD.
6. Equipment that is covered under the State of New Mexico's Medicaid program shall not be purchased under the DD Waiver.

14.4.2 *Service Requirements*

1. Environmental Modifications to the home owned by the person, owned by the guardian, owned by the family, owned by the provider, or leased homes must be compliant with the DD Waiver Standards and should meet the Americans with Disabilities Act (ADA) applicable guidelines when ADA guidelines will also meet the person's functional needs.
2. Environmental Modifications must comply with state and local building codes and standards.
3. Withholding or denial of final payment may occur if the person in service or their guardian files a dispute to the respective DDS Regional Office regarding the quality of work and the DDS Regional Office agrees with the complaint.
4. The cost of the Environmental Modification plus the administrative fee shall not exceed the maximum cost of \$5,000.00 every five ISP years.

DD Waiver Services
Chapter 14: Other Services
Environmental Modification

5. The DDS Verification of Benefit Availability form must be obtained from the Regional Office prior to approval of this service.
6. Administrative costs of the Environmental Modification Service Provider (EMSP) will not exceed fifteen percent (15%) of the total cost of the environmental modification project managed by the Provider Agency.
7. The EMSP must coordinate environmental modification pre-plan reviews with the person, guardian, or other family members, CMs, Provider Agencies as applicable and the therapist who conducted the assessment report.
8. The EMSP must coordinate with the therapist and/or qualified individual who provided the assessment to acknowledge, document and assure planned modifications will meet the person's clinical and functional needs:
 - a. Coordination should occur at an in-person on-site evaluation.
 - b. If in-person on-site coordination cannot occur or if this is not needed because the planned modification is very minor, coordination can occur via e-mail or phone with Regional Office approval.
 - c. Both the evaluator and the EMSP should document what was agreed upon regarding the Environmental Modification Plan during this meeting or through alternate communication.
9. The EMSP must develop an Environmental Modification assessment of the home and scope of work needed to complete the modification.
10. The EMSP must provide or secure licensed contractor(s) or vendor(s) to provide construction and/or remodeling services.
11. The EMSP must ensure that proper design criteria are addressed in planning and design of the adaptation.
12. The EMSP must provide administrative and technical oversight of construction projects.
13. The EMSP must inspect the final environmental modification project to ensure that the adaptation (s) meet the approved plan submitted for environmental adaptation.
14. The EMSP must interpret codes and clarify building procedures to the person, guardian, homeowner or other family members, CM, and Provider Agencies and DDS prior to construction activities.
15. When requested, the EMSP must provide consultation to the person, guardian, homeowner or other family members, CMs, Provider Agencies, subcontractors and DDS concerning environmental modification projects to the person's residence prior to or during construction activities.
16. The EMSP must review plans submitted by sub-contractors, if applicable, for environmental modifications to ensure that the plans are architecturally sound, address

functional needs outlined in the Environmental Modification Evaluation, and comply with state and local building codes and standards.

17. The EMSP must review accuracy of construction costs submitted by sub-contractors, if applicable.
18. The EMSP must ensure inspection of the final environmental modifications to ensure compliance with all local, state, and federal codes and requirements.
19. The EMSP must meet reasonable timelines for completion of environmental modifications:
 - a. The EMSP must contact person/guardian/homeowner within one business week of being notified of the signed SFOC to schedule the initial site visit.
 - b. The EMSP must provide an itemized price quote to the CM within ten business days after first visit with homeowner/person/guardian.
 - c. Any changes to the original itemized quote or materials must be reviewed by the Case Manager and approved by the individual and/or guardian.
 - d. The EMSP must complete all modifications within six weeks of the approved budget. A waiver of this timeline must be sought from the Regional Office if extraordinary circumstances prevent the EMSP from meeting this requirement.
 - e. The EMSP must work directly with Regional DDSD representative where the provider headquarters are located at signing of initial contract and at renewal of each new contract period, for training and updates from DDSD. (This may be accomplished through remote teleconferencing.)
20. The EMSP must provide a minimum of a one-year written warranty of the work completed, including both materials and labor, to person, guardian, homeowner or other family members, and CM.

14.4.2.1 **Cost of Materials:**

1. Materials utilized in projects shall be of Medium Grade and meet industry construction standards while considering the personal preferences of the homeowner.
2. DD Waiver funds may not be used for upgrades in materials that do not offer functional benefits to the person.
3. Purchase receipts for all materials must be kept in the Provider Agency's file and must be furnished to the CM.

14.4.2.2 **Use of Funding**

1. Cost estimates, items and project plans are required to specifically identify the materials to be purchased and the labor costs associated with the expenditure of DD Waiver versus non-DD Waiver funds.

2. DD Waiver funds may not be utilized to upgrade fixtures or other construction materials solely based on aesthetic qualities or personal preferences when lower cost fixtures or materials can provide the same or similar functional benefit to the person.
3. EMSP's may not provide any materials/services not in the original approved bid.
4. DD Waiver funds cannot be used to repair environmental modification upgrades or other augmentations to environmental modifications when DD Waiver funds did not cover the original environmental modification.
5. Any augmentation or upgrade to the DD Waiver funded portion of the environmental modification may void any warranties in place.
6. When one or more individual(s) in DD Waiver services who are roommates will benefit from an environmental modification, each impacted roommate shall equally divide the cost of the environmental modification from their respective ISP budget.

14.4.3 *Agency Requirements*

The EMSP must demonstrate the following:

1. The EMSP must have documentation verifying that the provider and any subcontractors utilized are bonded and Licensed Building Contractor(s) are authorized to complete the project by the State of New Mexico.
2. The EMSP must obtain all necessary permits as required by local and state laws.
3. The EMSP must demonstrate knowledge and work history showing the ability:
 - a. to interpret the principles and practices of architecture, building codes and standards, building materials and construction methods, structural, mechanical, plumbing, and electrical systems;
 - b. to interpret and prepare architectural working drawings and specifications, mediate contractual problems, and ensure compliance with all laws, rules, and standards of the State of New Mexico, including the federal, state, and local building codes;
 - c. to understand and implement contracting practices and procedures, construction cost estimating and knowledge of comparable costs to accomplish the adaptations;
 - d. to incorporate architectural design, standards and technical data relating to building design and construction; and
 - e. to interpret, implement and ensure that Federal ADA standards and applicable guidelines are followed in all environmental adaptations when applicable to the person's needs.

14.5 Independent Living Transition

Independent Living Transition Service provides funding for one-time expense(s) for people who transition from 24-hour setting under Living Supports (Supported Living, Family Living or IMLS) to a home or apartment of their own with intermittent support that allows the person to live more independently in the community.

14.5.1 *Scope*

1. Independent Living Transition includes but is not limited to:
 - a. Expenses associated with security and/or rental deposits that are required to obtain a lease on an apartment or home;
 - b. Set up fees or deposits for utilities (cell phone or land line, internet, electricity, heating etc.);
 - c. Furnishings and household goods to establish safe and healthy living arrangements (bed, chair, dining table and chairs, bed linens and bath towels, eating utensils, food preparation items and a telephone or cell phone); and
 - d. Initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning fee prior to occupancy.
2. Independent Living Transition Provider Agencies are not required to attend IDT meetings. However, the Independent Living Transition Provider will provide documentation or information to the IDT to support the planning process. This information may be provided in person or through the CM.

14.5.2 *Service Requirements*

1. Written justification must address the need for Independent Living Transition Service to fulfill supports in the ISP and identify the associated ISP Desired Outcomes. DD Waiver funds are the payer of last resort; the team is required to identify all other sources of funds prior to accessing this service.
2. DDS Verification of Benefit Availability form must be obtained from the Regional Office prior to approval of this service.
3. Funds may not be utilized to pay for food, clothing or rental/mortgage costs excluding deposits as specified above.
4. The Administrative cost of the Independent Living Transition Provider will not exceed fifteen percent (15%) of the total cost of dollars expended. The Administrative cost must be included within the one-time maximum cost of \$1,500.

14.5.3 *Agency Requirement*

1. Independent Living Transition Provider Agencies must maintain documentation in the form of a log to include:
 - a. The person's name on all pages of all documents;

- b. signature of author on all documents;
 - c. dates of expenditures;
 - d. amount and reason for expenditure based on the following funding categories:
 - i. security and/or rental deposit,
 - ii. utility deposit,
 - iii. household goods (specify items),
 - iv. furniture (specify items),
 - v. pest control or allergen control, and
 - vi. cleaning fees prior to occupancy.
2. Receipts for expenditures must be maintained.
3. The Independent Living Transition Provider must submit a copy of the Independent Living Transition log to the CM.

14.6 Non- Medical Transportation

The Non-Medical Transportation Service enables people to gain access to waiver and non-medical community services, events, activities, and resources as specified in the ISP. A person may access mileage reimbursement and/or reimbursement for a transportation pass.

14.6.1 *Scope*

Non-Medical Transportation services include transportation services between the person's home and non-medical services, resources or activities related to work, volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic, cultural, and spiritual activities or events that support activities or achievements of ISP Desired Outcomes.

14.6.2 *Service Requirements*

1. Mileage reimbursement for non-medical transportation is one mile with a maximum cap of \$810 per ISP year.
2. A public transportation pass plus up to ten percent (10%) administrative cost of the purchase price must be included within the maximum cost of \$460 for transportation passes per ISP year.
3. This service cannot be used to replace transportation available through the Medicaid State Plan including but not limited to transportation to medical care appointments.
4. This service cannot be used to replace the transportation responsibility of:
 - a. Living Supports-Family Living;
 - b. Living Supports-Supported Living;
 - c. Living Supports IMLS; or
 - d. Customized Community Supports.
5. For people who receive Family Living, Supported Living or IMLS, Non-Medical Transportation services may only be provided:
 - a. In situations where extensive travel (more than one hundred (100) miles round trip) is required to meet Desired Outcomes in the ISP; or
 - b. for the purchase of a public transportation pass.
6. The Non-Medical Transportation provider is required to provide both funding for purchase of public transportation on behalf of the person supported and to provide direct Non-Medical Transportation services.
7. Each service option must be clinically justified and utilized to fulfill identified activities associated with the ISP Vision and Outcomes.
8. The Non-Medical Transportation provider is required to deliver this service to all DD Waiver participants selecting their agency through a SFOC regardless of whether the person also receives other services from the agency.

9. The Non-Medical Transportation Provider must submit a copy of a transportation log to the CM on a semi-annual basis throughout the person's ISP year.
10. The Non-Medical Transportation Provider is not required to attend IDT meetings.
11. The Non-Medical Transportation Provider, if requested, will provide documentation or information to the IDT (in person or through the CM) to support the planning process.

14.6.2.1 Driver Responsibilities

1. Drivers must not leave any person unattended in the vehicle.
2. Drivers must remove keys from the vehicle whenever they are not in the driver's seat.
3. Drivers must lock all doors while the vehicle is moving.
4. Drivers must ensure that all persons use appropriate safety restraints as required for the person (seat belts, car seats, or other age-appropriate restraint systems).
5. Drivers must follow all traffic laws.
6. Driver must log unanticipated stops or delays during transportation. This does not apply to when an individual utilizes ride shares or public transportation passes.

14.6.3 Agency Requirements

14.6.3.1 Provider Agency Records

1. A signed consent form must be obtained prior to transporting a child (age birth through seventeen). The appropriate parent, guardian, or legal representative is complete the consent form. The signed form is maintained at the Non-Medical Transportation Provider Agency.
2. The Non-Medical Transportation Provider must maintain documentation when transporting people in the form of a transportation log to include:
 - a. proper individual identification shall be included on all pages of documents;
 - b. date(s) of service, including dates and signatures of authors on all documents;
 - c. time in and time out;
 - d. location(s) where the person begins travel and the destination point, i.e., point to point, not round trip); and
 - e. total miles traveled.
3. The Non-Medical Transportation Provider is responsible for compiling and maintaining documentation supporting the use of transportation passes. Documentation supporting the implementation of activities in the ISP including Desired Outcomes may be used for audit and billing purposes.

14.6.3.2 Driver Qualifications

All drivers are required to:

1. possess a valid New Mexico driver's license, and be free of physical or mental impairment that would adversely affect driving performance. Eligible drivers will not

have any Driving Under the Influence convictions, or chargeable (at fault) accidents within the previous two years;

2. be trained to implement individual-specific techniques to ensure the safe transportation of individuals who have unique medical, physical, or behavioral considerations; and
3. complete training by the Provider Agency to report incidents or accidents.

14.6.3.3 Vehicle Requirements

1. All vehicles used to provide Non-Medical Transportation are required to comply with state automobile insurance requirements.
2. Vehicles used to transport people with physical disabilities shall be accessible. Special lifts and other equipment shall be in safe working order.
3. The provider will ensure the following when transporting people:
 - a. Written procedures for reporting incidents will be kept in all vehicles used to provide non-medical transportation services.
 - b. Vehicles used for people who use wheelchairs have locking mechanisms which are used to immobilize wheelchairs during travel.
 - c. A basic First Aid kit is kept in all vehicles.

14.6.3.4 Exceptions for Use of Public Transportation

The purchase of a pass for travel on public transportation does not require the Public Transportation System to be a Non-Medical Transportation Provider. Only Public Transportation Systems operated in accordance with State of New Mexico Regulations and Licensing Requirements may be used for the provision of Non-Medical Transportation services.

14.7 Supplemental Dental Care

Supplemental Dental Care allows adults (over age 21) on the DD Waiver to receive one preventive examination and cleaning each ISP year that is in addition to the benefit provided through the Medicaid State Plan. Skilled clinical dental services are provided by a licensed dentist or a certified dental hygienist.

14.7.1 *Scope*

The Supplemental Dental Care Provider Agency will function as a payee for one preventive examination and cleaning each ISP year that is in addition to the benefit provided through the Medicaid State Plan.

14.7.2 *Service Requirements*

1. To access this service, the person's established dental provider must identify that an additional routine preventive oral examination and cleaning is required to maintain and/or preserve oral health.
2. The Supplemental Dental Care Provider Agency must submit a copy of the documentation of service delivery to the CM when requested.
3. A Supplemental Dental Care Provider Agency is not required to attend IDT meetings must provide documentation of the visit from the dental clinician as needed or requested by the CM.
4. The Supplemental Dental Care Provider Agency may include a service fee up to ten percent (10%) of the total cost of the services to cover administrative costs.

14.7.3 *Agency Requirements*

1. The Supplemental Dental Care Provider Agency is required to ensure that a licensed dentist per New Mexico Regulation and Licensing Department provides the oral examination.
2. The Supplemental Dental Care Provider Agency is required to ensure that a dental hygienist certified by the New Mexico Board of Dental Health Care provides the routine dental cleaning services.
3. The Supplemental Dental Care Provider Agency functions as a payee for the service, bills the person's DD Waiver budget for this service within the timely filing period and will reimburse the clinical dental provider within 30 days of receipt of payment.
4. The Supplemental Dental Care Provider Agency is required to maintain accurate records regarding all services billed and reimbursed to the dental clinician.

14.8 Respite

Respite is a flexible family support service. The primary purpose of respite is to provide support to the person and give the primary unpaid caregiver time away from duties. Respite services include assisting with routine ADL (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating); enhancing self-help skills; increasing social and community awareness; providing opportunities for leisure, play, neighborhood and community involvement and other recreational and social activities; and providing opportunities for the person to make their own choices about daily activities.

Respite may be provided in:

- a. the person's home;
- b. the provider's home;
- c. a community setting of the person's or family's choice (e.g., community center, swimming pool, park); or
- d. a location in which other people are provided care (e.g., a respite home).

There are two rates and models for respite: individual and group (for less than or equal to five people).

14.8.1 *Scope*

The scope of Respite includes, but is not limited to, the following:

1. training and assistance for community integration, including implementation of preferential meaningful activities;
2. assistance in developing and/or maintaining social, spiritual, and individual relationships, including the development of generic and natural supports of the person's choosing;
3. implementing plans as applicable to the person in services (e.g. WDSI, TSS, HCPs including CARMPs, MERPs, PBSPs, RMPs, PPMPs and BCIPs);
4. assistance in implementing health maintenance supports and accessing urgent medical care when needed; and
5. assistance with medication management needs to include reminding, observing, and monitoring self-administration of medication.
6. When respite is only service on budget for someone 21 and older, service tracks progress on Action Plans and Desired outcomes.

14.8.2 *Service Requirements*

1. People receiving Family Living, Supported Living, IMLS, and CIHS- independently (not with a family or natural support) may not access respite.

2. Medication administration is not a support in respite and must be arranged for separately by the primary caregiver.
3. Respite services are available to a person of any age living with an unpaid primary caregiver including CIHS living with unpaid family.
4. The use of respite services is determined by the primary caregiver in consultation with the IDT and recorded in the person's ISP.
5. If respite is the only service included in the ISP other than Case Management, for an adult age 21 or older, the following is required:
 - a. The IDT shall complete a Decision Consultation and Team Justification Form (DC/TJF) to explain why respite alone the appropriate service delivery approach for the person is. This document must be attached to the ISP.
 - b. The Respite Provider Agency must submit semi-annual progress reports to the CM that describe progress on the Action Plan(s) and Desired Outcome(s).

14.8.3 *Agency Requirements*

Respite Provider Agencies must meet the following requirements:

1. The Respite Provider Agency must provide an individual accounting of any personal funds used monthly, including receipts for expenditures in the community.
2. DSP providing Respite cannot also be a primary caregiver or a person who resides in the same dwelling as the person supported.
3. When Respite is provided overnight, DSP may sleep when the person is asleep, but only when the IDT members agree to this and the environment is safe and secure.
4. Respite Providers must use the state approved EVV system to meet EVV requirements as detailed in ([Chapter 21.4 Electronic Visit Verification](#)). Services rendered that are not captured in the EVV system and do not have the approval / exception from the state cannot be paid.

14.9 Socialization and Sexuality Education (SSE)

People with I/DD have sexual rights that must be respected, valued, and nurtured. Sexuality is a process that occurs across the lifespan. Sexuality is a natural and healthy aspect of living and is an essential part of anyone's physical, emotional, mental, and social well-being and identity. Persons with I/DD need to be able to interact with others that they encounter day-to-day, and to be free to develop close friendships or romantic relationships that they choose. Socialization & Sexuality Education is provided in a class format called the Friends & Relationships Course (FRC). The FRC is a comprehensive lifelong education program that combines an inclusive and safe environment with differentiated instruction strategies to foster the continuous development and training of knowledge and skills to 1) increase social networks with healthy, meaningful relationships; and 2) increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation, and abuse. The FRC supports students to reflect on their own cultural, religious, and moral values while considering social responsibility, to promote informed decision making with respect to relationships and sexuality. A critical design of the FRC classes is to strengthen a mutual collaboration -an interdependence- between the student and their support guide, to learn, practice, and improve their skill-building together. By learning together, a stronger interdependent connection is developed; placing equal value in communication, competence, trust, and respect of both parties. Persons with I/DD learn to ask for, develop, and strengthen the practical support they receive from others, assisting them to experience fulfillment and satisfaction in their lives, while at the same time increasing their interest and participation in community life.

The FRC requires a support guide to participate in classes with every student, teaching them to support the social and sexual lives of persons with I/DD while building a healthy interdependent connection. The support guide is selected from the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, and/or other professionals). FRC classes include trained and paid self-advocate peer mentors with I/DD who serve as role models and leaders to ensure an integrated and coordinated approach to service delivery.

The IDT provides services and supports to FRC students in such a way that the skills the person is learning in the FRC are being practiced, reinforced, and expanded in all settings. The IDT is required to integrate these skills and supports into the person's Desired Outcomes and TSS where and when appropriate.

14.9.1 *Scope*

The scope of Socialization and Sexuality Education (SSE) includes, but is not limited to:

1. providing a comprehensive adult education program, using the FRC curriculum, to include topics within the following content area: socialization, sexuality, and sexual health education; and
2. collaborating with members of the person's IDT to:
 - a. secure a support person to attend classes with the student, and to continue support for skills learned in class outside of the classroom; and

- b. integrate classroom goals and learning objectives into the individual student's ISP and PBSP, if person has a PBSP;
3. recruiting people who have attended classes and demonstrated leadership skills to be trained and hired as self-advocate peer mentors; and
4. emphasizing course content on how to assert participants' rights to be free from aversive, intrusive measures; chemical, mechanical, and programmatic physical restraint; isolation; incarceration; and ANE.

14.9.2 *Service Requirements*

14.9.2.1 Friends and Relationships Course (FRC) Teacher/Peer Mentor Qualifications: The FRC is taught by qualified individuals who have demonstrated competency through training, supervised teaching, and fulfilling specific certification criteria. DDSD also requires that self-advocates be trained as peer mentors to assist teachers and students by acting as role models and mentoring students.

1. FRC teachers shall meet the following qualifications:
 - a. Master's degree in Psychology, Counseling, Special Education, Social Work, or related field; or
 - b. Registered Nurse (RN) or Licensed Practical Nurse (LPN); or
 - c. Bachelor's degree in Special Education; or a related field such as psychology or social work; or
 - d. Recreational therapist (CTRS), certification obtained through the National Council for Therapeutic Recreation certification; or valid New Mexico Public Education Department Recreational Therapy Instructional Support provider license; and
 - e. Completion of the following student pre-requisites and student teacher training requirements, resulting in the approval to teach.
2. To be trained and hired, the peer mentor is required to:
 - a. have attended the series for which they will mentor; and
 - b. have demonstrated leadership skills.

14.9.2.2 *Teacher Training Requirements*

All SSE trainers (Student and Lead Teachers) are required to do the following:

1. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;

14.9.2.2.1 *Student Teacher Training*

Prior to being considered for approval as an FRC student teacher, interested individuals shall successfully complete the following prerequisites:

1. meet requirements as defined in 14.9.2.1 Friends and Relationships Course (FRC) Teacher/Peer Mentor Qualifications; and
2. submit a written request to the BBS Chief requesting student teacher training and intention to become BBS-certified lead teacher.

14.9.2.2.2 BBS-Certified Lead Teacher

Approved student teachers shall successfully complete the following requirements to become a BBS-certified lead teacher:

1. arrange for supervision from a BBS-certified lead teacher prior to student-teaching training; and
2. assist in classes for a minimum of two series, taught by a BBS-certified lead teacher and complete required training courses (Introduction to Supporting Sexuality for Persons With I/DD and Train-the-Trainer SSE Course); or
3. with prior written approval of the BBS Chief or Designee, complete a combination of class attendance, training courses (Introduction to Supporting Sexuality for Persons With I/DD and Train-the-Trainer SSE Course) and arranged student-teaching opportunity; and
4. upon completion of requirements, submit a written request to the BBS Chief or designee requesting a review of supervised teaching experience including a letter of recommendation by the BBS-certified teacher, and training completion for approval to become a BBS-certified lead teacher.

14.9.2.2.3 Training and Oversight Requirements for BBS-Certified Lead Teachers

All BBS-certified lead teachers must participate in continued FRC training and planned professional development opportunities during the first two years of teaching FRC classes. In addition, FRC teachers will participate in any additional training as requested by DDSD-BBS. The following oversight and BBS quarterly meetings are required of all teachers:

1. at least two statewide SSE Quarterly Meetings offered by BBS; and
2. allowance of FRC class observation by BBS Chief or designee, as requested.

14.9.3 Agency Requirements

The FRC is conducted in the most inclusive way possible, integrating students with a range of cognitive function, cultural and ethnic backgrounds and disabilities, and sexual orientations and lifestyles. SSE Provider Agencies must meet the following requirements to conduct the FRC:

1. Prior to receiving approval from the BBS to provide the service the agency shall identify:
 - a. at least one BBS-certified Lead Teacher to teach the class; and
 - b. at least one peer mentor to support the class.

DD Waiver Services
Chapter 14: Other Services
Socialization and Sexuality Education (SSE)

2. Conducting classes in a location which is in a community setting (i.e., community center, college) is strongly recommended. Hybrid or virtual class locations may be offered as an alternative upon approval and instruction from DDS.
3. Requirements for class organization are to:
 - a. an SSE Provider agency provides billable SSE services at one unit per FRC series taught by a BBS-certified lead teacher or FRC student-teacher supervised by a BBS-certified lead teacher as described in section 14.9.3.1 Student Teacher Training;
 - b. an SSE agency provider may provide billable SSE services a maximum of 1 billable unit per term and a maximum of three units per ISP year; with no lifetime restrictions;
 - c. develop an FRC class schedule and distribute to regional stakeholders. Classes will be scheduled across three terms per year: Fall (September to November); Winter (December to March); Spring (March to May); or Summer (June to August);
 - d. coordinate with the BBS to determine what area of the county, region, or state there is a need for a class;
 - e. engage in all activities necessary to disseminate information about scheduled classes to CMs, BSCs, parents, guardians, and other key team members in a timely way to ensure student registration and attendance;
 - f. ensure that no more than 25 people with I/DD are registered for each class, not counting any persons attending to support those people (regardless of funding source);
 - g. use DDS-approved FRC curriculum and design when delivering SSE services;
 - h. ensure FRC program evaluations and QI/QA surveys are implemented; and
 - i. upon series completion, submit a series end progress note for each student to the individual, their guardian and CM, and submit FRC series end data (list of graduates, student-teacher(s), and peer mentor(s); program evaluation data) to BBS.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 15: Provider Enrollment

15.1 Provider Enrollment Unit

The Provider Enrollment Unit (PEU) enrolls agencies and sole proprietors to provide services through the DD Waiver and manages numerous processes related to enrollment and Provider Agreements. The PEU processes both new and renewal provider applications, waivers of provider accreditation (See [Chapter 16.2 Accreditation](#) for more information), amendments to Provider Agreements, Expiration of Provider Agreement, expiration and termination of Provider Agreements, Provider Agency withdrawal from the DD Waiver, as well as moratoria on new clients to Provider Agencies. The PEU maintains the most current information on Provider Agencies and the SFOC forms which list all available Provider Agencies for each DD Waiver service in all thirty-three counties of the State. The PEU also tracks licensure and insurance policies of DD Waiver Provider Agencies.

15.2 Application Process

Enrollment is ongoing. The entire process takes approximately 90 days for new providers and 60 days for renewing providers.

1. The provider application is provided by PEU and posted on the DOH-DDSD website. The application includes requirements such as:
 - a. Application forms;
 - b. Accreditation, as applicable;
 - c. Financials;
 - d. Responses to program and service specific questions;
 - e. The Agency's authoritative documents related to specific DD Waiver Service Standards; and
 - f. Licensure (when applicable to service type).
2. The application is reviewed by a DDS committee and/or subject matter experts.
3. Applicants must meet the CMS Final Settings requirements.
 - a. New applicants must fully meet the CMS Final Rule Settings Requirements to be approved.
 - b. Renewing Provider Agencies have a transition period to fully meet the CMS Final Rule Settings Requirements based on the state's approved Statewide Transition Plan.
4. Agencies will receive an approval, a request for additional information, or a denial.
 - a. If the application is approved, the PEU will produce a new Provider Agreement for the provider to sign.
 - i. New providers will be given information to obtain a Medicaid number.
 - b. If the DDS reviewer(s) request additional information, the PEU contacts the Provider Agency with the request.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 15: Provider Enrollment

- c. Renewing Provider Agencies could be placed on a State-Imposed Moratorium if the reviewer(s) request additional information for a third time.
 - d. New and renewing Provider Agencies may incur a \$500 fee if the reviewer(s) request additional information for a fourth time.
 - e. If the application is denied, the PEU will send a letter to the applicant, advising them of the decision and the reason(s) for the denial.
 - f. Renewing Provider Agencies who have received an Expiration of Provider Agreement notice, must begin the transition process immediately.
5. New Provider Agencies cannot begin providing DD Waiver services until the HSD/MAD has approved their application and the PEU has placed their agency on the SFOC form.
 6. If a Provider Agency deleted services upon renewal of their Provider Agreement, the Provider Agency must provide written confirmation stating that the current DD Waiver recipients have been transitioned and billing for the deleted service(s)/county(s) is complete.

15.2.1 *Term of Agreement*

1. Renewing providers may receive up to a three (3) year term based on scoring and on the recommendations of the DDS personnel. The Term of the Agreement may be impacted by agency referrals to the Internal Review Committee (IRC), the number of corrective action plans implemented within the previous twenty-four (24) months; and number of plans demonstrating closure with any deficiencies or findings. Corrective action plans include but are not limited to:
 - a. Individual Quality Review (IQR) findings;
 - b. Corrective and Preventive Action Plans related to reporting of Abuse, Neglect and Exploitation (ANE);
 - c. Plan of Correction (POC) related to Quality Management Bureau (QMB) compliance surveys;
 - d. Civil Monetary Penalties (CMP), Performance Improvement Plans (PIP), and Statewide Imposed Moratoriums related to Regional Office Contract Management; and
 - e. Directed Plans of Corrective Active (DCA) related to Internal Review Committee.
2. New providers will receive a one (1) year provisional term and may receive two (2): one (1) year provisional Provider Agreements to allow time for the agency to obtain accreditation when required by DDS.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 15: Provider Enrollment

15.3 Amendments

DDSD may approve an amendment to a Provider Agreement when a provider wants to add or delete services, counties, or regions or when the term of a Provider Agreement needs to be extended for any reason. Amendments are processed according to the following steps:

1. Provider Agencies must mail the Amendment Form to the PEU and must include an original signature. Faxed or emailed amendment requests are not accepted.
2. If the term of a Provider Agreement needs to be extended, the PEU sends a pre-filled Amendment Form to the provider for signature.
3. To add a county, region, or service to a Provider Agreement, the Provider Agency must submit an Amendment Form, the appropriate Additional Program Description(s) and licensure (if applicable) to the PEU. A Provider Agency may not amend their Provider Agreement to add services or a county to a region where the provider already has a moratorium.
4. To delete a county, region, or service from a Provider Agreement, the Provider Agency must submit an Amendment Form and written confirmation stating that any current DD Waiver recipients have been transitioned and billing for the deleted service(s)/county(s) has been completed.
5. If any of the necessary items are missing from an amendment request, the PEU contacts the Provider Agency for the missing items.
6. The PEU submits a complete amendment request to the appropriate DDSD Regional Office(s) for review.
7. The Regional Office(s) responds with an approval, a request for additional information, or a denial.
 - a. If the amendment request is approved, the PEU processes the amendment request and sends a confirmation letter to the Provider Agency.
 - b. If the DDSD Regional Office requests additional information, the PEU contacts the Provider Agency with the request.
 - c. If the amendment request is denied, the PEU sends a denial letter to the Provider Agency.

15.4 Moratoria

15.4.1 *Self-Imposed Moratorium*

A self-imposed moratorium is the removal of a Provider Agency from the SFOC form in specific counties for a limited amount of time, per the provider's request. This allows the Provider Agency to refrain from accepting new clients during the term of the moratorium. Provider requests for a self-imposed moratorium must be related to extenuating circumstances and conditions, for example: (a) many individuals have been accepted into service within a short time frame, (b) loss of key staff, (c) temporary economic issues that impact the agency's ability to accept additional individuals and (d) staff illness or physical disability affects the ability of the

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 15: Provider Enrollment

agency staff to travel long distances. A self-imposed moratorium must be approved by the DDS and may be approved in part or in whole.

Provider Agencies requesting a self-imposed moratorium must:

1. fill out a Self-Imposed Moratorium Form and submit the form to the PEU for processing; and
2. provide services to all of individual(s) who selected their agency via a signed SFOC form prior to the approval date of the self-imposed moratorium.

1.1.1 *State-Imposed Moratorium*

A state-imposed moratorium is issued by the DDS or the Internal Review Committee (IRC). A state-imposed moratorium removes the provider from the SFOC for an unspecified amount of time. Provider Agencies placed on a state-imposed moratorium receive a letter explaining the reason(s) for the action and what must occur for the moratorium to be lifted.

15.5 *Provider Withdrawal from the DD Waiver*

Provider Agencies may choose to withdraw from the DD Waiver at any time but retain responsibility for providing services until all DD Waiver participants have been transitioned to new Provider Agencies or no longer need the services. When verification that all transitions have occurred, and the agency's billing is complete, the PEU works with HSD/MAD to close the provider's DD Waiver Medicaid number or to remove the DD Waiver from the provider's Medicaid number.

To withdraw from the DD Waiver program, Provider Agencies are required to:

1. Submit the following to the PEU at least 30 calendar days prior to the estimated closure date:
 - a. written notice of intent to withdraw;
 - b. a copy of the notice that will be provided to the person and/or guardians and their CMs; and
 - c. a current list of individuals who will need to be transitioned including each person's legal name, address, phone number, social security number, and CM.
2. Continue providing services to individuals on the agency's existing caseload until those individuals have been transitioned to another agency or no longer require services.
3. Follow all transition requirements detailed in [Chapter 9: Transitions](#).
4. Notify the PEU when all individuals have been transitioned and billing is complete.

15.6 *Expiration or Termination of Provider Agreement*

A Provider Agreement may expire or may be terminated by the DOH. The Provider Agency remains responsible for providing services to ensure health and safety until all DD Waiver participants have been transitioned to new Provider Agencies or no longer need the services. If necessary, the PEU will extend the Provider Agreement until the transition of services and provider billing is complete.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 15: Provider Enrollment

Upon verification that all transitions have occurred and the agency's billing is complete, the PEU works with HSD/MAD to close the provider's DD Waiver Medicaid number or to remove the DD Waiver from the provider's Medicaid number.

Immediately upon receipt of the written notice from DDS of the non-renewal, expiration or termination from DD Waiver program, the Provider Agency must:

1. provide written notice to all staff and individuals/guardians within five calendar days of receipt;
2. continue to provide essential services and supports during the period of expiration or termination management until the transition of all individuals is complete;
3. work with the DDS Regional Office to ensure adequate transition planning takes place;
4. follow all transition requirements detailed in [Chapter 9: Transitions](#); and
5. notify the DDS Regional Office(s) and/or the PEU when all individuals have been transitioned and billing is complete.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 16: Qualified Provider Agencies

Chapter 16: Qualified Provider Agencies

Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards and relevant NMAC All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies.

16.1 Caregivers Criminal History Screening Program

The Caregivers Criminal History Screening Program (CCHSP) is essential to the enforcement of the DOH policy of “Zero Tolerance” of Abuse, Neglect & Exploitation (ANE) and to the DHI mission of enhancing the quality of health systems for all New Mexicans. CCHSP includes Provider Agency requirements to complete a caregiver criminal history screening background check and to check the Employee Abuse Registry (EAR). Requirements are as follows:

1. For the purposes of the DD Waiver, the CCHSP applies to any non-licensed person whose employment, contractual or volunteer service with a DD Waiver Provider Agency includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that Provider Agency including:
 - a. DSP, Direct Support Supervisors and Service Coordinators for CCS, CIE, Respite, CIHS, and Living Supports (Family Living, Supported Living, and IMLS);
 - b. any unlicensed CMs;
 - c. administrators or operators of facilities who are routinely on site where support is provided;
 - d. any unlicensed providers of SSE; and
 - e. any compensated persons such as employees, contractors, volunteers, and employees of contractors.
2. All non-licensed personnel must obtain a caregiver criminal history screening background check within 20 calendar days of hire (NMAC7.1.9). Provider Agencies must also check the EAR prior to hiring or contracting with an employee (NMAC 7.1.12).
3. Individuals with a disqualifying criminal conviction or who have been placed on the EAR for a substantiation of ANE are not eligible to work as a caregiver or have access to patient/client/resident information or records.

16.2 Accreditation

Provider Agencies of Case Management, CCS, CIE, CIHS, Living Supports (Family Living, Supported Living, and IMLS), and Respite are required to become accredited by CARF International or The Council on Quality and Leadership. Accreditation requirements include:

1. obtaining accreditation for each required service;
2. meeting initial accreditation requirements within 18 months of becoming a provider;

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 16: Qualified Provider Agencies

3. obtaining accreditation for any required service added to a Provider Agreement during the next accreditation survey or no later than 18 months after adding the service; and
4. keeping accreditation current unless a waiver of accreditation is granted by meeting any of the following criteria:
 - a. The Provider Agency has not provided services to any individuals within nine months of being placed on the SFOC form.
 - b. The Provider Agency has three or fewer individuals, and/or received an annual sum of less than \$100,000 of Medicaid funding from the prior year, specifically for the DD Waiver.
 - c. The Provider Agency has received two consecutive, three-year accreditation terms.
 - d. Quality review and quality assurance activities conducted by state agencies do not result in DDS revocation of the exemption.

16.3 Direct Support Professional Educational and Experience Requirements

DSP refers to the staff and subcontractors employed by DD Waiver Provider Agencies that provide direct, daily, hourly and routine supports. DSP are primary implementers of the ISP and carry out individualized strategies developed and trained to promote health, safety, and the achievement of ISP visions and Desired Outcomes. DSP are full participating members of the IDT.

DSP and their supervisors (DSS) or Service Coordinators are an integral part of the structure of Provider Agencies that provide Community Integrated Employment, Customized Community Supports, Respite, Customized In-Home Supports, and Living Supports (Family Living, Supported Living, and IMLS).

Minimum education requirements for DSP and DSS are:

1. DSP must be 18 years or older; and have a high school diploma or GED. DSP hired prior to January 1, 2013; DSP in family living, related by affinity or consanguinity; and DSP in Respite are exempt from this requirement. The exemption to the high school diploma or GED requirement for DSP hired prior to January 1, 2013, remains applicable only when there is less than a 24-month gap in employment at any time.
2. DSS must be 21 years of age or older, have a high school diploma or G.E.D, and have a minimum of one year of experience working with people with I/DD or related field or have a degree in a related field as a substitute for experience.

16.4 Professional Licensure

Professionals licensed by their respective boards must practice under the confines of their license and provide a current license to their agency annually. Agencies must provide current licenses to DDS PEU upon request. All relevant professional licensure for all hired and subcontracted personnel must be active in the state of New Mexico for:

1. Nursing as separate service or bundled into a Living Support;
2. Behavioral Support Consultation;

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 16: Qualified Provider Agencies

3. Case Management Services;
4. CMAs;
5. Environmental Modification;
6. Nutritional Counseling;
7. OTs, COTAs, PTs, PTAs and SLPs; and
8. Risk Evaluators for PRSC.

16.5 Board of Pharmacy

All DD Waiver Provider Agencies with service settings where medication administration/assistance to two or more unrelated individuals occurs must be licensed by the Board of Pharmacy and must follow all Board of Pharmacy regulations related to medication delivery including but not limited to:

1. pharmacy licensing;
2. medication delivery;
3. proper documentation and storage of medication;
4. use of a pharmacy policy manual; and
5. holding an active contract with a Pharmacy Consultant.

16.6 Conflict of Interest

DD Waiver Provider Agencies must mitigate any conflict of interest issues by adhering to at least the following:

1. Any individual who is an employee or subcontractor of an entity that is compensated for providing DD Waiver services to an individual must not serve as guardian or Power of Attorney for that individual, except when related by affinity or consanguinity [§ 45-5-31(1) A NMSA (1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.
2. DD Waiver Provider Agencies may not employ or sub-contract with DSP who are an immediate family member to support the person in services, except when the person is in Family Living, Respite, or CIHS.
3. DD Waiver Provider Agencies may not employ nor subcontract with a spouse or domestic partner to support the person in services.

16.7 Compliance with Federal and State Rules and DD Waiver Service Standards

DD Waiver Provider agencies must comply with all applicable federal and state rules and DD Waiver Service Standards. Agencies are required to submit policies or procedural descriptions in their initial and renewal application which address applicable requirements.

16.7.1 Exception to the Standards

In extraordinary circumstances, a Provider Agency may need to request an exception to the standards. An exception may be based on individual circumstances or extenuating

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 16: Qualified Provider Agencies

circumstances at the agency. Any exception to the standards needs prior approval from DDSO according to the following:

1. For exceptions to standards that directly impact a person in service, the exception may be granted using the Exception Authorization Process, formerly known as the H Authorization Process, which requires the CM to submit the request on required forms along with supporting documentation to the respective DDSO Regional Office Director or designee for review and determination.
2. For exceptions to the standards related to service and/or agency requirements, the exception may be granted through a review of specific circumstances by designated DDSO staff, which requires the agency to submit the request to the local Regional Office. The local Regional Office forwards the request to the appropriate DDSO Management staff for review and determination.
3. All exceptions must be approved prior to implementing.
4. Federal and state requirements are considered when reviewing any requests for exceptions.
5. Any Provider Agency operating under an approved exception must have supporting documentation on file for quality review activities.
6. Exceptions may be time limited or revoked based on individual and/or agency circumstances.

16.8 DDSO Contract Management

DDSO is authorized, by agreement with the HSD, to enforce DD Waiver Service Standards and service regulations with DD Waiver Provider Agencies and to impose sanctions on Provider Agencies for failure to perform in accordance with standards applicable under statute, regulation, and contract.

As such, DDSO Regional Directors, Bureau Chiefs, and/or Deputy can provide technical assistance or administrative actions, such as a Performance Improvement Plan (PIP) to assist Provider Agencies.

If the technical assistance and/or administrative actions taken are unsuccessful in resolving the concern, the DDSO Regional Director, Bureau Chief, and/or Deputy Director determines the appropriate level of sanction. Any determination of a High Impact violation will be referred to the Internal Review Committee (IRC) for consideration of action.

16.8.1 *Technical Assistance and Administrative Actions and Sanctions*

The DDSO Director, Deputy Director(s), Bureau Chief(s), and/or Regional Office Directors may provide technical assistance or directly impose administrative actions, Civil Monetary Penalties (CMP)s, and sanctions on community-based Provider Agencies for non-compliance with (or violations of) regulations, service standards, guidance documents, and/or Provider Agreement requirements.

The DDSO Regional Office Director must engage in activities that are less than sanctions to

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 16: Qualified Provider Agencies

resolve the issue and/or concern prior to the imposition of any CMP or other sanctions. Because each administrative action may not be appropriate to the situation and/or concern, implementation of each or all types of technical assistance or administrative action is not required prior to the imposition of a CMP or sanction. Provider Agency requirements related to technical assistance or administrative actions by the Regional Office may include but are not limited to:

1. providing information, documentation, or follow up;
2. meeting with Regional Office personnel to assure that agency policies, procedures, guidelines, and practices comply;
3. following any mandatory directed technical assistance from the Regional Office;
4. implementing a PIP; and
5. completing a focused survey conducted by DHI-QMB when requested via the IRC.

16.9 Quality Management Bureau (QMB) Surveys

The Department of Health's Division of Health Improvement (DHI) is the regulatory entity providing compliance oversight for the DD Waiver. The QMB survey team conducts unannounced on-site, systems-based surveys and other quality improvement activities related to the health, welfare and safety of individuals receiving these supports.

Provider Agencies of Case Management, (Living Care Arrangements) Supported Living, Family Living, Intensive Medical Living Supports, Customized In-Home Supports and (Community Inclusion Services) Customized Community Supports, and Community Integrated Employment are required to submit to QMB compliance surveys based on the CMS waiver assurances and New Mexico's approved DD Waiver, DD Waiver Service Standards, and other State and Federal rules and regulations.

Compliance surveys are based on the compliance determination an agency receives, which range from 12 to 36 months. No provider may exceed a 3-year cycle based on CMS requirements; however, surveys may occur more frequently based on the providers compliance determination. Compliance Determinations are used to identify a provider's overall level of compliance and indicate the frequency of the review cycle for future QMB reviews.

Sampling is conducted using a randomized stratified duplicated sample for LCA and CI services. Survey samples are a duplicated (when possible) to go across services for LCA and CI Services. The purpose of drawing a sample based on the services provided is to reflect a proportionate representation of individuals in services. DHI uses a duplicated count to determine the total number, meaning that if an individual receives more than one service through the selected agency, he or she is counted for each service received. For Case Management compliance surveys, randomized sampling is based on the number of Individuals over 18 years old that are receiving the DD Waiver case management services.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 16: Qualified Provider Agencies

Provider Agencies undergoing a QMB Compliance Survey undergo the following:

1. Record reviews including Individual agency case files (LCA, CI, Case Mgt), residential case file, community inclusion site case files, personnel records, administrative policy and procedures, quality assurance plans, etc.
2. Interviews including: Administrators, Direct Support Professional (DSP providing services to in Individual at the time of the survey, i.e., LCA, CI DSP), Individuals receiving services, Case Managers (Case Mgt surveys), etc.
3. Observations: Residential and Community Inclusion (when applicable)
4. Once a survey is completed each DD Waiver provider surveyed by QMB receives an overall determination of *Compliance*, *Partial Compliance* or *Non-Compliance* based on standard level deficiencies and/or with conditions of participation (CoP) level deficiencies.
5. A CoP is a fundamental regulation, standard, or policy with which a provider must comply to ensure individual health and welfare.
6. CoP are determined by the DDS and DHI and are reviewed and updated when programmatic changes occur. (See the DHI website at [Quality Management \(nmhealth.org\)](http://nmhealth.org) for updates to survey tools and CoP listing.)
7. All deficiencies are identified and cited in the QMB Report of Findings and require a plan of correction along with ongoing Quality Assurance/Quality Improvement processes when identified.
8. Upon completion of a QMB survey, the DD Waiver Provider Agency, DDS and other State entities receive a Report of Findings. Once the Report of Findings is distributed, Provider Agencies have 45 business days to complete the POC process. The Provider Agency is required to:
 - a. submit a Plan of Correction (POC) within ten working days to address all identified deficiencies; and
 - b. once the POC is approved, submit evidence of correction of all deficiencies and an ongoing Quality Assurance/Quality Improvement process.
9. Providers are encouraged to seek DDS technical assistance from their respective Regional Offices during the exit conference of the survey and additionally, in the Report of Findings, when significant issues are identified during the compliance survey, QMB may refer the agency to DDS for technical assistance.
10. Provider Agencies receiving a determination of *Non-Compliance* may receive a verification survey, within 90-180 working days of their POC approval.
11. Provider Agencies may be referred by QMB to the Internal Review Committee (IRC) for consecutive *Non-compliance* with standards and regulations, failure to respond to the POC, failure to submit required documentation, or failure to comply with a POC. Actions

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 16: Qualified Provider Agencies

of the IRC may include but are not limited to Directed Corrective Action, civil monetary fines, or additional sanctions.

12. Once the approved Plan of Correction is implemented and all deficiencies are corrected the agency will be deemed in compliance.

16.10 Individual Quality Review for Jackson Class Members (JCMs)

The DHI/QMB Individual Quality Review (IQR) team, conducts individualized surveys of JCMs. All services received by the individual JCM are reviewed to determine the quality of services and supports. The IQR survey includes a documentation review of provider records, observations and interviews of the JCM, guardian, DSP, nurses, CM and ancillary providers. All IQR protocol sections/interview questions and guides can be found on the DHI / QMB website: [Individual Quality Review \(nmhealth.org\)](https://www.nmhealth.org/individual-quality-review)

The IQR survey may result in findings related to needs and supports not being met for the individual JCM. All findings are based on the documentation reviewed and interviews of the Interdisciplinary Team (IDT). Findings are identified as issues noted during the IQR survey. These issues need the attention of the IDT to address and bring resolution to ensure the JCM has quality supports and services in place. Types of findings are as follows:

1. Standard Findings : Issues noted in the IQR survey that need the attention of the IDT and follow the standard 30, 60, 90-day timeframe. These findings are categorized by type.
2. Immediate Findings : Issues noted during the IQR survey that need immediate attention for individuals who have urgent health, safety, environmental and/or abuse/neglect/exploitation issues identified which the team is not successfully addressing in a timely fashion. These findings must be followed up on immediately and resolved within 30 calendar days. For individuals found to have immediate needs where abuse, neglect or exploitation is suspected, a DHI ANE report will be filed, and this will be added to the individual findings.
3. Special Findings : Issues noted during the IQR survey for individuals for whom issues have been identified that, if not effectively addressed, are likely to become an urgent health and safety concern. These findings must be followed up on and resolved within 60 calendar days.
4. Repeat Findings : Issues noted during previous the IQR surveys that have been identified for the JCM.

16.10.1 Provider Responsibilities during the IQR

The JCM is selected through a randomized, stratified sample process. DHI/QMB provides notification to the Individual/Guardian, CM and relevant Provider Agencies and works with the IDT members to schedule interviews and on-site observations, as well as providing the designated timeline for document production.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 16: Qualified Provider Agencies

Once the individuals to be surveyed have been selected, Provider Agencies have the responsibility to:

1. produce the required documentation requested by DOH within the designated timelines. Failure to provide required documents by the designated timeline may result in a civil monetary penalty.
2. participate in the scheduled interviews and on-site observations and provide any requested information during the IQR survey. It is the responsibility of the provider to ensure DSP are prepared and present at the pre-scheduled interview time. Failure of DSP to complete interview will result in findings.
3. review the Findings: Findings Letter is received after completion of the regional survey.
4. meet DDSD Lead as a team to review findings and develop an action plan to resolve each Finding.
5. provide evidence to the DDSD to resolve each Finding at 30 calendar days, 60 calendar days, 90 calendar days and 120+ calendar days according to the following:
 - a. Provider Agencies may submit evidence and other information to support resolution of the findings at any point and do not have to wait for the next 30-day increment to provide the information to DDSD.
 - b. If the evidence produced by the IDT is deemed sufficient for closure by the assigned DDSD follow up lead, DOH will close that Finding and notify the CM of this closure.
 - c. If the evidence produced is deemed to be insufficient, Provider Agencies will reassess the plan, actions and/or strategies to resolve the identified issues. The 30,60, 90-day time frames remain for further follow-up.
 - d. Provider Agencies must utilize IQR data when developing and implementing their Quality Improvement Strategy (QIS) (See [Chapter 22 Quality Improvement Strategy](#)).

16.11 Internal Review Committee (IRC)

The IRC may receive referrals from the QMB, IMB, DDSD, or the HSD/MAD. Based on the severity of deficiencies identified, the IRC has the authority to take administrative action, including directed corrective action, moratorium on new admissions, or civil monetary penalty. The IRC may also recommend high level sanctions including withholding payment, transition of individuals in service, placing the provider under the supervision of a monitor, or reduction of a contract term, amount, or scope.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 17: Training Requirements

Chapter 17: Training Requirements

The purpose of this chapter is to outline requirements for completing, reporting, and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD approved core curriculum training.

These Service Standards affirm the following values:

1. Training promotes health, safety, person-centered practices, community involvement, and meaningful outcomes for people receiving services.
2. Staff are interested in and should have access to training that promotes competence and career development.
3. Training promotes the retention of staff.
4. Best practices in adult learning and developmental disabilities continue to change; therefore, training methodology and specific skill competencies should be reviewed and revised on a regular basis.

These Service Standards apply to trainers and mentors of core curriculum training courses and Provider Agencies of the following services:

1. Living Supports (Supported Living, Family Living and IMLS),
2. Customized In-Home Supports (CIHS),
3. Customized Community Supports (CCS),
4. Community Integrated Employment (CIE),
5. Crisis Supports,
6. Case Management services,
7. Substitute Care and Respite,
8. Nutritionists,
9. Adult Nursing Services (ANS) and Nursing provided in Supported, Family Living or via Adult Nursing Services (ANS),
10. Behavior Support Consultation (BSC),
11. Therapies: Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP).

17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors
Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports.

1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:
 - a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in [Chapter 17.9 Individual-Specific Training](#) below.
 - b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

- c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.
 - d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).
 - e. Become certified in a DDS-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDS-approved system if any person they support has a BCIP that includes the use of EPR.
 - f. Complete and maintain certification in a DDS-approved Assistance with Medication Delivery (AWMD) course if required to assist with medication delivery.
 - g. Complete DDS training regarding the HIPAA located in the New Mexico Waiver Training Hub.
2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDS required core trainings as identified in the NM Waiver Training Hub, Job Classification Documents, and be on shift with a DSP who has completed the relevant IST.
 3. Staff providing direct services shall complete safety training within the first 30 calendar days of employment and before working alone with a person receiving services. The training shall address at least the following:
 - a. Operating a fire extinguisher;
 - b. Proper lifting procedures;
 - c. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat);
 - d. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting people who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle);
 - e. Operating wheelchair lifts (if applicable to the staff's role);
 - f. Wheelchair tie-down procedures (if applicable to the staff's role); and
 - g. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency).
 4. DSP and DSS must also complete DDS-approved core curriculum training facilitated by certified trainers and mentors which includes:
 - a. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
 - b. Introduction to Person Centered Planning web-based within 30 calendar days

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

of hire and before working alone with any person receiving DD Waiver services; and before taking the Planning Individual Service Plan (ISP) DSP-DSS course;

- c. Keys to Health within 30 calendar days of hire and before working alone with any person receiving DD Waiver services;
 - d. Introduction to the Waivers web-based within 30 calendar days of hire;
 - e. Individual Service Plan (ISP) DSP/DSS within 60 calendar days of hire;
 - f. Communication Supports Training within 90 calendar days of hire;
 - g. Positive Supports Training within 90 calendar days of hire;
 - h. Advocacy in Action training within 90 calendar days of hire;
 - i. Person-Centered Planning within 60 calendar days of hire;
 - j. Assistance with Medication Delivery (AWMD) within 90 days of hire if designated as required in the Medication Administration Assessment Tool (MAAT);
 - k. Introduction to Supporting Sexuality for Persons with Intellectual and/or Developmental Disabilities (I/DD) designated in the ISP or by the IDT within 90 days of hire; and
 - l. Any other training that DDSD designates as being required.
5. Staff providing services on a temporary or interim basis shall comply with the training requirements of the staff for whom they are replacing.

17.1.1 Additional Training Requirements for Community Integrated Employment Agencies and Staff

1. All staff at each CIE Agency are required to complete “Supported Employment Training Across Waivers” training prior to providing any employment service, recorded in the New Mexico Waiver Training Hub.
1. At least one staff person in each CIE Agency must hold the Association for Community Rehabilitation Educators (ACRE), Certificate or be a valid Certified Employment Support Professional (CESP) through the Association for People Supporting Employment First (APSE), at all times.
 - a. CIE Agencies have until July 2022 to come into compliance with this requirement.
 - b. CIE Agencies are strongly encouraged to develop and implement a plan for all staff to become certified in either ACRE or CESP in the next five (5) years.
 - c. CIE Agencies must maintain and track accurate ACRE and CESP staff certification records.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 17: Training Requirements

17.1.2 Additional Requirements for Crisis Response Staff (CRS) and their DSS

After completing DDSD-approved core curriculum training, designated CRS shall successfully complete the following crisis-related training no later than 90 calendar days after approval of the provider agreement or being designated to the Crisis Response Staff position:

1. Crisis Response Training totaling 16 hours, to include these topics:
 - a. Crisis Response,
 - b. Clinical Training,
 - c. Settings/Consideration Grid,
 - d. Positive Behavioral Supports for Crisis, and
2. Introduction to Supporting Sexuality for Persons with I/DD.

17.1.3 Training Requirements for Service Coordinators (SC)

Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports.

1. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:
 - a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the [Chapter 17.10 Individual-Specific Training](#) below.
 - b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub.
 - c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.
 - d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).
 - e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.
 - f. Complete and maintain certification in AWMD if required to assist with medications.
 - g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub.
2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings as identified in the NM Waiver Training Hub, Job Classification Document, and be on shift with a DSP who has completed relevant IST.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

3. SCs shall complete safety training within the first 30 calendar days of employment and before working alone with a person receiving services. The training shall address at least the following:
 - a. operating a fire extinguisher;
 - b. proper lifting procedures;
 - c. general vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat);
 - d. assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting people who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle);
 - e. operating wheelchair lifts (if applicable to the staff's role);
 - f. wheelchair tie-down procedures (if applicable to the staff's role); and
 - g. emergency and evacuation procedures (e.g., roadside emergency, fire emergency).
4. SC shall also complete at DDSD-approved core curriculum training facilitated by certified trainers and mentors which includes:
 - a. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
 - b. Intro to Person Centered Planning web-based within 30 calendar days of hire and before working alone with any person receiving DD Waiver services; and before taking the Individual Service Plan (ISP) CM/SC course;
 - c. Keys to Health within 30 calendar days of hire and before working alone with any person receiving DD Waiver services;
 - d. Introduction to the Waivers web-based within 30 calendar days of hire;
 - e. Individual Service Plan (ISP) CM/SC within 60 calendar days of hire;
 - f. Promoting Effective Teamwork within 60 calendar days of hire;
 - g. Communication Supports Training within 90 calendar days of hire;
 - h. Positive Supports Training within 90 calendar days of hire;
 - i. Advocacy in Action Training within 90 calendar days of hire;
 - j. ISP Critique within 90 calendar days of hire (must have prerequisite Person-Centered Planning first, and 60 calendar days experience with ISP's);
 - k. Introduction to Supporting Sexuality for Persons with I/DD within 90 calendar days of hire;
 - l. Complete the Aspiration Risk Management (ARM) course offered by the DDSD within 180 calendar days of hire.
5. If a service coordinator at an agency providing Crisis Supports, SCs must complete a Crisis Response Orientation by 90 calendar days (of hire or entering into a provider

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

agreement for this service) to include the following topics:

- a. Knowledge of crisis response;
 - b. DD Waiver Service Standards regarding behavior support, healthy relationships, and sexuality, and use of psychotropic medications; and
 - c. Monitoring process for the crisis service; and
6. Any other training that DDS designates as being required.

17.2 Training Requirements for CMs and Case Management Supervisors

1. CMs must successfully:
 - a. complete IST requirements in accordance with the specifications described in the ISP of each person supported;
 - b. complete training regarding the HIPAA located in the New Mexico Waiver Training Hub;
2. CM and CM Supervisors shall also complete DDS-approved core curriculum training facilitated by certified trainers and mentors which includes:
 - a. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
 - b. Introduction to Person Centered Planning, web-based within 30 calendar days of hire and before taking the Individual Service Plan (ISP) CM/SC course;
 - c. Keys to Health within 30 calendar days of hire;
 - d. Introduction to the Waivers, web-based within 30 calendar days;
 - e. Individual Service Plan (ISP) CM/SC within 60 calendar days of hire;
 - f. Promoting Effective Teamwork within 60 calendar days of hire;
 - g. ISP Critique within 90 calendar days of hire (must have prerequisite Person-Centered Planning CM/SC first, and 60 calendar days experience with ISP's);
 - h. Communication Supports Training within 90 calendar days of hire;
 - i. Positive Supports Training within 90 calendar days of hire;
 - j. Advocacy in Action training within 90 calendar days of hire;
 - k. Introduction to Supporting Sexuality for Persons with I/DD within 90 calendar days of hire;
 - l. Complete the Aspiration Risk Management (ARM) course offered by the DDS within 180 days of hire.
 - m. Any other training that DDS designates as being required.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

3. Substitute CMs shall comply with the training requirements of the CM for whom they are substituting.
4. All case managers will be required to complete 14 hours of training annually.
 - a. ANE (Abuse, Neglect, and Exploitation) Awareness training is required annually and can be used towards the 14 hours for annual training.
 - b. Training must include topic areas in health and person-centered planning related to health care for people with IDD.
 - c. Remaining hours to be self-selected from list of DDSD approved providers of training, related to a person with IDD. Participation in pilot programs, meetings, webinars, or community of practice meetings approved or sponsored by DDSD can be used toward annual requirement. List of DDSD approved Training Available in New Mexico:
 - i. Any relevant CEUs that are offered at various IDD and DD conferences throughout the year.
 - ii. DOH/DDSD, Continuum of Care-UNM, TEASC-UNM, Disability CDD-UNM, Partners for Employment (CDD-UNM), ARC New Mexico, Parents Reaching Out (PRO), New Mexico Development Disabilities Planning Council (DDPC), New Mexico Governor’s Commission on Disability, Division of Vocational Rehabilitation.
 - iii. Agencies are required to track these annual 14 hours of trainings and must comply with DDSD audits and monitoring.

17.3 Training Requirements for Substitute Care and Respite

Substitute care and respite staff shall complete a minimum of 40 hours of training within the first year of assignment. Thereafter, they shall complete a minimum of 10 hours per year. Specific requirements shall include:

1. Applicable safety training requirements described in [Chapter 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors](#) above.
2. Agency-specific course requirements (which may include DDSD core curriculum trainings as well as Personal Care Training);
3. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
4. The maximum number of IST hours outside of a formal classroom setting that can be applied to the 40-hour requirement is eight.
5. The maximum number of IST hours outside of a formal classroom setting that can be applied to the 10-hour requirement is four.
6. Assistance with Medication Delivery (AWMD) within 90 days of hire if designated as required in the MAAT.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 17: Training Requirements

7. Introduction to Supporting Sexuality for Persons with IDD as designated in the Individual Service Plan (ISP) or by the Interdisciplinary Team (IDT).

17.4 Nutritionists

All Nutritionists serving DD Waiver participants are required to complete the following:

1. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
2. Introduction to Person Centered Planning, web-based within 30 calendar days of hire;
3. Within 180 calendar days of hire complete ARM Training for RD's/LDs.
4. Any additional trainings mandated by DDSD.

17.5 Nurses

Nurses employed or subcontracted by the Adult Nursing, Supported Living, Family Living, and IMLS Provider Agencies must meet the following training requirements:

1. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
2. Completion of the Introduction to Intellectual and Developmental Disabilities (IDD) Nursing in The New Mexico DD Waiver within the first 30 calendar days of hire or assignment to this service;
3. Introduction to the Waivers, web-based within 30 calendar days of hire;
4. Person Centered Planning for Therapists, BSCs and Nurses, web-based within 60 calendar days of hire;
5. Within the first 60 calendar days of hire or assignment to the service, observation of a full two-day AWMD Course to ensure awareness of expectations of DSP assisting individuals with medication;
6. Health Care Planning for Nurses within 90 calendar days of hire;
7. Complete Effective Individual Specific Training Techniques (EIST) within 90 calendar days of hire;
8. Completion of the DDSD-approved curriculum Subtle Signs of Illness and Injury within 90 calendar days of hire;
9. ARM Training within 180 days of hire;
10. Any additional trainings mandated by DDSD.

17.6 Behavior Support Consultants (BSCs)

All BSCs must successfully complete a set of core trainings during the first years of providing BSC services. Academic interns and other agency personnel that interact with persons served must also attend these trainings. In addition to the requirements below, BSCs will participate in any additional trainings that are mandated by DDSD-BBS.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

1. The following Trainings are required:
 - a. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
 - b. Introduction to the Waivers, web-based within 30 calendar days of hire;
 - c. Person Centered Planning for Therapists, BSCs and Nurses, web-based within 60 calendar days of hire;
 - d. ARM Training within 90 days of hire;
 - e. Complete Effective Individual Specific Training Techniques (EIST) within 90 calendar days of hire;
 - f. Completion of the DDS-approved curriculum Subtle Signs of Illness and Injury within 90 calendar days of hire;
 - g. ARM Training within 180 days of hire;
 - h. Beyond the ABCs within 180 days of hire;
 - i. Any additional trainings mandated by DDS.
2. The following trainings/BBS Quarterly Meetings are required within the first 12 months. BSCs may request a training substitution approval from the BBS Clinical Director or designee to fulfill the mandatory training requirements for the Psychotropic Medication training or the Co-Occurring Disorders (DD/MI) and Neurobehavioral Issues training:
 - a. Psychotropic Medication for individuals with I/DD;
 - b. The Risk Management Strategies for the Preliminary Risk Screening course offered by DDS-BBS;
 - c. Co-occurring Disorders (DD/MI) and Neurobehavioral Issues;
 - d. Human Rights Committee Requirements Training for Voting Members of HRC's offered by the DDS-BBS; and
 - e. At least one BSC Quarterly Meeting offered by BBS.
3. After the first year, and ongoing, the BSC must:
 - a. Attend a minimum of two BSC Quarterly Meetings offered by BBS annually; and
 - b. Participate in any additional trainings mandated by DDS/BBS. BSCs may request a training substitution approval from the BBS Clinical Director or designee to fulfill the training requirements mandated by DDS/BBS.

17.7 Therapists (OT, PT, & SLP)

All therapists serving DD Waiver participants are required to complete the following:

1. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
2. Introduction to the Waivers, web-based within 30 calendar days of hire;

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

3. Person Centered Planning for Therapists, BSCs and Nurses, web-based within 60 calendar days of hire;
4. Complete Effective Individual Specific Training Techniques (EIST) within 90 calendar days of hire;
5. Completion of the DDSD-approved curriculum Subtle Signs of Illness and Injury within 90 calendar days of hire;
6. Training in Therapy Standards/Participatory Approach within 6 months;
7. Complete ARM Training within 90 days of hire;
8. Any additional trainings mandated by DDSD.

17.8 Reporting and Documentation Requirements

These Service Standards establish minimum requirements for reporting and documentation of DDSD training requirements. Requirements are:

1. All agencies are required to identify a minimum of one individual who will serve as agency administrator. Agency administrator(s) are responsible for taking the online training on use of the New Mexico Waiver Training Hub and passing the competency. Agency administrators are required to monitor training compliance for their agencies a minimum of once every month.
2. Agency administrators shall submit all personnel changes (hires, resignations or terminations, name changes, job classification changes) to the Training Hub using approved processes within five (5) working days of the date of the change occurring. This applies to the following job classifications: DD Waiver DSP, DD Waiver CIE, DD Waiver Direct Support Supervisors, DD Waiver Service Coordinators, DD Waiver CMs, DD Waiver Case Management Supervisors, DD Waiver Nurses, DD Waiver Therapists (PT, OT, SLP), and D Waiver BSCs.
3. A person's training history will be tracked by their unique identifier within the New Mexico Waiver Training Hub.
4. All personnel working for Provider Agencies that provide Supported Living, IMLS, Family Living, CIHS, CCS, and Crisis Supports must be listed as DSP in the database.
5. Within five working days of a training, certified trainers of core curriculum modules (except AWMD) shall, using approved forms/processes, submit course information to the New Mexico Waiver Training Hub.
6. Names and unique identifier information (first three letters of last name, first two letters of first name and last four numbers of the social security number, i.e., (John Doe would be DOE-JO-1234) of all course participants and whether each participant passed (P), failed (F) or was a no show. AWMD must be entered after successful demonstration of the on-the-job skills demonstration as per AWMD module introduction within five

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

working days after the person successfully completes the on-the-job skills demonstration.

7. Within five working days of a train-the-trainer session, certified mentors of core curriculum modules shall, using approved forms/processes, submit trainer certification information to the New Mexico Waiver Training Hub.
8. Agencies shall maintain accurate and complete training records and maintain documented proof that former and current staff have completed required trainings. Documented proof consists of one or more of the following:
 - a. Transcripts produced by the New Mexico Waiver Training Hub, which are the official record of a person's training history;
 - b. Agency compliance reports;
 - c. Competency verification forms;
 - d. Signed and dated course rosters (for agency trainers);
 - e. Copies of course completion certificates/cards (when courses do not require trainees to complete a competency verification form/test);
 - f. Completed on-site skills demonstration forms for AWMD; and
 - g. Agency sign-in sheets (only for IST sessions outside of a formal classroom setting).
9. Within ten working days of a request, agencies shall provide former and current staff with copies of the first page of their completed competency verification forms and/or course completion certificates/transcripts/cards, as requested.
10. Agencies shall develop a written procedure, specifying the standardized process for agency tracking of IST requirements.
11. Agencies shall be subject to training audits conducted by NMDOH staff or designees. Training audits may include (but not be limited to) the following:
 - a. Training record reviews;
 - b. Interviews with agency personnel; and
 - c. In-class monitoring.

17.9 Individual-Specific Training

The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill.

Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence.

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback.

Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported.

1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, Teaching and Support Strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends.
2. IST for therapy-related Written Direct Support Instructions (WDSI), Healthcare Plans (HCPs), Medical Emergency Response Plan (MERPs), Comprehensive Aspiration Risk Management Plans (CARMPs), Positive Behavior Supports Assessment (PBSA), Positive Behavior Supports Plans (PBSPs), and Behavior Crisis Intervention Plans (BCIPs), PRN Psychotropic Medication Plans (PPMPs), and Risk Management Plans (RMPs) must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds problems with implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher.
3. The competency level of the training is based on the IST section of the ISP.
4. The person should be present for and involved in IST whenever possible.
5. Provider Agencies are responsible for tracking of IST requirements.
6. Provider Agencies must arrange and ensure that DSP's and CIE's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings.
7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 17: Training Requirements

periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.

17.9.1 IST Training Rosters

IST Training Rosters are required for all IST trainings:

1. IST Training Rosters must include:
 - a. The name of the person receiving DD Waiver services;
 - b. The date, start time, and end time (duration) of the training;
 - c. The competency level of the training is based on the IST section of the ISP: IST topic for the training;
 - d. The type of IST training (Seizure HCP, Dehydration HCP, Seizure MERP, etc.).
 - e. The person should be present for and involved in IST whenever possible.
 - f. Provider Agencies are responsible for tracking of IST requirements.
 - g. Provider Agencies must arrange and ensure that DSP's and CIE's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings.
 - h. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.
 - i. The signature of each trainee;
 - j. The level of training (awareness, knowledge, or skilled) the trainee has attained. The role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and
 - k. The signature and title and/or role of the trainer.
2. A training roster (required for CARMPs) includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See [Chapter 5.5 Aspiration Risk Management](#) for more details about CARMPs.)
3. A copy of the training roster is submitted to the agency employing the staff trained within seven calendar days of the training date. The original is retained by the trainer.

17.9.2 Designated Trainer Record

A Trainer Designation Record is required when a therapist, nurse or BSC trains a Service Coordinator, Supervisor, and/SC or DSP or another IDT member to be a designated trainer for all or part of a plan. This permits a designated trainer to train the plan or designated part of the plan to others.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

1. The Trainer Designation Record must be completed before a designee can formally train others. The designee must agree to be a designated trainer. The plan author must use professional judgment to decide what plans or parts of plans would be appropriate for training by a designated trainer.
2. The plan author must train the designated trainer to implement the plan and verify that the designated trainer is able to effectively train others on implementation.
3. The Trainer Designation Record shall contain:
 - a. the name of the person receiving DD Waiver services;
 - b. the name and signature of the person who has agreed to be the designated trainer;
 - c. the name of the plan to be trained;
 - d. the elements or parts of the plan that may be trained by the designated trainer;
 - e. the name and signature of the author;
 - f. the name and signature of the designated trainer(s); and
 - g. the date designated and the date rescinded, as appropriate.
4. A copy of the Trainer Designation Record shall be submitted to the agency employing the designated trainer staff designated to train or to the agencies whose staff will be trained within seven calendar days of the designation date. The agency should retain a copy in the designee's personnel file or (if the designated trainer is not agency staff) in the file of the person whose plans will be trained.
5. The designated trainer will be responsible for providing a training roster to the agency whose staff is trained, within seven days of each training conducted.

17.10 [DDSD Core Curriculum Trainer Certification](#)

For the vast workforce of DSP and DSS to receive the core curriculum training required to be able to support people receiving services through the DD Waiver, DDSD has established a Train-the-Trainer (T-t-T) program for Provider Agencies who would like to also have in-house trainers. In conjunction with T-t-T seminars that are offered throughout the state, free core curriculum classes are also offered for DD Waiver Provider Agencies. Before registering for a T-t-T seminar, there are pre-requisites that must be met for each DSP training. A list of the pre-requisites for each training can be obtained through the Training Unit. Most T-t-T seminars consist of observation of mentor training the course or a half-day module review followed by a live training and feedback session. Participation in T-t-T seminars is not a guarantee of certification; the participant must demonstrate a command of the material, the ability to utilize effective training techniques, and person-centered values and language.

Responsibilities of trainers in DDSD Core Curriculum classes include:

1. Adhering to DDSD's Training Code of Ethics;
2. Maintaining fidelity to DDSD's training modules (i.e., not alter, shorten, or otherwise deviate from the material);

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 17: Training Requirements

3. Adhering to the DD Waiver Service Standards;
4. Safeguarding (e.g., do not share or have others enter for you) their Statewide Training Database password;
5. Attending regional Statewide and/or Quarterly Trainer Meetings to get support, receive updates, ask questions, and talk about training-related issues;
6. Keeping competencies, on-site skills demonstration paperwork, and signed rosters on file for audit purposes;
7. Allowing Regional Training Coordinators or other members of the Training Unit to co-facilitate or monitor trainings;
8. Ensuring advocate co-facilitators, when working with them, are supported to participate meaningfully in training.

All certified trainers of DDS core curricula are required to attend Regional Trainer Meetings at a minimum of three times per year; certified trainers must work with their DDS Regional Trainer, if unable to meet the attendance requirement to make arrangements for discussing the training updates. A minimum of one (1) trainer per provider agency must be in attendance to represent their respective agency at each Regional Trainer Meeting.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 18: Incident Management System

Chapter 18: Incident Management System

An Incident Management System (IMS) is a critical part of an agency's practice to ensure swift and appropriate response to any allegations or substantiated findings related to abuse, neglect, and exploitation (ANE), suspicious injury, environmental hazard, or death. All DD Waiver Provider Agencies shall establish and maintain an IMS, which emphasizes the principles of prevention and staff involvement. A comprehensive IMS for DD Waiver Provider Agencies involves training, monitoring, cooperation with DOH-DHI, reporting and continuous risk management activities.

18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting

All employees, contractors, and volunteers, interns shall be trained on the ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies are responsible for ensuring the training requirements outlined below are met.

1. Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year;
2. Training shall be conducted in a language that is understood by the employee, subcontractor, or volunteer.
3. Training must be conducted by a DOH certified trainer and in accordance with the Train the Trainer curriculum provided by the DOH.
4. Documentation of an employee, subcontractor or volunteer's training must be maintained for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work.

18.2 ANE Reporting and Evidence Preservation

The DD Waiver provider who suspects or is aware of ANE, suspicious injury, environmental hazard, or death is ultimately responsible for appropriate reporting. The DD Waiver Provider Agency may be sanctioned in accordance with NMAC 7.1.14.11 for failure to report incidents of ANE, suspicious injury, environmental hazard, or death; for failure to provide or maintain evidence of an existing IMS and employee, subcontractor, or volunteer training; or for failure to adequately protect people from ANE.

All DD Waiver Provider Agencies shall:

1. immediately report alleged crimes to law enforcement;
2. once ANE, suspicious injury, environmental hazard or death is suspected, ensure the person's health and safety, as well as others potentially affected;
3. after health and safety are assured, immediately call the DHI hotline at 1-(800)-445-6242 to report;

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 18: Incident Management System

4. ensure the Provider Agency's employee, subcontractor, or volunteer with firsthand knowledge of the alleged incident makes the report with assistance in reporting from an experienced staff or Provider Agency manager as needed;
5. refrain from internal investigations until DHI's investigation is completed, except to the extent necessary to make the report and ensure the health and safety of the person;
6. safeguard, secure and not disturb any records or physical evidence related to an alleged incident of ANE; and
7. if physical evidence must be removed or affected, take photographs, or do whatever is reasonable to document the location and type of evidence found which appears related to the incident, including, for example:
 - a. taking overall (wide) photographs, unless prohibited by agency policy;
 - b. taking close-up photographs of evidence (e.g., bruises, clothing, location of fall);
 - c. diagramming the scene; and
 - d. listing all evidence found including the name of finder, date, time, location.

18.3 Immediate Action and Safety Plans (IASP)

Upon discovery of any alleged incident of ANE, the DD Waiver Provider Agency shall:

1. develop an Immediate Action and Safety Plans (IASP) for potentially endangered individuals;
2. be immediately prepared to report the IASP verbally to the DHI during the reporting of the initial allegation;
3. report the IASP in writing on the DHI- issued IASP form within 24 hours;
4. revise the plan according to the DHI's direction, if necessary;
5. Send the IASP to the Case Manager;
6. closely follow and not change or deviate from the accepted IASP, without approval from the DHI.

18.4 Agency Cooperation during Division of Health Improvement (DHI) Investigations

All DD Waiver Provider Agencies who are subject to an investigation shall:

1. facilitate immediate physical or in-person access, and assist with scheduling interviews by DHI personnel investigating the incidents;
2. provide unrestricted access to the DHI for announced or unannounced visits to any facility, building or location operated by the Provider Agency;
3. provide, upon request of DHI, immediate access to formal and informal applicable records, regardless of media, including but not limited to financial records, individual records, ISP, volunteer and personnel records, employee contact information, including training records, incident reports, quality assurance activities and agency policy and procedure manuals; and
4. provide, upon request of the DHI, copies of records within timelines established by DHI.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 18: Incident Management System

18.5 Reports of Death

Any death should be reported using the DHI toll-free hotline at 1-800-445-6242. Further instructions can be found at: <https://nmhealth.org/about/dhi/ane/racp/>.

In the event of a death of a person receiving services through the DD Waiver, the following must occur:

1. The Provider Agency must immediately notify the CM and the DHI of the person's death.
2. Regardless of circumstances, the CM must ensure any death is immediately reported to DHI after knowledge of the death.
3. The CM must submit the CIU to provide notification of the person's death (See [Chapter 3 Use of the Client Information Update Form \(CIU/MAD 054\)](#)).
4. The person's primary file must be made available to DOH-DHI upon request.
5. If systemic issues are identified in the mortality review process, the DDSD will work with the relevant Provider Agency to address concerns in a quality improvement process.

18.6 Corrective and Preventive Action Plans for Substantiated Findings.

Provider Agencies will be held accountable for the actions of employees, volunteer, subcontractors, or contractors when incidents are substantiated by the DHI investigation.

The DD Waiver Provider Agency shall:

1. establish and maintain a quality improvement program for reviewing alleged complaints and incidents of ANE made against them as a provider;
2. provide to the DHI written documentation of corrective actions taken;
3. take all reasonable steps necessary to prevent further incidents; and
4. share the approved Corrective and Preventive Action (CPA) plan with the person's CM.

18.7 Notifications

After an allegation of ANE has been reported to DHI, DD Waiver Provider Agencies have requirements related to notifying participants, guardians, and IDT members regarding allegations of ANE. Notification responsibilities are outlined below:

1. The non-responsible reporting provider shall verbally notify the responsible provider within 24 hours of the report being made to IMB.
2. The responsible provider shall:
 - a. verbally notify the Guardian and CM within 24 hours of the report being made to IMB;
 - b. verbally notify the accused person and alleged victim, when appropriate and using situational discretion;
 - c. provide the IASP to the CM for IDT distribution; and
 - d. provide the CPA plan to the CM only.
3. The CM shall verbally notify the alleged victim of Closure Letters and outcomes of the investigation at the next monthly site visit.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 18: Incident Management System

18.8 Case Management and DD Waiver Provider Agency Responsibilities for Risk Management
DD Waiver Provider Agencies have a continuous responsibility to monitor for risk of harm especially during and after an investigation. Responsibilities including the following requirements:

1. After an ANE report is made, if any member of the IDT, receives information or observes that the IASP is not being followed during the investigation, the person shall report the information to the DHI hotline at 1-800-445-6242. Further information can be found at <https://nmhealth.org/about/dhi/ane/racp/>.
2. In situations where DHI substantiates the ANE report, the CM must:
 - a. Convene the DD Waiver participant's IDT to review the DHI findings detailed in the DHI issued *Decision Letter: Substantiated*;
 - b. Modify the person's ISP, if necessary, to address any concerns identified in the investigation; and
 - c. Submit the IDT meeting minutes with a signature page to DHI within 10 business days of receiving the Decision Letter.
 - i. The IDT meeting minutes must address all the concerns identified in the IMB Decision letter.
 - ii. If the IDT already met and addressed all the concerns identified in the letter, there is no need to hold another meeting. If the IDT meeting did not address all concerns identified, then the CM may need to hold another IDT meeting.
3. At any time, in situations where a person is at significant risk of harm, the CM must convene the IDT within one working day, in person or by teleconference, and modify the ISP, if necessary, within 72-hours.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 19: Provider Reporting Requirements

Chapter 19: Provider Reporting Requirements

DOH-DDSD collects and analyzes system wide information for quality assurance, quality improvement, and risk management in the DD Waiver Program. Provider Agencies are responsible for tracking and reporting to DDSD in several areas on an individual and agency wide level. The purpose of this chapter is to identify what information Provider Agencies are required to report to DDSD and how to do so.

19.1 Consumer Census and Service Summary per Provider Agency

DD Waiver Provider Agencies must maintain a current client census and service summary available to DOH-DDSD within 24 hours of a request. Required data elements of the client census and service summary include:

1. consumer's last name;
2. consumer's first name;
3. guardian name and relationship to consumer;
4. date of birth;
5. Medicaid ID;
6. ISP term begin and end dates;
7. COE effective dates;
8. services provided by the specific DD Waiver Provider Agency;
9. setting of service and address, if providing CCS, CIE, Family Living, Supported Living, IMLS or CIHS;
10. region of service; and
11. assigned lead's name and contact information when applicable (e.g., individual therapist, BSC, CM, or service coordinator).

19.2 General Events Reporting (GER)

The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows:

1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use the GER
2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into a Therap GER module entry per standards set through the [Appendix B GER Requirements](#) and as identified by DDSD.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 19: Provider Reporting Requirements

3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. Events that are tracked for internal agency purposes and do not meet reporting requirements per DD Waiver Service Standards must be marked with a notification level of "Low" to indicate that it is being used internal to the provider agency.
4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in [Chapter 18 Incident Management System](#).
5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.
6. Each agency that is required to participate in General Event Reporting via Therap should ensure information from the staff and/or individual with the most direct knowledge is part of the report.
 - a. Each agency must have a system in place that assures all GERs are approved per Appendix B GER Requirements and as identified by DDSD.
 - b. Each is required to enter and approve GERs within 2 business days of discovery or observation of the reportable event.

19.2.1 *Events Required to be Reported in GER*

The following events need to be reported in the Therap GER: when they occur during delivery of Supported Living, Family Living, Intensive Medical Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment or Adult Nursing Services for DD Waiver participants aged 18 and older:

1. Emergency Room/Urgent Care/Emergency Medical Services
2. Falls Without Injury
3. Injury (including Falls, Choking, Skin Breakdown and Infection)
4. Law Enforcement Use
5. All Medication Errors
6. Medication Documentation Errors
7. Missing Person/Elopement
8. Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission
9. PRN Psychotropic Medication
10. Restraint Related to Behavior
11. Suicide Attempt or Threat
12. COVID-19 Events to include COVID-19 vaccinations.

19.3 *Reporting to the Statewide Aspiration Risk List*

Aspiration Risk Screening is required for all adults, including young adults (18-20 years old) receiving Family Living, IMLS, or Supported Living. Individuals in other LCAs may also choose to

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 19: Provider Reporting Requirements

receive Aspiration Risk Screening. The Aspiration Risk Screening tool is completed according to requirements detailed in [Chapter 5.5.1 Screening for Aspiration Risk Using the Aspiration Risk Screening Tool \(ARST\)](#). DDSD maintains a Statewide Aspiration Risk List (SARL) and requires reporting of all individuals who are at moderate or high risk of aspiration as follows:

1. When person is determined, through a nurse's completion of the ARST, to be at moderate or high risk of aspiration, the CM must submit the current SARL form to the Statewide Aspiration Risk Coordinator.
2. The SARL form must be submitted:
 - k. within seven calendar days following the IDT meeting after initial screening;
 - l. annually; and
 - m. as needed when the e-CHAT and ARST are updated according to requirements detailed in [Chapter 5.5.1 Screening for Aspiration Risk Using the Aspiration Risk Screening Tool \(ARST\)](#).

19.4 Employment First Reporting Requirements

Provider Agencies operate under the assumption that all working age adults with developmental disabilities can work if given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options, per New Mexico's status as an Employment First state. Provider Agencies who offer Community Integrated Employment and/or CCS are required to submit quarterly data to the Regional Office Community Inclusion Coordinators by the 15th day following the reporting month. Reporting months are August, November, February, and May. Information must be sent through the Therap system secure communication (SComm) on the approved DDSD documentation.

19.5 Semi-Annual Reporting

The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities.

Semi-annual reports are required as follows:

1. DD Waiver Provider Agencies, except AT, EMSP, PRSC, SSE and Crisis Supports, must complete semi-annual.
2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older.
3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days).

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 19: Provider Reporting Requirements

4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.
5. Semi-annual reports must contain at a minimum written documentation of:
 - a. the name of the person and date on each page;
 - b. the timeframe that the report covers;
 - c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;
 - d. a description of progress towards Desired Outcomes in the ISP related to the service provided;
 - e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing);
 - f. significant changes in routine or staffing if applicable;
 - g. unusual or significant life events, including significant change of health or behavioral health condition;
 - h. the signature of the agency staff responsible for preparing the report; and
 - i. any other required elements by service type that are detailed in these standards.
6. Semi-annual reports must be distributed to the IDT members when due by SComm.
7. Semi-annual reports can be stored in individual document storage.

19.6 Regional Office Request for Assistance (RORA)

The RORA system is the formal process for reaching out to DDSD for technical assistance, support or for raising a concern to DDSD. Issues may include broad system level issues, or issues specific to a provider agency or individual served. The RORA form and instructions on how to complete and submit the form can be accessed on the DDSD website: [Regional Offices \(nmhealth.org\)](https://www.nmhealth.org/RegionalOffices).

1. The RORA form should be completed and submitted to the appropriate Regional Office via Therap SComm or via fax.
2. CMs and Provider agencies are required to use the RORA system after unsuccessful attempts to resolve any issues that affect a person's health, safety, access to specialty appointments, access to durable medical equipment or assistive technology devices, Therapy/BSC/behavioral health assessments and treatments and the implementation of the ISP (e.g., provision of timely reports needed for planning, or monitoring; inability to contact MCO Care Coordinator; no response for provider agency; or when there are no available Provider Agencies of a specific service type in a county or region.)
3. RORA's for Specialty Services Requests (SSR) can be filed by anyone.
4. CMs are required to file RORAs' for SSR after monitoring activities do not result in access to Specialty Services according to the following applicable timelines:
 - a. Durable Medical Equipment (DME) and Assistive Technology/Augmentative Communication devices not received within 150 days;

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 19: Provider Reporting Requirements

- b. DME repair/modification not completed within 60 days;
- c. Therapy assessments begin within 30 days of receipt of the FOC or 90 days of the need identified.
- d. Medical Specialist's appointments scheduled within 14 calendar days.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 20: Provider Documentation and Client Records

Chapter 20: Provider Documentation and Client Records

20.1 HIPAA

DD Waiver Provider Agencies shall comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). All DD Waiver Provider Agencies are required to store information and have adequate procedures for maintaining the privacy and the security of individually identifiable health information. HIPAA compliance extends to electronic and virtual platforms.

20.2 Client Records Requirements

All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.

DD Waiver Provider Agencies are required to adhere to the following:

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings.
4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.
5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.
6. The current Client File Matrix found in [Appendix A: Client File Matrix](#) details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.
7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 20: Provider Documentation and Client Records

20.3 Record Access for Direct Support Professional (DSP) during Service Delivery

DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time.

1. Access to required modules in Therap records must be available - via Therap.
2. All DSP must have access to Therap and records in Therap of the individuals they support while at service support sites for LCA and agency facilities.
3. If DSP are carrying hard copy records into community settings, Protected Health Information (PHI) must be guarded and secured.
4. DD Waiver participants should be encouraged to carry individual identifying information for emergency services including Medicaid/Medicare information.
5. Provider Agencies must refer to the [Appendix A Client File Matrix](#) for records required at service delivery sites.
6. DSP shall carry into community settings the minimum amount of PHI necessary to address emergency situations or carry out essential functions of the purpose of the trip.

20.4 Timely Distribution and Sharing of Records

DD Waiver Provider Agencies are required to meet timelines for producing and distributing documents related to a person's DD Waiver services. When applicable, required content for reports and completing of assessments in Therap are described in each service's scope and requirements. General requirements are:

1. The agency that authors each annual assessment and semi-annual report is responsible for distributing those documents to members of the IDT within the required time frames detailed in [Chapter 19.5 Semi-Annual Reporting](#). Where applicable, Therap SComm can be used for distribution.
2. Prior to agency transfers, provider Agencies must follow all record transfer requirements detailed in [Chapter 9: Transitions](#).
3. Case Management agencies are responsible for distributing the ISP and budget to the members of the IDT, including the person receiving services and their guardian, if applicable.

20.5 Creating and Maintaining Records in Therap

Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. Therap provides a variety of functions and modules, not all of which are required to be used to complete an individual record. DD Waiver Provider Agencies who are required to use Therap may also choose to purchase additional modules that are not required by DDSD.

Utilization and data entry requirements for Therap vary by DD Waiver Provider Agency, service type and function. Provider Agencies are required to enter, update, transfer and maintain information in Therap according to requirements detailed below.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

The Provider Agency requirements for creating and maintaining individual records in Therap are:

1. Therap is used for all individuals 18 and older.
2. The CM must notify the DDS Therap Administrator three months prior to an individual turning 18, to create the initial record and oversight account.
3. Therap is required to be used by Provider Agencies of Case Management; Living Supports; Community Inclusion, ANS, and Customized in Home Supports.
 - a. BSCs, Registered Dietitians and Therapists (OT, PT and SLP), Case Managers, Service Provider Agencies are required to use Therap for all secure communication via Therap in SComm, review GERs, and revise the CARMP in “CARMP Draft” All Therapists, BSCs, RDs, and CMs, must notify the Therap Unit of their caseload changes within (7) calendar days of additions or removals.
4. Data entry in the Therap system follows a hierarchy of responsibility that is based upon the person’s team of DD Waiver Provider Agencies.
5. The Primary Provider Agency is responsible for creating, updating, and submitting required information in Therap.
6. Providers that store and assist with medication must utilize The Therap eMAR for medication documentation by November 1, 2022.
7. The Primary Provider Agency is determined by the hierarchy below:
 - a. Living Supports (Supported Living, IMLS and Family Living);
 - b. CCS-Group if the person is not receiving any Living Supports;
 - c. Adult Nursing when no Living Supports or CCS-Group are budgeted;
 - d. Customized in Home Supports; and
 - e. Case Management.

20.5.1 *Secure Communication (SComm)*

The SComm is a HIPAA compliant module used to facilitate the exchange of information similar to electronic mail. The use of SComm to communicate with IDT’s, DDS, DHI to share information on administrative, personal, or individual care related issues is mandatory.

1. IDT’s must utilize individual care SComms when communicating concerning the individual.
2. Secondary Provider Agencies are still responsible for utilizing Therap to communicate with other Provider Agencies via SComm.
3. SComm must be utilized when communicating with DDS about any individual served on the DD Waiver.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

4. To coordinate and communicate securely with the IDT, it is required that all Therapists, Nutritionist and BSCs, and CMs) have an account in Therap and use SComm as the ONLY source for ALL future secure communication.
5. Non-Corporate guardians must be offered Therap accounts by primary providers. Guardians are encouraged to use SComm. DDS is responsible to support access for corporate guardianship agencies.

20.5.2 Individual Demographics Forms (IDF)

The Individual Demographics Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form.

1. The IDF Forms and Modules must be reviewed and updated annually or as needed due to changes, whichever occurs first.
2. The *Individual Demographic Form* all fields must be maintained.
3. The *Individual Details* must be maintained including:
 - a. ID Numbers
 - i. ID Type, which must include region based on the individuals residential address and the waiver or payment type.
 - ii. ID Number, which is in all capitals consisting of the first three letters of the individual's last name, then the first two of the individual's first name, and finally the last four of the individual's Social Security Number. (i.e.: DOE-JO-1234).
 - b. Medical Information
 - i. Developmental Disability.
 - ii. Intellectual Disability.
 - iii. Primary Care Physician (list is populated through Shared Contacts).
4. Contact List
 - a. Case Manager, Therapists, Pharmacy, Specialists, and other IDT members must be maintained. It is recommended to use *Shared Contacts* for all supports that are not natural supports or court appointed guardians. Case Manager is also populated from the assigned CM Agency in the Individual Homepage.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

- b. Guardians must be entered as *Individual Contacts* with the appropriate guardian type and authority entered. Court guardianship paperwork can be scanned and attached in the entry.
5. Insurance Information
 - a. All applicable fields must be entered and scans of all cards and other membership documentation may be scanned and attached.
6. Program Enrollments
 - a. The individuals should be enrolled in programs related to services they are receive.
 - b. Program Address and Contact information should be up to date.
7. Diagnosis Lists and Allergy Profiles must be maintained, preferably by nursing
 - a. Diagnoses should include ICD-codes when available.
8. Consents
 - a. Signed Consents and Acknowledgements can be scanned and stored in consents.
9. Assessments
 - a. Assessments and scans can be attached in assessments.

20.5.3 *Health Tracking*

The Health Tracking is a feature of Therap that contains multiple required elements designed to support the Healthcare Coordinator, DSP, supervisors, nurses, CMs in tracking, communicating and acting upon changes in health status. Information from Health Tracking may be shared with other members of the IDT as needed. The use of Health Tracking is required by the provider agencies.

1. Appointments, Results and Follow Up – Appointments, results, and follow up must be entered in Therap within seven calendar days of the related activity (e.g., scheduling, results and follow up) for all appointments that the provider (Primary or Secondary) assisted the person to arrange or to attend. Lab Test –Lab tests and results must be entered in Therap by the Primary Provider Agency within seven calendar days of receiving results if the person has routine or standing lab orders and the Provider Agency assists the person to arrange or obtain such lab work. Lab results may be attached to an appointment titled as “Lab Results”.
2. Height/Weight – Height and weight must be completed by both the Primary Provider Agency and any Secondary Provider Agencies that support the person by collecting height and weight. In addition to completing at least annual height and weight, the frequency of data collection is dependent upon orders from the physician, recommendations from IDT members, HCPs, or prudent nursing judgement. Data collected must be entered in this section of Health Tracking within 24 hours of the data collection.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

3. Medication History – Medication history must be completed by the Primary Provider Agency for all individuals. If the CM is the Primary Provider Agency responsible for data entry, the only required element of the *Health Tracking* is Medication History. New medications or treatments and any changes to medication or treatment orders for the person must be updated in this section as soon as possible but no later than 24 hours after the change.
4. Blood Glucose, Height/Weight, Infection, Intake/Elimination, Menses, Respiratory Treatment, Seizures, Skin/Wound, and Vital Signs- All Provider Agencies are responsible for entering this data in Therap within 24 hours of the data collection when these tasks, data collection or tracking are part of a PBSP, HCP or a MERP during the time of service delivery. All pressure ulcers are assessed for size, stage and healing and documented by nurses at least weekly.
5. Immunizations – Immunizations must be entered in Therap within seven calendar days of any completed immunizations. The Primary Provider Agency completes information based upon historical information in the medical records and ongoing updates based on physician visits, orders and ongoing vaccinations or immunizations. Secondary Provider Agencies with awareness of immunizations must update their records and communicate the new information to the Primary Provider Agency within seven calendar days of any completed immunizations the agency assisted with.

20.5.4 *Health Passport and Physician Consultation Form*

All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are:

1. The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History.
2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Physician Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care, emergency room, or are admitted to a hospital or nursing home. (If the person is taken by a family member or guardian, the *Health Passport* and *Physician Consultation* form must be provided to them.)
4. The Physician Consultation form must be reviewed, and any orders or changes must be noted and processed as needed by the provider within 24 hours.
5. Provider Agencies must document that the *Health Passport* and *Physician Consultation* form and Advanced Healthcare Directives were delivered to the treating healthcare professional by one of the following means:
 - a. document delivery using the *Appointments Results* section in *Therap Health Tracking Appointments*; and
 - b. scan the signed *Physician Consultation Form* and any provided follow-up documentation into Therap after the person returns from the healthcare visit.

20.5.5 Nursing Assessment Tools

Nursing Assessment for people receiving services on the DD Waiver is comprised of three tools in Therap: An Aspiration Risk Screening Tool (ARST), a Medication Administration Assessment Tool (MAAT), and an electronic Comprehensive Health Assessment Tool (e-CHAT). Required use of the nursing assessment tools are as follows:

1. The nursing assessment tools (ARST, e-CHAT and MAAT) must be completed according to all requirements described in [Chapter 13.2.7 Documentation Requirements for all DD Waiver Nurses](#).
2. Nurses must clearly document their level of licensure after their names as part of their electronic signature for entry and approval in Therap.
3. The Primary Provider Agency is responsible for completion of the e-CHAT and must adhere to the following requirements:
 - a. If a person receives both Living Supports and Customized Community Supports-Group, both agency nurses must communicate and collaborate on the status of the person in each setting.
 - b. Nurses for CCS-Group, the Secondary Provider Agency, may complete their own e-CHAT relating the person's needs in that setting even if the person receives Living Supports. The primary provider nurse must share their e-CHAT with other nurses.
 - c. The annual e-CHAT may not be copied and pasted; a new e-CHAT form must be created annually.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

20.5.6 CARMP Draft in Therap

The Therap “CARMP Draft” is the module to be used during the interdisciplinary development/revision of the CARMP. The CARMP Draft provides a secure, shared point of access for team members (Nurse, CM, OT, PT, SLP, RD and BSC’s) to access, download, and upload a working CARMP Draft. It allows for a virtual, collaborative workspace for the IDT.

1. CARMP Draft is required for **ALL** CARMP development, review, and/or revision.
2. A new CARMP Draft must be started for the virtual workspace for each annual review or new revision session.
3. All contributing IDT Members must ensure they have access (in caseload and user privileges) by working with their agency Therap Administrator in a timely manner.
4. The CM will coordinate the CARMP Draft process in collaboration with applicable IDT members, establishing the order and timeline in which each author will contribute to that CARMP Draft session.
5. Each CARMP author attaches their revisions according to order established, adds their name to the CARMP Draft Questionnaire and notifies the IDT via SComm when their work is complete.
6. The SComm ensures the next author can complete their contribution to the CARMP Draft in order.
7. Each revision should have the discipline of the author added at the end of the attached file name.
8. If the SUBMIT button was clicked accidentally by any team member, a new CARMP Draft development session must be initiated.
9. When the CARMP is complete, the CM must add the final date to the CARMP, attach the final draft to the CARMP Questionnaire and **submit**. **Submit** finalizes that CARMP and closes the CARMP Draft session.
10. The Primary Provider Agency Nurse must attach the CARMP final CARMP to an Individual Care Plan in Therap.
11. The Primary Provider Agency ensures that the current, complete CARMP and Aspiration MERP are readily available to staff/DSP in all service delivery settings.

20.6 Medication Administration Record (MAR)

Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports.

1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap.
2. Providers have until November 1, 2022, to have a current Electronic Medication Administration Record online in Therap in all settings where medications or treatments are delivered.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 20: Provider Documentation and Client Records

3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.
4. Provider Agencies must configure and use the MAR when assisting with medication.
5. Provider Agencies Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety.
6. Provider agencies must include the following on the MAR:
 - a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed.
 - b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber.
 - c. Documentation of all time limited or discontinued medications or treatments.
 - d. The initials of the person administering or assisting with medication delivery.
 - e. Documentation of refused, missed, or held medications or treatments.
 - f. Documentation of any allergic reaction that occurred due to medication or treatments.
 - g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements:
 - i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;
 - ii. clear follow-up detailed documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment; and
 - iii. documentation of the effectiveness of the PRN medication or treatment.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

Chapter 21: Billing Requirements

This chapter outlines requirements related to billing and service reimbursement for DD Waiver Provider Agencies.

21.1 General Billing Requirements

To bill for services provided, a DD Waiver provider must have:

1. a fully executed Provider Agreement with the DOH;
2. an approved Provider Participant Agreement (MAD 335);
3. an active Medicaid number; and
4. prior authorization.

Refer to Medicaid Billing requirements in NMAC 8.302.2

Providers need to utilize the Medicaid Portal for all billing procedures and instructions, to include void and adjust.

21.2 Prior Authorization Requirements

Prior Authorization numbers for DD Waiver participants are issued by the New Mexico TPA contracted by HSD. The TPA completes system entry into the Medicaid Management Information System (MMIS) of approved DD Waiver services by type, amount, and effective dates. Prior authorization cannot be issued until all requirements related to service approval are met and an active COE 096 is in place for the DD Waiver participant.

All DD Waiver Provider Agencies are responsible for verifying a person's Medicaid COE 096 for the dates of service. Provider Agencies complete the following steps in order to bill for services:

1. Verify the COE on the NM Medicaid web portal to ensure an active COE.
2. Notify the CM immediately if no active COE is shown in the web portal or the COE is expired.
3. Work with the CM to meet all submission requirements to obtain timely approval of the DD Waiver participant's ISP and budget.
4. Complete the following activities to ensure accurate and complete budget submissions for approval:
 - a. provide documents demonstrating clinical justification for service requests as required;
 - b. review the ISP and budget required to be sent by CMs via secure communications and
 - c. verify the ISP and budget accurately reflect the planning conducted at least 48 hours or two business days prior to the CM submission of a packet to the TPA and/or OR.
5. Bill only within specified effective dates and for service types and amounts approved on the person's budget.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

6. In extenuating circumstances, work with the DDS Regional Office through the CM to submit ISPs and budgets outside of the normal submission deadlines. (Special conditions must be met which include a demonstration of the need for an exception to process.)

21.2.1 *Retroactive Start Dates*

Retroactive start dates for DD Waiver services are not allowable unless approved under extenuating circumstances. Retroactive start dates may only be approved by DDS if, at a minimum:

1. There is a current SFOC for the provider;
2. The service type, amount, and start date were discussed and agreed to by the person and guardian in the planning and budget development process;
3. The service was actually provided; and
4. Applicable providers identify improvement practices to avoid future issues.

21.3 *Recording Keeping and Documentation Requirements*

DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:

1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.
2. Comprehensive documentation of direct service delivery must include, at a minimum:
 - a. the agency name;
 - b. the name of the recipient of the service;
 - c. the location of the service;
 - d. the date of the service;
 - e. the type of service;
 - f. the start and end times of the service;
 - g. the signature and title of each staff member who documents their time; and
3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.
4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:
 - a. treatment or care of any eligible recipient;
 - b. services or goods provided to any eligible recipient;
 - c. amounts paid by MAD on behalf of any eligible recipient; and

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

- d. any records required by MAD for the administration of Medicaid.

21.4 Electronic Visit Verification

Section 12006(a) of the 21st Century Cures Act (the Cures Act) requires that states implement Electronic Visit Verification (EVV) for all Medicaid services under the umbrella of personal care and home health care that require an in-home visit by a provider. EVV is a technological solution used to electronically verify whether providers delivered or rendered services as billed. Personal Care Services are services supporting Activities of Daily Living (ADLs) or services supporting both ADLs and Instrumental Activities of Daily Living (IADLs). Home Health Care Services (HHCS) are services providing nursing services and/or home health aide services. The Cures Act allows states to implement EVV in a phased approach starting with the services meeting federal guidelines for PCS and later HHCS. The use of the state approved EVV system does not replace other standards requirements.

EVV system has potential for benefits that may include:

- a. Improved practices inherent in the use of EVV.
- b. Centralized, real-time monitoring and comprehensive reporting on services provided.
- c. Use of EVV data to identify delivery issues and make care delivery more efficient.
- d. Improving program integrity and higher quality of services.
- e. Improving risk management and fraud protection.
- f. Secure, HIPAA compliant automated claims.

The EVV system verifies the:

- a. **Type** of service performed.
- b. **Individual receiving** the service.
- c. **Date** of service.
- d. **Location** of service delivery.
- e. **Individual providing** the service.
- f. **Time** the service begins and ends.

The state supplies agencies with a single approved EVV system that must be used. Effective January 1, 2021, DD Waiver providers of CIHS and Respite are required to implement the use of state approved EVV system. As home health care services are phased in according to federal and state requirements, additional services may require the use of EVV.

21.4.1 EVV Requirements

Providers of required services (Personal Care beginning 1/1/2021 and Home Health beginning 1/1/23) must use the state approved EVV system to meet EVV requirements and:

1. Establish an agency point of contact for EVV operations and state updates.
2. Enter and delete of agency participants and employees in the system timely.
3. Confirm all applicable service authorizations data to operate the EVV system.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 21: Billing Requirements

4. Correct errors in the system when allowed by state.
5. Ensure that employees have access to the state approved EVV system and can clock in and out for all assigned work.
6. Assure employees are trained and are using the EVV system.
7. Adjust operations as needed that relate to agency's payroll, scheduling, and/or claims system as needed to accommodate the agency's business practices and the requirements for EVV system use.
8. Provide requested data and information about the agency's implementation of EVV in the format and schedule established by DOH.

21.5 Utilization Review for Program Compliance

All DD Waiver services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.

1. Upon request of the DOH, HSD or any other relevant state agency, the Provider Agency must submit requested documentation to support services billed.
2. Failure to submit requested documentation to support services billed may result in recoupment.

21.6 Rates and Rate Table

Rate determination and oversight are joint responsibilities between the DDS and HSD. Rates and rate methodology are approved by CMS. Most DD Waiver services are reimbursed on a prospective, fee-for-service basis, except for select items that are reimbursed based on the purchase price plus administrative fees (e.g., AT and RPST).

The rate models in effect for DD Waiver services are based on specific assumptions related to Provider Agencies' costs, including:

- a. wages and benefits;
- b. productivity assumptions to account for non-billable responsibilities such as missed appointments, travel time, training, progress notes and record reviews;
- c. other direct care costs, such as transportation and program supplies; and
- d. indirect costs such as program support and administration.

The DD Waiver Rate Table is maintained by the HSD and is updated periodically based on legislative appropriations, rate studies, or other program decisions that affect reimbursement rates. The DD Waiver Rate Table provides the service type, billing code and billing unit.

21.7 Billable Activities

Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

21.8 Non-Billable Services, Activities, Circumstances

The following are not billable:

1. Services furnished to a person who:
 - a. does not reside in New Mexico;
 - b. does not have a current and active COE 096.
 - c. is not eligible for DD Waiver services; or
 - d. is hospitalized or in an institutional care setting.
2. Services which are not provided face-to-face/video conferencing unless the type of non-face-to-face/video conferencing support is expressly included in the scope of work (e.g., development of assessments and plans for therapies and BSC).
3. Care provided by a parent or guardian to their minor child under age 18.
4. Care provided by a spouse.
5. Activities that are not included in the:
 - a. scope of service; or
 - b. the person's approved ISP.
6. Administrative fees unless the allowable percentage is described in the scope of service.
7. Services that are not provided in accordance with the provider's license and supervision requirements.
8. Mental health treatment, transportation, therapy or nursing services otherwise billable under the Medicaid State Plan benefit or through the behavioral health system.
9. Services covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to individuals under age 21.
10. Room and board, including building maintenance, upkeep, and improvement.
11. Service amounts that exceed limits to frequency, type, and amount established in the approved DD Waiver.
12. Services that duplicate a service(s) already bundled into the LCA (e.g., nursing and nutritional counseling which are bundled into Supported Living).
13. Attendance at IDT meetings when attendance is already built into the service reimbursement rate, i.e. Case Management, services under Living Supports and services under Community Inclusion. (See [Chapter 6: Individual Service Plan \(ISP\)](#) for requirements related to IDT membership and meeting attendance).
14. Services provided at the same time by different Provider Agencies unless collaborative or shared support is expressly allowed and described in the service scope and requirements.
15. Services that require the use of the state approved EVV system that are not captured in the EVV system (when required) and do not have the approval / exception from the state.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

16. Time associated with:

- a. travel to and from a site of any billable service, except when transporting the person in accordance with the scope of the service;
- b. preparing or updating reports, progress notes and logs;
- c. employer activities including administrative duties, preparing, or maintaining routine paperwork and billing documentation, employer staff meetings or meetings with supervisors that are not client specific;
- d. professional development and continuing education;
- e. missed appointments;
- f. friendly visits where activities within the scope of service and ISP are not conducted;
- g. program set up and clean up;
- h. review of relevant records, unless included in professional and clinical assessment activities;
- i. semi- annual reports, unless it is the annual re-evaluation or professional assessment as outlined in the standards related to the specified service;
- j. participation in assessments not performed by the specific service provider, unless expressly indicated in the service scope and definition;
- k. outreach or marketing activities including time spent developing and distributing information or educational materials about their agency and services to people potentially eligible for the DD Waiver or in the process of selecting a provider; or
- l. use of the state approved EVV system.

21.9 Billable Units

The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.

21.9.1 Requirements for Daily Units

For services billed in daily units, Provider Agencies must adhere to the following:

1. A day is considered 24 hours from midnight to midnight.
2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.
3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.
4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows:

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

- a. The discharging Provider Agency bills the number of calendar days those services were provided multiplied by .93 (93%).
- b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.

21.9.2 Requirements for Monthly Units

For services billed in monthly units, a Provider Agency must adhere to the following:

1. A month is considered a period of 30 calendar days.
2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed.
3. Monthly units can be prorated by a half unit.
4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.

21.9.3 Requirements for SSE Series Units

SSE services are billed in Series units, that is, sets of classes provided to a group of students comprises an SSE Series. A Provider Agency providing SSE must adhere to the following:

1. A series is a set of classes provided to a group of students.
2. Each series of classes is one (1) unit for billing purposes. For individuals who attend less than half the classes provided in a series only 0.5 units are billable.
3. SSE Series units can be billed in two half units; one half may be billed at the beginning of the series for startup costs if the provider wishes.

21.9.4 Requirements for 15-minute and hourly units

For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:

1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.
2. Services that last in their entirety less than eight minutes cannot be billed.

21.9.5 Requirements for at Cost Services

Services provided at cost are billed according to the purchase price and allowable administrative fees detailed in the service standards. Provider Agencies must adhere to the following requirements:

1. Purchase price plus administrative fees must not exceed the maximum allowable dollar amount in the approved Waiver.
2. Applicable maximum dollar amounts are:
 - a. Assistive Technology is \$500 per ISP year.
 - b. Fiscal Management of Educational Opportunities is \$550 per ISP year.

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 21: Billing Requirements

- c. Environmental Modifications is a maximum dollar amount of \$5,000.00 every five years.
- d. Independent Living Transition Service is a maximum lifetime amount of \$1,500.00 inclusive of any allowable administrative fees.
- e. Remote Personal Support Technology (RPST) may not exceed \$5,000.00 per ISP year.
- f. Non-Medical Transportation is \$850 for mileage and \$460 for transportation passes per ISP year.

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 22: Quality Improvement Strategy (QIS)

Chapter 22: Quality Improvement Strategy (QIS)

A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles:

1. quality improvement work in systems and processes;
2. focus on participants;
3. focus on being part of the team; and
4. focus on use of the data.

DD Waiver Provider Agencies have different business models, organizational structures, and approaches to service delivery. The DD Waiver can only truly assess progress, if the factors used to determine quality improvement (QI) are consistent across the system, i.e. QMB compliance surveys, IQRs, DD Waiver Service Standards, regulations (NMAC), litigation and Court Orders.

As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan.

22.1 Data Sources

To achieve system change, improve performance and outcomes, and meet minimum requirements of the DD Waiver Service Standards, data must be collected consistently by Provider Agencies. Appropriate analysis must be conducted to interpret data findings. Data must be stored in a manner that allows for convenient retrieval. Finally, information must be presented in useable formats. Data sources for discovery and analysis include, but are not limited to:

1. Satisfaction surveys;
2. QMB survey findings;
3. DDS training database;
4. IQR findings;
5. New Mexico Regulation and Licensing Boards;
6. CCHSP;
7. EAR;
8. GER, and
9. EVV reports: EVV required KPI for providers of EVV services as determined by DDS.

22.2 QI Plan and Key Performance Indicators (KPI)

Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and

Section III: Quality Assurance and Continuous Quality Improvement

Chapter 22: Quality Improvement Strategy (QIS)

sustained improvement. It describes the frequency of data collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI on an annual basis or as determined necessary. The KPI are monitored for improvement on an annual basis and can change based on sustained improvement. The DDSQI will evaluate trends over time when determining new KPI. KPI updates will be through numbered memos, at least annually.

22.3 Implementing a QI Committee

A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following:

1. Activities or processes related to discovery, i.e., monitoring and recording the findings;
2. The entities or individuals responsible for conducting the discovery/monitoring process;
3. The types of information used to measure performance;
4. The frequency with which performance is measured; and
5. The activities implemented to improve performance.

22.4 Preparation of an Annual Report

The Provider Agency must complete an annual report based on the quality assurance (QA) activities and the QI Plan that the agency has implemented during the year. DDSQI will provide an updated annual report template to be utilized by provider agencies. The annual report shall:

1. Be submitted to the DDSQI PEU by February 15th of each calendar year. Agencies who do not submit by the required deadline are subject to sanctions including but not limited to civil monetary penalties.
2. Be kept on file at the agency, and made available to DOH, including DHI upon request.
3. Address the Provider Agency's QA or compliance with at least the following:
 - a. compliance with DDSQI Training Requirements;
 - b. compliance with reporting requirements, including reporting of ANE;
 - c. timely submission of documentation for budget development and approval;
 - d. presence and completeness of required documentation per the Client File Matrix;
 - e. compliance with CCHS, EAR, and Licensing requirements as applicable; and
 - f. a summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans include but are not limited to:
 - i. IQR findings;
 - ii. CPA Plans related to ANE reporting;

Section III: Quality Assurance and Continuous Quality Improvement
Chapter 22: Quality Improvement Strategy (QIS)

- iii. POCs related to QMB compliance surveys; and
 - iv. PIPs related to Regional Office Contract Management.
4. Address the Provider Agency QI with at least the following:
- a. data analysis related to the DDSD required KPI; and
 - b. the five elements required to be discussed by the QI committee each quarter
(See [Chapter 22.3. Implementing a QI Committee above.](#))

Appendices

Appendix A Client File Matrix

1. Documents can be accessible in hard copy or electronic form.
2. Matrix does NOT represent a required filing system.
3. LCA includes Supported Living, IMLS, Family Living and CIHS.
4. Documents are only required when services are on approved budget and applicable to the service.
5. It is the provider's responsibility to determine the documents minimally necessary to provide the service at offsite locations.
6. For provider owned and operated onsite service delivery only.

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|--|-------------------|----------------------------|---------|-----------------------|------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Administrative Files | | | | | | | | | | |
| Medicaid & Medicare Card (if applicable) | Person/Guardian | Per expiration | X | X | X | X | X | X | | |
| Guardianship & POA | Guardian/POA | As applicable; per changes | X | X | X | X | X | X | X | X |
| Initial Allocation Letter | CM | Do not purge | X | | | | | | | |
| Copy SSN Card | CM | Do not purge | X | | | X | X | | | |
| Consent-Release Information | Provider Agencies | As applicable | X | | | X | X | X | X | X |
| Choice | | | | | | | | | | |
| Yes Match & Supporting Docs | CM | Do not purge | X | | | X | | | | |
| PFOC | CM | Do not purge | X | | | | | | | |
| Waiver Change Form | CM | As applicable | X | | | | | | | |
| SFOCs | CM | As updated | X | | | X, only for service | X, only for service | X, only for service | X, only for service | X, only for service |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|---|---------------------|--|---------|-----------------------|------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Level of Care | | | | | | | | | | |
| Approved LTCA form (MAD 378) with prior authorization | CM | Annually, do not purge initial MAD 378 | X | | | | | | | |
| For Adults: CIA | CM | Annually | X | | | | | | | |
| Rights and Settings Requirements | | | | | | | | | | |
| Enforceable lease for provider owned and controlled setting | Applicable Provider | Annually and as needed | | | | X, SL, IMLS, FL only | | | | |
| Home Study "Annually or if there is a change in the family household" | Provider | Annual | | | | X-FL Only | | | | |
| Statement of Rights-Acknowledgement | CM | Annually | X | | | X | X | X | X | X |
| Signed Grievance - Complaint Procedure of the Agency | Per Provider Agency | Annually | X | | | X, author only | X, author only | X, author only | X, author only | X, author only |
| Human Rights Committee Approvals | Follow Hierarchy | Quarterly, or as required | X | | | X, as applicable to the service | X, as applicable to the service | X, as applicable to the service | X, as applicable to the service | X, as applicable to the service |
| IDT Meeting Minutes | CM | Annually and as required | X | | | X | X | X | X | X |
| Planning and ISP | | | | | | | | | | |
| Individual Transition Plan (ITP) | CM | For transitions | X | | | X | X | X | X | X |
| Written Notice of Annual ISP meeting | CM | Annually | X | | | | | | | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|---|---------------------------------------|---|---------|-----------------------|------------------------|--|--|----------------|----------------|---------------|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| DDSD Assessment Tracking Sheet -Assessment Checklist | CM | Annually, updates as needed | X | | | X | X | | | |
| ISP, Addendum A (including notice of ANE reporting and acknowledgement), and Signature Page | CM | Annually & as revised; do not purge initial documents | X | X | X | X | X | X | X | X |
| Teaching and Supports Strategies (TSS) | Responsible Provider Agencies per ISP | No later than 14 days prior to beginning of ISP term, updates as needed | X | X | X | X, for service provided | X, for service provided | X | X | X |
| Individual Specific Training (IST) Section | CM | Annually, updates as needed | X | | | X | X | X | X | X |
| Assistive Technology (AT) Inventory | SLP, OT, PT, nurse | Semi-annual | X | X | X | X | X | X, when author | X, when author | |
| Remote Personal Support Technology (RPST) | SLP, OT, PT, BSC, Nurse, | Semi-annual | x | X | X | X | x | X, when author | X, when author | X when author |
| Written Direct Support Instructions (WDSI) | SLP, OT, PT | Annually, updates as needed | X | X, when applicable | X, when applicable | X, for service provided | X, for service provided | | X, when author | |
| Data Tracking and Progress | | | | | | | | | | |
| Data Tracking for Action Plans | Responsible Provider per ISP | Monthly | | X, Current Month | X, Current Month | X, current & prior ISP year for service provided | X, current & prior ISP year for service provided | | | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|--|------------------------------|--|-------------------------------------|-----------------------|------------------------|--|--|--|---|---|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Progress Notes/Daily Notes | Responsible Provider per ISP | Per service delivery | | X, Current month | X, Current month | X, current & prior ISP year for service provided | X, current & prior ISP year for service provided | X, current & prior ISP year for service provided | | |
| Monthly Site Visits | LCA Provider | Monthly | | | | X, SL, IMLS, & FL only | | | | |
| Semi-Annual Reports | Responsible Provider per ISP | Per standards | X, current & prior ISP for all svcs | | | X, current & prior ISP year when author | X, current & prior ISP year when author | X, current & prior ISP year when author | X, current & prior ISP year when author | X, current & prior ISP year when author |
| IQR Findings | IQR Surveyors | Per annual sample | X, current & prior ISP | | | X, current & prior ISP year as applicable | X, current & prior ISP year as applicable | X, current & prior ISP year as applicable | X, current & prior ISP year as applicable | X, current & prior ISP year as applicable |
| Budget | | | | | | | | | | |
| RFI, approval, partial approval, denial letters and notices of Fair Hearing Rights | CM | Annually and as issued | X | | | | | | | |
| Approved MAD 046 or BWS JCM or non-JCM | CM | Annually and as issued; do not purge initial documents | X | | | X, for services approved on budget | X, for services approved on budget | X | X | X |
| Crisis Supports Prior Authorization Memo | BBS | When applicable | X | | | | | | | X, when supports additional units |
| Verification of Benefits Availability form. | CM | As requested, | X | | | | | | | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|--|------------------------------------|------------------------------------|---------|-----------------------|------------------------|-------------------------|-------------------------|----------------|----------------|----------------|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Budget Based AT application | AT applicant & CM | Per service request | X | | | X, when author | X, when author | X, when author | X, when author | X, when author |
| Documents verifying "at cost services" | Applicable provider | Per service request | X | | | | | | | |
| BWS-Sent 2 business days before submission | CM | | X | | | | | | | |
| Training | | | | | | | | | | |
| Verification of IST i.e., rosters | All Provider Agencies | Annually with updates as needed | | | | X, for service provided | X, for service provided | X | X | X |
| Nursing delegation documents (Training, Monitoring, Rescind) | Delegating Nurse | Annually and as needed | | | | X | X | X | | |
| Trainer Designation Forms, as applicable | SLP, OT, PT, BSC, RN as applicable | Following designation | | | | X | X | X | X | X |
| Therapy | | | | | | | | | | |
| Initial Therapy Evaluation | SLP, PT, OT | As budgeted | X | | | | | | X | |
| Assessments/Therapy Re-Evaluation Report | SLP, OT, PT | Annually | X | | | | | | X | |
| Progress notes | SLP, OT, PT | Per visit | | | | | | | X | |
| Therapy Documentation Form (TDF) which includes the Therapy Intervention Plan (TIP) and Semi-Annual Report | SLP, OT, PT | Annual, Semi-annual, and as needed | X | | | x | x | | X | |
| Discontinuation of Therapy Services Report | SLP, OT, PT | When a provider discontinues, | X | | | X | X | | X | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|---|----------------------------------|---|---------|-----------------------|------------------------|---------------------|---------|-----|---------|-----|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Behavior Support | | | | | | | | | | |
| PBSA | BSC | Annual | X | | | X | X | X | | X |
| PBSP | BSC | Annual, updates as needed | X | X | X | X | X | X | | X |
| Progress notes | BSC | Per visit | | | | | | | | X |
| Semi-Annual report | BSC | Per standards | X | | | | | | | X |
| BCIP | BSC | Annually, if applicable | X | X | X | X | | X | | X |
| PPMP | BSC | When applicable | X | X | X | X | X | X | | X |
| PRSC Consultation Note | PRCS provider | When applicable | X | | | | | | | X |
| PRSC Meeting Minutes | PRSC Provider | When applicable | X | | | | | | | X |
| RMP (included in PBSP) | BSC | When applicable | X | X | X | X | X | | | X |
| Employment | | | | | | | | | | |
| Documentation: DVR unavailable | CIE provider | As appropriate | X | | X | | X | | | |
| Certificates - documentation of earning, employment verification & benefits | CIE provider | Reviewed Semi-annually Employment verification monthly | | | X, most recent | | X | | | |
| PCA and/ or Career Development Plan | Per responsible CCS-CIE provider | Per ISP | X | | X | | X | | | |
| Business Plan | CIE (Self-Employment) | As applicable | X | | X | | X | | | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|---|-----------------------------------|--|----------------|-----------------------|------------------------|---|---|----------------------------|----------------------------|----------------------------|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| ANE | | | | | | | | | | |
| Incidents Reports | Reporting provider | As reported | X, if reporter | | | X, if reporter | X, if reporter | X, if reporter | X, if reporter | X, if reporter |
| Immediate Health and Safety Action Plan (IASP) | Responsible Provider | As needed | X | | | X | X | X | X | X |
| Corrective and Preventive Action Plan | Responsible Provider | As needed | | | | X, If responsible provider | X, if responsible provider | X, if responsible provider | X, if responsible provider | X, if responsible provider |
| Decision & Closure Letters | DHI-IMB | As needed | X | | | X, if reporter | X, if reporter | X, if reporter | X, if reporter | X, if reporter |
| Case Management | | | | | | | | | | |
| Monthly Site Visit forms | | Child: 4X year Adults 1x mth JCM at 2x mth | X | | | | | | | |
| CM Contact Notes | CM | Monthly, per activity | X | | | | | | | |
| Documents related to Health care Coordination | | | | | | | | | | |
| Individual Data Form (IDF) | By hierarchy of Provider Agencies | Annually, updates as needed | X | X | X | X | X | | | |
| History and physical | CM | Annually | X | | | X | X, CCS-group | X | | |
| Health Passport | By hierarchy of Provider Agencies | Annual & if e-CHAT or information changes | X | X, print copy for DSP | X, print copy for DSP | X | X | X | | |
| Physician Consultation Form (complete after appointments) | By hierarchy of Provider Agencies | As needed | | | | X, service provider responsible for appointment & | X, CCS-Group service provider responsible | X | | |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|--|---|---|---------|-----------------------|------------------------|---------------------|-----------------------------|-----|---------|-----|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| | | | | | | follow up | for appointment & follow up | | | |
| Health Tracking required elements per standards | By hierarchy of Provider Agencies | Updated according to applicable timelines in 20.5.2 | X | | | X | X, CCS- G | | | |
| e-CHAT | Nurse by hierarchy Provider Agencies | Annually, updates as needed | X | | | SL, IMLS, FL only | CCS-group | X | | |
| e-CHAT Summary Page | Nurse by hierarchy Provider Agencies | Annually, updates as needed | X | | | SL, IMLS, FL only | CCS-group | X | | |
| ARST | Nurse by hierarchy Provider Agencies | Per standards | X | | | SL, IMLS, FL only | CCS-group | X | | |
| MAAT | Nurse by hierarchy Provider Agencies | Per standards | X | | | SL, IMLS, FL only | CCS-group | X | | |
| Healthcare Plans (including CARMP) | Nurse by hierarchy Provider Agencies | Annually and per the Standards | X | X | X | X | CCS-group | X | | |
| CARMP, including training, monitoring and revision | CM and IDT members as applicable | Annually and per the standards | X | X | X | X | X | X | X | X |
| MERP | Nurse by hierarchy Provider Agencies | As applicable | X | X | X | X | X | X | | |
| IMLS or ANS Parameter Tool | Applicable provider of nursing supports | As needed at least annually | X | | | X | X, ANS only & as applicable | X | | |
| DNR notification & Advanced Directives | CM | As applicable | X | X | X | X | X | X | x | x |

| Documents by Topic | Responsible Party | Frequency of Update | CM File | Service Delivery Site | Service Delivery Site: | Administrative File | | ANS | Therapy | BSC |
|---|--|---|---------|-----------------------|---|----------------------|---|-----|---------|-----|
| | | | | LCA | CCS-CIE | LCA | CCS-CIE | | | |
| Healthcare Provider-Orders | Per implementing provider | As applicable | X | X | X | X | X | X | | |
| Decision Consultation and Team Justification Form | CM | As needed and review annually | X | | | X | X | X | X | X |
| Hospice orders/plans | Per implementing provider | As needed | X | X | CCS-group | X | X | X | x | x |
| Nutritional evaluation and semi-annual | RD/LD | Annually/ semi-annually | X | | | X | | X | | |
| Nutritional plan | RD/LD | Annually & as needed | X | X | X | X | X | | | |
| Nutritional Evaluation-CARMP | RD/LD | Annually and quarterly | X | | | X | x | | | |
| Psychological Assessment | Psychologist | Initial only | X | | | | | | | |
| Nursing Discharge Summary | Nurse | = or < 10 business days after decision | X | | | X, SL, IMLS, FL only | CCS group | X | | |
| Semi-Annual Nursing Report | Agency Nurse DC/JTF | Semi-annually | X | | | X, SL, IMLS, FL only | CCS group | X | | |
| Medication Administration Record (MAR) | Responsible Provider and nursing oversight | Monthly and when needed for new medications | | X, current month | X, current month if medication delivered during the service | X | X, if medication delivered during the service | X | | |

Appendix B GER Requirements

The following events need to be reported in the Therap GER: when they occur during delivery of Supported Living, Family Living, Intensive Medical Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment or Adult Nursing Services for DD Waiver participants aged 18 & older.

- Emergency Room/Urgent Care/Emergency Medical Services
- Falls Without Injury
- Injury (including Falls, Choking, Skin Breakdown and Infection)
- Law Enforcement Use
- All Medication Errors
- Medication Documentation Errors
- Missing Person/Elopement
- Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission
- PRN Psychotropic Medication
- Restraint Related to Behavior
- Suicide Attempt or Threat
- COVID-19 Events

Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. to an appointment in Health Tracking for ER/Urgent Care/Emergency Medical Services and Out of Home Placement: Medical.

Provider Agencies must enter and approve GERs within 2 business days except for Medication Errors which must be entered into GER on at least a monthly basis.

If there is suspicion of Abuse, Neglect or Exploitation, please call the Division of Health Improvement 24-hour Hotline at **1-800-445-6242**

| Event | Description | Entry Requirement | Notification Level |
|----------------------|--|--|--------------------|
| COVID-19 Event | Any COVID related event including Testing, Testing Results, Suspected Contact/Exposure, Hospitalization and Death. | <p>Event: Other Event Type: Communicable Disease Sub-Type: COVID-19</p> <p>Select the related event:</p> <ul style="list-style-type: none"> • Contact/Exposure (Suspected or Confirmed) • Testing • Positive • Negative • Symptoms <p>Also, indicate Hospitalization and COVID-19 related Death.</p> | HIGH |
| COVID-19 Vaccination | Any COVID-19 Vaccination, Vaccination Reaction, Vaccination Declination | <p>Event: Other Event Type: COVID-19 Vaccine, Sub-type: choose appropriate vaccine manufacturer and dose or declined. Identify if there was a reaction</p> <ul style="list-style-type: none"> • In addition to GER Vaccine information must be entered into the immunization section of Therap’s Health Tracking. • Enter COVID-19 Vaccine Data into the Therap Immunization Section <ul style="list-style-type: none"> ○ Identify the vaccine manufacturer ○ Enter which vaccine step (i.e., first or second shot) or declined. <p>Identify if there was an allergic reaction such as shortness of breath, wheezing, dizziness, hives, and swelling of the face (if applicable) in the box provided under .in the description of the event.</p> | HIGH |

| Event | Description | Entry Requirement | Notification Level |
|---|--|--|--------------------|
| ER/Urgent Care/EMS | Any use of ER/Urgent Care or “walk in” clinic | Event: Other Event Type: Hospital Sub-Type: ER w/o Admission In the event summary, indicate if the actual location is urgent care rather than emergency room or services took place without transport to emergency room. Please specify hospital or urgent care name if applicable. | HIGH |
| Fall Without Injury | Individual unintentionally comes to rest on the ground (floor, sidewalk, or pavement) without injury | Event: Other Event Type: Fall Without Injury | MEDIUM |
| Injury Note: If an injury results in the use of emergency room, urgent care or emergency services, report as “ER/Urgent Care/EMS” | Falls Choking Skin Breakdown Infection <i>See definitions for above terms</i> | Fall with injury: Event: Injury; Injury Type: choose appropriate; Injury Cause: Fall (Note: you must pick body part injured; signs of injury such as pain or bruising may develop days after the fall.) Choking: For Injury Type, select choking instead of airway obstruction on the dropdown. (Choose throat for your body part for this Injury Type) Skin breakdown: For admitted, acquired and surgical sites. Event Type: Injury Type: Other, type in “skin breakdown” Infection: Any contagious infection diagnosed & treated by a physician Injury Type: Infection (then pick body part that is infected) Other Injury requiring medical intervention (other than use of ER/Urgent Care/EMS services): Injury Type: as indicated by injury | MEDIUM |
| Law Enforcement | Any use of law enforcement, including if an individual is arrested and taken to jail. | Event: Other Event Type: Law Enforcement Involvement | HIGH |

| Event | Description | Entry Requirement | Notification Level |
|--|---|---|--------------------|
| Medication Errors | Discontinued medication given, wrong dose, wrong route, wrong time, missed dose (omission), medication given without an order. Wrong documentation is "low". See DHI ANE Guide for medication errors reportable to DHI-IMB. | <p><u>DDSD requires all moderate medication errors be entered into Therap GER. Provider Agencies can no longer utilize an alternate system to track moderate medication errors.</u></p> <p>Enter in GER on at least a monthly basis however more frequent reporting is allowed and encouraged:</p> <p>Event: Medication Error</p> <p>Error Type: choose as appropriate</p> <p>If an omission is due to refusal, select Error type "omission" and then select "medication refused" from the drop down under "Cause of Error" so that refusals can be sorted as a separate group.</p> | MEDIUM |
| Medication Errors (documentation issues only) | Blanks on the MAR or treatment sheet, initialed in the wrong box | <p><u>DDSD requires all low-level medication errors be entered into Therap GER. Provider Agencies can no longer utilize an alternate system to track low level medication errors.</u></p> <p>For omission due to refusal see tip #3 below.</p> <p>Enter in GER on at least a monthly basis however more frequent reporting is allowed and encouraged:</p> <p>Event: Medication Error</p> <p>Error Type: Charting</p> | LOW |
| Missing Person or Elopement | An individual whose whereabouts are unauthorized and whose support and supervision needs are cause for immediate concern | <p>Event: Other</p> <p>Event Type: AWOL/Missing Person</p> | HIGH |

| Event | Description | Entry Requirement | Notification Level |
|--|--|--|--------------------|
| Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission | <i>Any planned or unplanned stay in a hospital, long term care, skilled nursing, sub-acute or rehab facility</i> | Event: Other Event Type: Hospital or if not hospital and use Out of Home Placement then specify location in event subtype. Specify hospital, rehabilitation center, sub-acute hospital, nursing home names, or jail/detention center. Event Detail: Document delivery and receipt of updated <i>Health Passport, the e-CHAT, medication history, and information on mobility, comfort, safety, and sensory items and/or any durable medical equipment</i> Must be reported within 48 hours | HIGH |
| PRN Psychotropic Medication | Use of a PRN Psychotropic medication prescribed by a physician and utilized according to a written plan | Event: Other Event Type: PRN Psychotropic Use Be sure to also complete notification section to document that the agency nurse was consulted per the DD Waiver Standards. | LOW |
| Restraint Related to Behavior | The use of personal, manual physical force to limit, prohibit or preclude imminently dangerous behavior by restricting movement through specified and allowed sustained physical contact or holding procedures | Event: Restraint Related to Behavior Non-approved or non-trained physical restraint should be reported to DHI-IMB. An extended restraint is greater than 10 minutes and in that case the agency must verbally notify the BBS Crisis Line at: 1-505-250-4292. | MEDIUM |
| Suicide Attempt or Threat | A physical act or expression of intent to inflict great harm or death. If law enforcement used, see law enforcement above. | Event: Other Event Type: Suicide If an event is associated with the intent (abrasion, bruise or cut, etc.) also add another event "injury" and complete that section as well. | LOW |

Important GER Tips and Definitions

1. Please pay close attention to the way events are categorized. For example, if the individual falls and is admitted into the hospital, categorize the event as hospital with admission rather than “fall.” Accurate categorization of events is critical to support data analysis and informed decision making.
2. Event Type "Other" is not allowed in combination with Event section "Other". Provider Agencies must use the level indicated in this guide for each type of event listed. This ensures that medium level aggregate reports run by DDSD include the correct categories and that high-level reviews are contained to those event types that require DDSD individual review.

| Term | Definition |
|----------------------------|--|
| Choking | Event requiring intervention by support staff to dislodge food/object from person’s airway (e.g., abdominal thrust). |
| COVID-19 Event | These events include Suspected or confirmed COVID-19 exposure, testing including results, hospitalization, and COVID-19 related death |
| COVID -19 Vaccination | Any approved vaccination for COVID-19 for individual receiving services |
| COVID-19 Declination | Refusal of any COVID-19 vaccines |
| Fall with Injury | When an individual unintentionally comes to rest on the ground (floor, sidewalk, or pavement) resulting in an injury of some sort that requires at least basic first aid or more involved medical intervention, unless the injury from the fall resulted in the use of ER, urgent care, or EMS services, in which case the event should be reported under "Use of ER/Urgent Care/EMS". |
| Fall without Injury | When an individual unintentionally comes to rest on the ground (floor, sidewalk, or pavement), but does not result in injury. |

| Term | Definition |
|---|--|
| Infection | Any contagious infection that is diagnosed and treated by a physician, such as infections or colonization with a multi–drug resistant organism or any diagnosed case of influenza, pneumonia, or gastroenteritis. Examples of infection or colonization with a multi-drug resistant organism include: Methicillin resistant staph aureus (MRSA); vancomycin resistant staph aureus (VRSA); or clostridium difficile. |
| Injury (Injuries of Known and Unknown Causes) | Damage or harm to the structure or function of the body caused by a known or unknown outside agent or force, which may be physical or chemical and requires professional medical or nursing intervention. This includes wounds (including surgical, accidental, pressure (decubitus) or vascular ulcers) and closed head injuries (i.e., concussion). |
| Medication Error | Any medication event that results in a breach of the five ‘R’s”, namely the right person, right medication, right time, right dose, and right route. The types of medication errors are wrong individual, wrong medication (which includes a medication given without an order or after it has been discontinued), the wrong time, missed dose (omission), wrong dose and wrong route. For omission due to refusal see tip #4. |
| Missing Person/Elopement | An individual whose whereabouts are unauthorized and whose support and supervision needs are cause for immediate concern. |
| Out of Home Placement | A medically related out of home placement (change in residential status), i.e., hospitalization, nursing home placement, rehabilitation center stays, etc. Does not refer to multi-day visits to friends or relatives. Does not include incarceration (jail) which should instead be noted under Use of Law Enforcement. |
| Restraint Related to Behavior | The use of personal, manual physical force to limit, prohibit or preclude imminently dangerous behavior by restricting movement through specified and allowed sustained physical contact or holding procedures. NOTE: All Emergency Physical Restraint is to be reported even if it is part of an endorsed BCIP, and/or any other plan; must note the duration of the restraint in the event description. |
| Skin Breakdown | Skin damage (e.g., ischemic hypoxia, necrosis, ulceration) that may complicate wounds including surgical, accidental, pressure (decubitus) or vascular ulcers. (See Injury) |

Appendix C HCBS Consumer Rights and Freedoms

As a person with an intellectual and/or developmental disability (I/DD), and a person receiving services, I have the same basic legal, civil, and human rights and responsibilities as everyone else. My rights shall never be limited or restricted unnecessarily; without due process and the ability to challenge the decision, even if I have a guardian. All my rights should be honored through any assistance, support, and services I receive.

Some Examples of My Rights Include:

- Get paid competitive wages to work in an inclusive setting
- Contribute to my community
- Access services in the community the same way people who don't receive services do
- Full inclusion in community and cultural life
- Have access to education and information in a way I can understand
- Choose where I live based on what I can afford
- Choose who I live with
- Lock my doors and home, and choose those who may come in
- Access common places in my home
- Exercise tenant rights in accordance with state law
- Accessibility wherever I go
- Choose to be alone and my privacy respected
- Privacy and confidentiality
- Access to all my personal information (financial, medical, programmatic, behavioral, legal)
- Receive information to make informed decisions regarding my health care.
- Choose supports that I need and want
- Choose from all available service Provider Agencies
- Independence
- Choose/develop my own schedule
- Go out at any time
- Develop my own person-centered plan of support
- Be treated with dignity and respect
- Control my money
- Be free from coercion, restraint, seclusion, and retaliation
- Have visitors at my home at any time
- Choose when/what to eat, and have access to food at any time
- Choose my clothing
- Be part of a family or start one
- Live with my partner or get married
- Form loving relationships, either platonic or sexual, with whomever I choose
- Be free from abuse, neglect, exploitation
- Have access to advocacy supports and resources
- Participate in any discussion about restricting my right
- Vote
- Exercise religion or belief of my choice

Any restriction or modification to these rights:

- Must demonstrate informed consent by me.
- Must have an assurance that interventions and supports will cause no harm to me.
- Must be the result of a documented health and safety issue.
- Must be reflected in the person-centered plan.
- Must have documented less intrusive supports that were attempted prior to the modification/restriction.
- Will be communicated to me; in a way I can understand.
- Requires regular review to measure and assess effectiveness of restriction/modification.
- Requires a fade-out plan for the restriction/modification.

Index

A

Abuse, Neglect and Exploitation (ANE), 33, 34, 68, 70, 83, 87, 231, 240, 253, 263–66, 267, 268, 289, 290, 302, 307, 318, 324

Accreditation, 240, 323

Action Plan(s), 64, 70, 71, 72, 82, 110, 120, 128, 170, 171, 175, 229, 259, 269, 270, 294

Activities of Daily Living (ADL), 108, 126, 228, 318, 325

Acuity, 45, 122, 196

Addendum A, 69, 70, 83, 97, 98

Administrative fees, 283, 286, 287

Adult Nursing Services (ANS), 50, 76, 106, 113, 115, 122, 124, 183–205, 183–205, 215, 248, 273, 279, 291, 292, 293, 294, 295, 297, 298, 299, 300, 301, 302

Advocate, 4, 65, 81, 82, 231, 262

Allocation

- expedited, 16, 17
- initial, 83, 291

American Speech Language Hearing Association (ASHA), 169

Americans with Disabilities Act (ADA), 10, 218, 221, 318

Annual Resource Allotment (ARA), 318

Aspiration

- Aspiration Risk Management (ARM) supports, 51, 62
- Collaborative Aspiration Risk Assessment, 51, 52, 56, 57
- Statewide Aspiration Risk List (SARL), 51, 53, 56, 57, 268, 269

Aspiration Risk Management (ARM), 72, 76, 170, 171, 177, 188, 190, 198, 201, 318

Aspiration Risk Screening Tool (ARST), 50, 51, 52, 53, 54, 55, 56, 58, 61, 64, 78, 186, 187, 188, 198, 277, 298

Assessments, 66

Assistance with Medication Delivery (AWMD), 106, 107, 109, 188, 189, 190, 195, 196, 201, 202, 203, 318

Assistive Technology (AT), 39, 40, 75, 76, 95, 108, 110, 120, 124, 126, 127, 128, 171, 173, 189, 206–9, 294, 295, 318

aversive intervention, 26

Awareness level, 259

B

Behavior Crisis Intervention Plan (BCIP), 25, 26, 27, 31, 32, 34, 35, 36, 37, 47, 78, 87, 110, 117, 120, 125, 127, 128, 154, 155, 158, 159, 160, 228, 249, 301, 310, 318

Behavior Support Consultation/Consultant (BSC), 24, 25, 27, 31, 32, 34, 46, 47, 48, 49, 53, 55, 56, 58, 65, 75, 76, 91, 109, 110, 117, 120, 128, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 233, 248, 256, 261, 267, 271, 273, 301, 302, 318, 323

Billable Activities, 284

Billable Units, 285

Billing Requirements, 280

Board of Nursing, 89, 190, 205

Board of Pharmacy, 107, 121, 195, 242

Budget, 18, 41, 43, 45, 50, 54, 55, 67, 69, 73, 74, 75, 76, 77, 78, 79, 81, 83, 86, 88, 90, 100, 106, 126, 158, 177, 179, 187, 201, 220, 221, 280, 281, 289, 291, 292, 293, 295, 296, 297, 298, 299, 300, 301, 302

Budget Worksheet (BWS), 78, 79, 93, 318

Bundled services, 106, 152, 181, 183, 204, 241, 284

Bureau of Behavior Supports (BBS), 61

Bureau of Behavioral Supports (BBS), 24, 29, 33, 35, 48, 49, 50, 74, 158, 160, 161, 162, 163, 164, 214, 215, 216, 233, 295, 308, 318, 323

Bureau of Systems Improvement (BSI), 323

Business Plan for Self-Employment. *See* Self-Employment

C

Care Coordinator, 19, 84, 85, 183

Career Development Plan, 101, 302

Caregiver Criminal History Screening Program (CCHSP), 240, 288

CARF, 240

Case Management, 16, 17, 19, 74, 75, 76, 80, 91, 92, 81–92, 229, 240, 242, 244, 267, 269, 272, 273, 284, 298, 300, 301, 303, 322, 323

Case Manager (CM), 18, 19, 21, 23, 25, 34, 39, 40, 42, 45, 49, 50, 52, 53, 54, 55, 56, 57, 60, 61, 64, 65, 67, 68, 69, 70, 71, 72, 73, 77, 78, 79, 81–92, 93, 94, 95, 97, 98, 99, 101, 115, 170, 174, 179, 184, 186, 197, 198, 209, 219, 220, 222, 223, 225, 229, 238, 243, 246, 247, 253, 254, 265, 266, 267, 269, 273, 274, 276, 280, 291, 292, 293, 295, 297, 298, 299, 303

Central Registry (Waiting List), 15, 16

Central Registry Unit (CRU), 15

Certified Medication Aide (CMA), 184, 189, 190, 201, 203, 204, 205, 242, 318

Certified Occupational Therapy Assistant (COTA), 168, 242

Child(ren), 16, 69, 70, 74, 75, 84, 86, 156, 225, 284, 323

Client Individual Assessment (CIA), 19, 84, 292, 318

Client Information Update

- CIU, 19, 93, 94, 96, 98, 318

Clinical Services Bureau (CSB), 64, 74, 323

Collaborative-Consultative Model

- of therapy, 166, 175

Communication Dictionary, 127

Community Inclusion, 24, 50, 76, 100, 130–52, 173, 187, 195, 269, 273, 284, 302, 323

Community Inclusion Unit, 323

Community Integrated Employment (CIE), 24, 87, 88, 105, 115, 118, 155, 186, 198, 200, 215, 240, 248, 267, 291, 318

- Self-Employment, 302

Community Programs Bureau (CPB), 318, 323

Comprehensive Aspiration Risk Management Plan (CARMP), 22, 44, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 72, 100, 109, 110, 120, 127, 128, 154,

156, 159, 173, 174, 177, 181, 182, 184, 188, 190, 192, 201, 228, 298, 318
Condition of Participation (CoP), 245, 318
Conflict of Interest, 90, 242
Contract Management, 74, 243, 290, 323
Core Curriculum, 248, 249, 251, 252, 253, 262, 324
Corrective and Preventive Action (CPA) plan, 265
Council on Quality and Leadership. *See* The Council on Quality Leadership
CPI, 32, 249
CPR, 249, 318
Crisis Response Staff (CRS), 214, 215, 216, 251
Crisis Supports, 76, 156, 214, 215, 216, 248, 251, 269, 295, 323
Customized Community Supports
 Individual (CCS-I), 327
Customized Community Supports (CCS), 24, 71, 87, 88, 105, 115, 118, 122, 155, 171, 186, 200, 215, 240, 248, 267, 269, 273, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 318
 CCS-Group, 50, 54, 55, 76, 187, 204, 273, 277, 326, 327
 CCS-Small Group, 198
 Individual (CCS-I), 75, 198, 327
Customized in Home Supports (CIHS), 76, 87, 88, 115, 116, 118, 122, 126, 128, 126–28, 155, 189, 200, 201, 214, 215, 228, 229, 240, 242, 248, 267, 318, 326. *See* Living care Arrangement (LCA)

D

Death
 report of, 264
Decision Consultation Process (DCP), 22, 23, 45, 51, 54, 55, 56, 60, 62, 84, 185, 200, 299, 318
Desired Outcomes, 39, 43, 49, 66, 68, 69, 70, 75, 78, 79, 82, 109, 115, 153, 154, 165, 170, 171, 196, 222, 224, 225, 230, 241, 259, 270
Developmental Disabilities System Quality Improvement Committee (DDSQL), 11, 289
Dietitian, 299
Dignity of Risk, 21, 104
Direct Support Professional
 DSP, 8, 32, 36, 50, 52, 57, 60, 61, 63, 65, 71, 105, 106, 111, 115, 116, 117, 120, 125, 128, 154, 155, 156, 172, 174, 177, 178, 179, 185, 191, 192, 194, 196, 197, 199, 200, 202, 211, 212, 213, 215, 229, 241, 245, 246, 247, 256, 258, 260, 271, 272, 278, 297
Direct Support Professional (DSP), 33, 34, 36, 44, 45, 47, 49, 50, 51, 52, 54, 55, 57, 59, 62, 63, 106, 107, 109, 110, 116, 117, 119, 120, 122, 123, 124, 125, 126, 128, 153, 154, 155, 159, 166, 170, 172, 173, 178, 179, 181, 183, 184, 185, 190, 191, 193, 194, 195, 197, 198, 199, 201, 202, 203, 205, 214, 216, 229, 240, 241, 242, 248, 249, 261, 262, 272, 275, 279, 318
Direct Support Supervisor (DSS), 241, 248, 249, 262
Discharge, 45, 54, 55, 69, 84, 95, 96, 97, 124, 125, 175, 186, 191, 199, 299, 304

Division of Vocational Rehabilitation (DVR), 101, 207, 302, 318
Driver, 225
Duty of Care, 21

E

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), 75, 76, 152, 284, 318
Eating Specialist, 52, 54, 56
e-CHAT, 52, 78, 88, 95, 184, 186, 187, 188, 190, 191, 192, 194, 196, 198, 200, 276, 277, 297, 298, 308, 318
Electronic Visist Verification
 EVV, 128, 129, 229, 282, 283, 285, 288, 318
Eligibility, 17
 annual recertification, 18
 COE, 17, 18, 280
 Financial, 18
 Medical, 15, 18, 19, 83, 90
 Waiver Changes, 99
Emergency Physical Restraint (EPR), 25, 32, 34, 31–37, 37, 249, 318
Employee Abuse Registry (EAR), 240, 288
Employment First, 71, 82, 269
Environmental Modification, 75, 76, 219, 220, 242, 318
Exception Authorization Process, 243

F

Fading, 26, 119, 156, 173, 174, 175
Fair Labor Standards Act (FLSA), 322
Family Living, 24, 50, 71, 76, 91, 103, 105, 106, 108, 110, 113, 114, 110–14, 115, 122, 124, 155, 181, 182, 183, 187, 188, 190, 194, 195, 197, 198, 199, 200, 201, 202, 203, 204, 205, 214, 222, 224, 228, 240, 241, 242, 248, 251, 255, 267, 268, 273, 279, 291, 292, 293, 295, 296, 297, 299, 300, 301, 302, 303, 304, 326, 327. *See* Living Care Arrangement (LCA)
Final Rule
 CMS, 10, 20, 235
Financial Rights and Responsibilities, 23
Findings and Recommendations, 88, 246
Fire extinguisher, 107, 249, 252
First Aid, 226, 249
Freedom of Choice
 Primary (PFOC), 16, 17, 41, 93, 319
 Secondary (SFOC), 41, 42, 67, 73, 83, 94, 235, 236, 281
Friends & Relationships Course (FRC), 230
Friends and Relationships Course (FRC), 49, 50, 230, 231, 233, 318

G

General Events Reporting (GER), 33, 34, 35, 37, 88, 267–68, 288, 304–10, 318
Guardian, 18, 20, 21, 22, 23, 24, 25, 29, 34, 35, 38, 40, 41, 42, 44, 45, 46, 50, 51, 54, 55, 56, 64, 65, 67, 70, 79, 81, 82, 83, 84, 85, 88, 93, 94, 95, 96, 97, 98, 107, 174, 177,

216, 217, 218, 219, 220, 225, 230, 233, 238, 239, 242, 246, 265, 272, 274, 277, 281, 284, 291, 311

H

Handle with Care, 32, 249
Health Insurance Portability and Accountability Act HIPAA, 24, 25, 29, 90, 249, 253, 271, 318, 322
Health Passport, 88, 109, 274, 276, 277, 297
Health Tracker, 275
Healthcare Coordination, 45, 44–46, 268, 272, 297, 298, 299
Healthcare Coordinator, 45
Healthcare Plan (HCP), 22, 35, 45, 100, 109, 110, 118, 119, 120, 124, 127, 128, 184, 185, 188, 190, 191, 192, 190–92, 193, 194, 199, 200, 201, 204, 228, 275, 276, 318
Hierarchy, 31, 34, 47, 186, 187, 273, 291, 292, 293, 295, 296, 297, 298, 300, 301, 302, 303
Home and Community Based Services (HCBS), 15, 16, 20, 21, 65, 96, 103, 324
Home and Community-Based Services (HCBS), 10
Hospice, 165, 172, 184, 192, 204, 299
Human Rights Committee (HRC), 24, 25, 26, 27, 29, 24–30, 32, 37, 46, 47, 104, 155, 160, 213, 214, 318
Human Services Department (HSD), 17, 99, 243, 280, 283, 284, 318
ISD, 19
MAD, 19, 235, 236, 238, 239, 247, 281

I

Incident Management Bureau (IMB), 33, 247, 265, 266, 267, 303, 307, 308, 319, 324
Income Support Division (ISD), 17, 18, 19, 96, 98, 319, 324
Independent Living Transition, 76, 222, 223, 287
Individual Action and Safety Plan (IASP), 264, 265, 266, 302, 318
Individual Data Form (IDF), 101, 274, 276
Individual Quality Review (IQR), 22, 74, 88, 246–47, 288, 289, 319
Individual Service Plan (ISP), 19, 23, 26, 32, 38, 39, 40, 43, 45, 50, 55, 58, 59, 60, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 65–74, 75, 76, 77, 78, 79, 81, 82, 83, 84, 85, 86, 88, 90, 92, 93, 97, 98, 100, 101, 105, 107, 108, 109, 110, 113, 115, 117, 118, 119, 120, 123, 124, 125, 126, 127, 128, 152, 154, 158, 165, 170, 171, 173, 175, 178, 179, 182, 188, 189, 193, 194, 198, 199, 201, 207, 208, 214, 215, 216, 217, 218, 221, 222, 224, 225, 229, 231, 241, 249, 253, 259, 264, 266, 267, 268, 269, 270, 272, 280, 281, 284, 286, 287, 293, 294, 302, 319
ISP QA, 74, 88
Individual Specific Training (IST), 32, 45, 58, 64, 70, 71, 72, 88, 91, 100, 110, 117, 119, 120, 128, 173, 194, 249, 253, 259, 293
Trainer Designation Record, 59, 261
Training Rosters, 260, 297
Individuals with Disabilities Education Act (IDEA), 319, 322

Informed choice, 38, 39, 40, 82
employment, 82
SFOC. *See* SFOC

Intake and Eligibility Bureau (IEB), 14, 17, 319, 323

Intensive Medical Living Services (IMLS), 50, 76, 103, 105, 106, 108, 110, 115, 116, 118, 122, 123, 124, 125, 122–25, 155, 181, 182, 187, 196, 197, 204, 214, 215, 222, 224, 228, 240, 241, 248, 255, 267, 268, 273, 291, 292, 293, 295, 296, 297, 299, 300, 301, 302, 303, 319. *See* Living Care Arrangement (LCA)

Interdisciplinary Team (IDT), 19, 22, 23, 31, 32, 39, 40, 44, 45, 48, 49, 50, 51, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 75, 77, 78, 79, 82, 83, 85, 86, 88, 90, 108, 109, 110, 115, 116, 117, 118, 119, 120, 123, 124, 125, 128, 154, 155, 158, 159, 161, 165, 166, 170, 171, 172, 173, 175, 176, 177, 179, 181, 182, 183, 184, 186, 187, 188, 189, 192, 193, 194, 195, 197, 198, 199, 201, 208, 214, 215, 216, 217, 222, 225, 229, 230, 241, 246, 247, 261, 265, 266, 269, 272, 275, 284, 293, 298, 319

Intermediate Care Facility (ICF/IDD), 318

Intermediate Care Facility (ICF/IID), 11, 15, 16

Internal Review Committee (IRC), 238, 243, 244, 245, 247, 319

internet, 82, 90, 104, 105, 106, 107, 112, 136, 137, 143, 179, 222

Intramuscular (IM), 190

intravenous (IV) injection, 190

J

Jackson Class Member (JCM), 74, 76, 86, 113, 114, 196, 201, 246, 271, 303, 319

K

Key Performance Indicators (KPI), 289, 290, 319

Knowledge level, 51, 259

L

Law Enforcement, 26, 268, 304, 306, 310

Level of care (LOC), 11, 18, 78, 81, 84, 93, 97, 99, 100, 186

License, 157, 158, 162, 168, 169, 184, 205, 225, 241, 284

Licensed Practical Nurse (LPN), 106, 122, 123, 184, 187, 189, 190, 192, 194, 197, 204, 205, 231, 319

Litigation Management Bureau (LMB), 323

Living Care Arrangement (LCA), 76, 78, 91, 100, 103, 125, 103–25, 268, 284, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 319

Living Supports, 24, 50, 54, 55, 76, 87, 88, 95, 103, 105, 106, 107, 108, 110, 115, 122, 125, 126, 155, 171, 173, 175, 187, 189, 195, 198, 215, 222, 224, 240, 241, 248, 273, 277, 284

M

MAD 335
 Provider Participation Agreement, 280, 322
MAD 378
 Long Term Care Abstract Form, 19, 84, 292
Managed Care Organization (MCO), 19, 45, 84, 85, 100,
 183, 319
MANDT, 249
Meaningful Day, 82, 323
Medical Emergency Response Plan (MERP), 44, 59, 61, 62,
 63, 100, 109, 110, 118, 119, 120, 127, 128, 184, 188,
 190, 191, 192, 194, 192–95, 199, 201, 204, 228, 276,
 319
Medical Stabilization, 46
Medication Administration Assessment Tool (MAAT), 78,
 186, 187, 188–90, 198, 277, 298, 319
Medication Administration by Licensed/Certified
 Personnel, 190
Medication Administration Record (MAR), 107, 195, 201,
 202, 279, 307, 319
Medication Errors, 268, 304, 307
Medication Oversight, 201, 202, 279
Mi Via, 15, 16, 17, 19, 91, 99, 323, 324
Moratorium, 41, 42, 237, 238, 247

N

Naso-gastric (NG) tube, 190
Nebulizer, 190
New Mexico Nurse Practice Act, 195
Non-Ambulatory Stipend, 119
Non-Medical Transportation, 75, 224, 225, 226, 287
Nurse, 29, 45, 47, 52, 56, 65, 89, 110, 116, 118, 119, 120,
 122, 123, 125, 128, 183, 184, 185, 186, 187, 188, 189,
 190, 191, 192, 193, 194, 195, 197, 198, 199, 200, 201,
 202, 203, 204, 205, 259, 261, 269, 279, 294, 298, 308,
 325
Nurse Delegation, 197
Nursing Assessment and Consultation Services, 198, 199
Nutritional Counseling, 75, 76, 115, 122, 152, 181, 182,
 242, 323

O

Occupational Safety and Health Administration (OSHA),
 249
Occupational Therapy/Therapist (OT), 53, 65, 78, 165, 168,
 169, 170, 273, 294, 297, 319
Office of Constituent Support, 323, 324
Olmstead Decision, 10
On-call, 106, 123, 197, 215
Ongoing Adult Nursing Services (OANS), 114, 198, 199,
 200, 201
Out of Home Placement (OOHP), 45, 69, 94, 184, 319
Outside Review(er) (OR), 77, 78, 79, 86, 98, 221, 280, 319,
 323

P

Participatory Approach, 109, 165, 166, 206
Performance Improvement Plan (PIP), 243, 244, 290
Person Centered Assessment (PCA), 82, 319
Person- centered planning (PCP)
 Person-centered practice, 40
Personal Support Technology (PST), 27, 75, 76, 126, 127,
 171, 173, 189, 210–13, 218
Person-centered planning (PCP), 20, 38–43, 48, 52, 65, 69,
 75, 78, 81, 85, 293, 319
 Person-centered practice, 40
 Person-centered thinking, 38
Pharmacy Consultant, 242
Physical Therapy Assistant, 167, 319
Physical Therapy/Therapist(PT), 53, 65, 78, 165, 170, 273,
 294, 297, 319
Physician Consultation, 109, 274, 276, 277
Plan of Correction (POC), 245, 290
Positive Behavior Supports Assessment (PBSA), 49, 78,
 154, 156, 158, 159, 160, 301, 319
Positive Behavior Supports Plan (PBSP), 26, 27, 31, 32, 35,
 47, 49, 50, 78, 109, 110, 117, 120, 125, 126, 127, 128,
 154, 155, 156, 158, 159, 160, 214, 228, 231, 301, 319
Power of Attorney, 242, 291
Preliminary Risk Screening and Consultation for Sexually
 Inappropriate Behavior (PRSC), 48, 50, 76, 152, 161,
 162, 164, 242, 248, 301, 302, 319, 323
Primary Care Practitioner, 22, 54, 61, 120, 123, 171, 183,
 189, 190, 194, 195, 202, 203
Primary Provider, 273, 276, 277
Prior Authorization, 123, 175, 199, 204, 292
PRN Psychotropic Medication, 26, 27, 47, 268, 304
PRN Psychotropic Medication Plan (PPMP), 26, 27, 32, 34,
 47, 78, 110, 120, 125, 127, 128, 154, 155, 158, 159,
 160, 199, 228, 301, 319
Professional Licensure, 125, 156, 157, 158, 167, 169, 182,
 215, 235, 237, 240, 241, 277
Program-centered, 43
Progress notes, 59, 62, 78, 158, 159, 160, 271, 283, 285,
 294, 300, 301
Proposed Budget Levels, 78, 325
Provider Agreement, 41, 124, 209, 235, 237, 238, 241, 243,
 280, 322
Provider Enrollment Unit(PEU), 41, 42, 169, 235, 236, 237,
 238, 239, 241, 289, 319, 323
prudent nursing practice, 123, 190, 191, 197, 200, 201
Psychosexual Evaluation, 101, 161
Psychotropic Medication, 26, 46–48, 159, 308

Q

Quality Assurance (QA), 88, 269, 289
Quality improvement (QI), 288
Quality Improvement Strategy
 QIS, 10, 11, 288
Quality Management Bureau (QMB), 74, 88, 244, 245, 246,
 247, 288, 290, 319

R

Rate Table, 283, 284, 285
Regional Office, 14, 17, 41, 42, 61, 73, 74, 80, 82, 84, 86, 88, 93, 94, 96, 97, 99, 115, 205, 216, 218, 219, 222, 237, 238, 239, 243, 269, 270, 281, 319, 323
RORA, 43, 82, 87, 88, 319
Regional Office Bureau (ROB), 323
Registered Dietitian, 55, 56, 62, 271, 273
Registered Nurse (RN), 103, 106, 122, 123, 124, 125, 184, 187, 189, 190, 192, 194, 197, 204, 205, 231, 319
Rehabilitation Act, 10, 322
Remote based, 130, 137, 142, 143
Request for Information (RFI), 295, 319
Respite, 75, 76, 110, 115, 116, 118, 122, 193, 228, 229, 240, 241, 242, 248, 254
Rights, 10, 12, 15, 16, 20, 21, 24, 25, 26, 27, 29, 31, 38, 83, 103, 214, 230, 231, 311
HCBS Consumer Rights and Freedoms, 21, 311
Risk Evaluator, 162, 163, 164, 242
Risk Management Plan (RMP), 26, 32, 78, 110, 120, 127, 128, 154, 155, 159, 160, 161, 302, 319
Room and board, 103, 107, 128, 284

S

Safety training, 249, 252
S-Comm. *See* Therap S-Comm
Secondary Provider, 275, 276
self-administration of medication, 190, 228
Self-Administration of Medication with Physical Assistance, 189
semi-annual report, 59, 77, 101, 154, 158, 159, 182, 186, 269, 271, 272, 285, 294, 300
Service coordinator, 25, 110, 120, 128, 267
Settings Requirements
CMS, 20, 235
Residential Settings or LCA, 103
Skill level, 51, 123, 125, 197, 203, 259
Skilled Treatment, 172
Social Security Card, 101, 291
Socialization and Sexuality Education (SSE), 48, 49, 50, 75, 76, 153, 230, 240, 248, 319, 323
Speech and Language Pathology (SLP), 54, 61
Speech Language Pathologist (SLP), 65, 78, 165, 169, 273, 294, 297, 300, 319
Statewide Aspiration Risk Management Coordinator (SARMC), 51
Statewide Transition Plan, 235
subcutaneous (SQ), 190
Substitute Care, 113, 248, 254
Supervision, 50, 92, 106, 110, 120, 124, 128, 157, 158, 160, 163, 164, 167, 168, 169, 184, 205, 247, 284

Supported Living, 115–21, 122, 124, 155, 181, 182, 183, 187, 204, 214, 222, 224, 228, 240, 241, 248, 251, 255, 267, 268, 273, 284, 291, 292, 293, 295, 296, 297, 299, 300, 301, 302, 303, 326, 327

T

Teaching and Support Strategies (TSS), 49, 50, 70, 71, 78, 88, 125, 127, 155, 166, 175, 228, 230, 319
Team Justification Process, 23
Technical Assistance, 36, 49, 89, 93, 216, 243, 244, 245, 323, 324
teleconference, 68, 69, 93, 94, 125, 266
telehealth, 62, 105, 106, 107, 111, 127, 154, 155, 161, 166, 170, 181, 207
The Council on Quality and Leadership, 240
Therap, 44, 45, 88, 89, 94, 101, 188, 192, 194, 267, 268, 269, 270, 271, 272, 273, 275, 276, 277, 279, 297, 298, 307, 323
S-Comm, 269, 270, 272, 273
Therapy, 76, 94, 109, 110, 120, 128, 152, 165–79, 248, 257, 273, 284, 291, 300, 323
Therapy Evaluation, 176, 300
Third Party Assessor (TPA), 17, 19, 81, 84, 86, 89, 93, 98, 280, 319
Trainer Designation Record, 261
Training Code of Ethics, 262
Training Database, 262, 288
Training Unit, 91, 262, 324
Transdisciplinary Evaluation and Support Clinic (TEASC), 101
Transition, 68
ITP, 99
transition meeting, 93, 94, 96, 99, 101, 188
Transitions, 69, 97, 93–102, 184, 186, 239

U

Utilization Review, 283

V

Verification of Benefit Availability, 219, 222, 295

W

Waiver Change Form, 99
Withdrawal, 238
Workforce Innovation and Opportunity Act (WIOA), 10
Written Direct Support Instructions (WDSI), 60, 70, 71, 78, 109, 110, 120, 124, 125, 126, 127, 128, 156, 166, 171, 172, 173, 174, 175, 178, 179, 228, 294, 320

Lists

List 1 Acronyms

| | | | |
|-------------|---|---------|---|
| ADA | Americans with Disabilities Act | CRU | Central Registry Unit |
| ADL | Activities of Daily Living | DDSD | Developmental Disabilities Supports Division |
| ANE | Abuse Neglect and Exploitation | DDSQI | Developmental Disabilities Services Quality Improvement |
| ARA | Annual Resource Allotment | DC/TJF | Decision Consultation and Team Justification Form |
| ARM | Aspiration Risk Management | DCP | Decision Consultation Process |
| ARST | Aspiration Risk Screening Tool in Therap | DHI | Division of Health Improvement |
| AWMD | Assistance with Medication Delivery | DME | Durable Medical Equipment |
| AT | Assistive Technology | DOH | Department of Health |
| BBS | Bureau of Behavioral Supports | DSP | Direct Support Professional |
| BCIP | Behavior Crisis Intervention Plan | DVR | Division of Vocational Rehabilitation |
| BSC | Behavior Support Consultation | ECHAT | Electronic Comprehensive Health Assessment Tool in Therap |
| BWS | Budget Worksheet | EMSP | Environmental Modification Service Provider |
| CARMP | Comprehensive Aspiration Risk Management Plan | EPR | Emergency Physical Restraint |
| CARMP Draft | CARMP IDT Process in Therap | EPSDT | Early Periodic Screening Diagnosis and Treatment |
| CCS | Customized Community Supports | EVV | Electronic Visit Verification |
| CIA | Client Individual Assessment | FRC | Friends and Relationships Course |
| CIE | Community Integrated Employment | GER | General Events Reporting |
| CIHS | Customized In-Home Supports | GERD | Gastro Esophageal Reflux Disease |
| CIU | Client Information Update | H&P | Health and Physical |
| CMA | Certified Medication Aide | HCBS | Home and Community Based Services |
| CMS | Centers for Medicare and Medicaid Services | HCP | Health Care Plan in Therap ICP |
| COE | Category of Eligibility | HIPAA | Health Insurance Portability and Accountability Act |
| CoP | Condition of Participation | HRC | Human Rights Committee |
| CPA | Corrective and Preventive Action Plan | HSD | Human Services Department |
| CPB | Community Programs Bureau | IASP | Individual Action and Safety Plan |
| CPR | Cardiopulmonary Resuscitation. | I/DD | Intellectual and/or Developmental Disabilities |
| | | ICF/IID | Intermediate Care Facility for Individuals with ID |

| | | | |
|---------|---|---------|---|
| ICP | Individual Care Plan in Therap | PCA | Person Centered Assessment |
| ID | Intellectual Disability | PCP | Person-centered planning |
| IDEA | Individuals with Disabilities Education Act | PPN | Primary Provider Nurse |
| IDT | Interdisciplinary Team | PEU | Provider Enrollment Unit |
| IEB | Intake and Eligibility Bureau | PFOC | Primary Freedom of Choice |
| IMB | Incident Management Bureau | POC | Plan of Correction |
| IMLS | Intensive Medical Living Services | PPMP | PRN Psychotropic Medication Plans |
| IQR | Individual Quality Review | PRN | Pro Re Nada- as-needed |
| IRC | Internal Review Committee | PRSC | Preliminary Risk Screening and Consultation |
| ISD | Income Support Division | PT/ PTA | Physical Therapy/Therapy(ist)/ PT Assistant |
| ISP | Individual Service Plan | QA | Quality Assurance |
| IST | Individual Specific Training | QI | Quality Improvement |
| ITP | Individual Transition Plan | QIS | Quality Improvement Strategy |
| JCM | Jackson Class Member | QMB | Quality Management Bureau |
| KPI | Key Performance Indicator | RFI | Request for Information |
| LCA | Living Care Arrangement | RMP | Risk Management Plan |
| LOC | Level of Care | RN | Registered Nurse |
| LPN | Licensed Practical Nurse | RORA | Regional Office Request for Assistance |
| MAAT | Medication Administration Assessment Tool in Therap | RPST | Remote Personal Support Technology |
| MAR | Medication Administration Record | SComm | Secure Communication in Therap |
| MCO | Managed Care Organization | SE | Supported Employment |
| MERP | Medical Emergency Response Plan in Therap ICP | SFOC | Secondary Freedom of Choice |
| NMAC | New Mexico Administrative Code | SLP | Speech Language Pathologist |
| Nurse | RN or LPN | SSE | Socialization and Sexuality Education |
| OOHP | Out of Home Placement | SARL | Statewide Aspiration Risk List |
| OR | Outside Review(er) | TPA | Third Party Assessor |
| OT/COTA | Occupational Therapy/Therapist/Certified OT Assistant | TSS | Teaching and Support Strategies |
| PBS | Positive Behavior Support | WCF | Waiver Change Form |
| PBSA | Positive Behavior Supports Assessment | WDSI | Written Direct Support Instructions |
| PBSP | Positive Behavior Supports Plan | WIOA | Workforce Innovation and Opportunity ACT |

List 2 Authorities

7.1.12 NMAC Health- Health General Provisions Employee Abuse Registry
7.1.14 NMAC Health-Health General Provisions Abuse, Neglect, Exploitation and Death Reporting, Training and Related Requirements for Community Provider Agencies
7.1.9 NMAC Health-Health General Provisions Caregivers Criminal History Screening Requirements
7.14.2 NMAC Quality Management System and Review Requirements for Provider Agencies of Community Based Services
7.14.3 NMAC Incident Reporting and Investigation Requirements for Provider Agencies of Community Based Services
7.26.3 NMAC Health Developmental Disabilities Rights of Individuals with Developmental Disabilities Living in the Community
7.26.4 NMAC Health Developmental Disabilities Client Complaint Procedures
7.26.5 NMAC Developmental Disabilities Service Plans for Individuals with Developmental Disabilities Living in the Community
7.26.6 NMAC Health Developmental Disabilities Requirements for Developmental Disabilities Community Programs
7.26.7 NMAC Health Developmental Disabilities (Appendix A) Individual Transition Planning Process
7.26.8 NMAC Health Developmental Disabilities (Appendix A) Dispute Resolution Process
7.28.2 NMAC Health Home Health Services Requirements for Home Health Agencies
7.30.8 NMAC Health Family & Children Health Care Services Requirements for Family Infant Toddler Early Intervention Services
8.200.400 NMAC Social Services Medicaid Eligibility -General Recipient Policies General Medicaid Eligibility
8.290.400 NMAC Social Services Medicaid Eligibility Home and Community Based Services Waiver (Categories 091,092,093,094,095,096)
8.302.2 NMAC Social Services Medicaid General Provider Agencies Policies Billing for Medicaid Services
8.310.2 NMAC Social Services- Health Care Professional Services General Benefit Description
8.313.2 NMAC Social Services- Long Term Care Services- Intermediate Care Facilities Intermediate Care Facilities
8.314.5 NMAC Social Services Long Term Care Services- Waivers Developmental Disabilities Home and Community -Based Services Waiver
8.351.2 NMAC Social Services Sanction or Remedies Sanctions and Remedies
8.352.2 NMAC Social Services Administrative Hearings Claimant Hearings
9.4.21 NMAC Human Rights Persons with Disabilities Guardianship Services
16.12.5 NMAC Occupational and Professional Licensing Chapter 12 -Nursing and Health Care Related Provider Agencies Part 5- Medication Aides
MAD:95-59 Provider Policies Case Management Services
MAD-MR: 10-22 Health Care Professional Services Dental Services
MAD-MR 10-14(8.290.500) and MAD-MR 12-14 (8.290.600) Medicaid Eligibility Home & Community Based Services Waiver Categories 090,091,092,093,094,095,096
NMSA 1978, § 45-5-301.1, New Mexico Statute
HSD/DOH Medicaid Waiver Case Management Code of Ethics
42 CFR Part 441, Subpart G - Home and Community-Based Services: Waiver Requirements
CMS Rulings such as decisions of the Administrator, precedent final opinions, orders and statements of policy and interpretation
Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the CMS Administrative Simplification Provisions
Fair Labor Standards Act of 1938 (FLSA), as amended 29 USC §201 et seq.; 29 CFR Parts 510 to 794
Pharmacy Act (Chapter 61, Article 11 NMSA 1978)
Rehabilitation Act of 1973, Public Law 93-112, September 26, 1973
New Mexico Nursing Practice Act, Chapter 61, Article 3, New Mexico Statute Authority (NMSA)
The DDS/DCBS Waiver Provider Agreement
HSD Medicaid Program Policy Manual
HSD Medical Assistance Division Provider Participation Agreement (MAD 335)
Individuals with Disabilities Education Act (IDEA) , Part C
Education Department General Administrative Regulations (EDGAR)

List 3 State Agencies, Divisions and Bureaus

Department of Health (DOH): provides a statewide system of Health Promotion and Community Health Improvement, Chronic Disease Prevention, Infectious Disease Prevention, Injury Prevention, and other Public Health services.

Developmental Disabilities Supports Division (DDSD): oversees three home and community based services (HCBS) 1915 (c) Medicaid waiver programs: the DD Waiver (Traditional Waiver), the Medically Fragile Waiver, and the Mi Via (Self-Directed) Waiver. The DDSD also administers the Family Infant Toddler (FIT) Program for children birth to three years old with or at risk for developmental delay or disability and provides several State General Funded (SGF) services. The DDSD is made up of 7 bureaus and additional program units.

Bureau of Behavioral Support (BBS): oversees all behavioral support, crisis, and sexuality needs statewide, aiding people and their support teams via SGF and DD Waiver programs. They are a resource for all questions pertaining to: Behavioral Support Consultation (BSC), Socialization and Sexuality Education (SSE), Crisis Supports, and Preliminary Risk Screening and Consultation (PRSC).

Clinical Services Bureau (CSB): provides technical assistance pertaining to Therapy questions, Nursing, Nutritional Counseling, Assistive Technology, and Remote Personal Support Technology (RPST).

Community Inclusion Unit: oversees Meaningful Day or Adult Habilitation activities along with activities related in assisting people with I/DD in obtaining and maintaining employment in the community.

Community Programs Bureau (CPB): oversees the DD Waiver, the self-directed Mi Via Waiver, the Supports Waiver, the Provider Enrollment Unit, the DD Waiver Case Management Unit and the Outside Review.

Provider Enrollment Unit (PEU): oversees Provider Agreements, Accreditation and maintains the SFOC forms.

Intake and Eligibility Bureau (IEB): The Intake and Eligibility Bureau (IEB) is comprised of the Central Registry and the Pre-Admission Screening and Resident Review (PASRR) units. The Central Registry Unit is responsible for the Central Registry Database and Wait List management activities for all waivers managed by DDSD. This includes processing DD Waiver registrations and applications, making application Eligibility Determinations for DD/IDD, and managing the Allocation Process for Developmental Disabilities Waiver/Mi Via Self-Directed Waiver and offer process for the Supports Waiver programs.

Litigation Management Bureau (LMB): oversees compliance with DDSD litigation, as well as other compliance tracking and follow up activities. The LMB facilitates document production and agency review conferences related to administrative Fair Hearings.

Regional Office Bureau (ROB): oversees the DD Waiver and Adult Residential and Day State General Fund programs. Oversight responsibilities include case management agency and service provider compliance with standards, regulations, and provider agreements. In addition, the ROB provides ongoing technical assistance, conflict resolution, contract management, and guidance to individual teams and programs.

Bureau of Systems Improvement (BSI): encompasses the Training, Data Management and Therap Units as well as the Office of Constituent Supports (OCS).

Data Management Unit: provides data reporting and analysis support to DDS and DOH overall.

Therap Unit: The Therap Unit provides support, technical assistance, data management/analysis to DDS and DD Waiver Provider Agencies utilizing the Therap system. The Therap Unit coordinates the annual state conference and the New Mexico page on Therap.

Training Unit: provides core curriculum training for CMs, Service Coordinators, Direct Support Professionals, and Direct Support Supervisors who work with people on the DD Waiver. The training unit also provides training for Train-the-Trainers for DDS core curriculum, as well as the Self-Advocacy Projects.

Office of Constituent Support: provides community resource and referral, team facilitation (including mediation and dispute resolution for interdisciplinary teams), community outreach, education regarding the services and supports provided by DDS.

Division of Health Improvement (DHI): provides compliance oversight for HCBS Waivers.

Quality Management Bureau (QMB): is a DOH / DHI oversight and monitoring entity, which conducts compliance surveys of agencies who have a provider agreement with the DDS to provide HCBS 1915c waiver services including. QMB consist of 2 distinct survey teams.

Community Program Compliance: The unit conducts on-site, systems-based surveys and other quality improvement activities related to the health, welfare and safety of Individuals receiving DD Waiver: Case Management, Living Care Arrangements, Inclusions Services; Mi Via Consultant Services; Med Frag: Case Management, Home Health, Respite and Private Duty Nursing Services.

Individual Quality Review (formerly the Jackson Community Practice Review): This group specifically conducts quality surveys of those individuals identified as Jackson Class Members. This is an extensive individual review of Jackson Class Member services and supports. The IQR determine if all the individual's health related needs are being met, as well as ensuring that the individuals Individual Service Plan is being implemented as called for.

Incident Management Bureau (IMB): conducts investigations and provides data-tracking of reported allegations of Abuse, Neglect & Exploitation (ANE) to improve the quality of services to prevent the abuse, neglect and exploitation of persons receiving services in community based HCBS waiver programs.

Human Services Department (HSD): serves over 800,000 New Mexicans by administering several large state and federally funded programs including Medicaid, Temporary Assistance for Needy Families (TANF), Food Stamps, and Child Support Enforcement.

Medical Assistance Division (MAD): Manages and administers the Medicaid program.

Exempt Services Bureau (ESPB): Administers the Medicaid 1915 (c) Home and Community-Based Waivers for the Mi Via, Medically Fragile and Developmental Disabilities Waiver programs. ESPB also manages various programs and contracts related to long-term care and school-based services.

Income Support Division (ISD): Determines eligibility and issues benefits for HSD assistance programs.

Tables

Table 1 Proposed Budget Levels

| PBL | Table 1 Proposed Budget Levels (PBLs) 1-7, with descriptions of typical support needs |
|-----|--|
| 1 | Adults in Proposed Budget Level 1 have minimal needs and require the least amount of staff support. Most of these adults have mild intellectual disabilities and can manage many aspects of their lives independently. Supports are typically of an intermittent nature, and people can spend significant amount of time alone and/or with unpaid natural supports. In general, they can engage independently in the community. |
| 2 | Adults in Proposed Budget Level 2 require more support than those in Budget Level 1, but typically only receive intermittent, rather than 24/7, paid supports. People in this Budget Level spend some alone, engaging independently in certain community activities and/or with unpaid natural supports. Many of these people have mild intellectual disabilities, although broader ranges of intellectual disabilities do occur in this Level. Although these people require more support to meet personal needs than those in Budget Level 1, their support needs are still minimal in several life areas. |
| 3 | Adults in Proposed Budget Level 3 include those who have mild to above average support needs and moderate to above average behavioral challenges but do not meet the extensive behavior support criteria of people in Budget Level 7. Adults in this group may be appropriate for 24/7 supports due to their behavioral issues and/or mental health diagnosis. Behavioral needs must indicate significant supervision needs due to a high frequency of disruptive behavior and/or presence of destructive behavior. Examples include behavior that impacts the person’s ability to retain a baseline level of independence, that interferes with quality of life, or that involves a health and safety risk needing behavioral recommendations to establish a safety net. Behavioral needs for these people, however, do not preclude them from engaging in many activities independently or semi-independently. |
| 4 | Adults in proposed Budget Level 4 have above average support needs relative to ADL. Support needs of those in Budget Level 4 may be associated with their level of intellectual disability. For people in this Budget Level, behavioral support needs range from mild to average and medical support needs are minimal. People in this level will require at least semi-regular 1-to-1 support in ADL or hands-on nursing support for medical needs. |
| 5 | Adults in Proposed Budget Level 5 have the highest support needs relative to ADL, which may also include significant physical supports. Some people in this group have medical support needs, although not in an amount to meet criteria for Budget Level 6. Support needs of those in Budget level 5 may be associated with their level of intellectual disability and some people may have mild to above average behavioral support needs. |
| 6 | Adults in Proposed Budget Level 6 have extensive to very complex medical support needs that require nurse management to minimize medical risk factors. Typically, maximum assistance with ADL is required to meet their extensive physical support needs and personal hygiene, including lifting/transferring and positioning. Someone in this Budget Level may be medically unstable or receiving hospice services due to diagnosed medical conditions. Having conditions that require regular significant medical attention or the need for regular hand-on support due to tube feedings, frequent seizures, etc. warrant inclusion in this Budget Level. |
| 7 | Adults in Proposed Budget Level 7 have extraordinary behavior support needs. These people typically require one-to-one supervision for at least a significant portion of each day. Many people in this group may have a mental health condition in addition to a developmental disability. Typically, these people would pose a safety risk to themselves or the community without continuous support. Placement in this group is generally not correlated to the person’s degree of ID. |

Table 2 Suggested Dollar Amounts²

| | | |
|------------------|---|------------|
| PBL 1 | CIHS: Living Independently 12 hours /week of paid in-home supports, 5 hours a week of CCS Group and 12 months of employment support. | \$ 35,020 |
| | CIHS: Living at Home with Family 10 hours a week of paid in-home supports, 5 hours a week of CCS Group and 12 months of employment support. Additionally, 500 hours per year of paid respite. | \$ 41,502 |
| | Family Living: 365 days of residential support. 12 months of employment supports and 5 hours per week of CCS-Group. | \$ 58,495 |
| | Supported Living: 365 days of residential support including 18 hours of nursing support per year, 12 months of employment supports and 20 hours per week of CCS-Group. | \$ 97,431 |
| 2 | CIHS: Living Independently: 18 hours a week of paid in-home supports, 10 hours a week of CCS Group and 12 months of employment support. | \$ 46,273 |
| | CIHS: Living at Home with Family: 15 hours a week of paid in-home supports, 10 hours a week of CCS Group and 12 months of employment support, and 500 hours per year of paid respite. | \$ 51,327 |
| | Family Living: 365 days of residential support, 12 months of employment supports and 10 hours per week of CCS Group. | \$ 61,175 |
| | Supported Living: 365 days of residential support including 18 hours of nursing support / year, 12 months of employment and 20 hours/ week of CCS-Group | \$ 97,431 |
| 3 | CIHS: Living Independently: 20 hours a week of paid in-home supports, 15 hours a week of CCS Group and 12 months of employment support. | \$ 51,811 |
| | CIHS: Living at Home with Family: 20 hours a week of paid in-home supports, 15 hours a week of CCS-Group and 12 months of employment support, 750 hours per year of paid respite. | \$ 65,821 |
| | Family Living: 365 days of residential support, 12 months of employment supports and 20 hours per week of CCS Group. | \$ 66,535 |
| | Supported Living: 365 days of residential support including 60 hours of nursing support/ year. Day service assumptions include 12 months of employment supports and 20 hours/ week of CCS Group. | \$ 113,867 |
| 4 | CIHS: Living Independently 25 hours a week of paid in-home supports, 20 hours a week of CCS Group and 12 months of employment support. | \$ 61,636 |
| | CIHS: Living at Home with Family: 20 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 12 months of employment support. Additionally, 750 hours per year of paid respite. | \$ 68,501 |
| | Family Living: 365 days of residential support, 12 months of employment supports and 20 hours per week of CCS-Group. | \$ 66,535 |
| | Supported Living: 365 days of residential support including 60 hours of nursing support/ year,12 months of employment supports and 20 hours/week of CCS-Group. | \$ 113,867 |

| PBL | Table 2 (cont.)² | |
|------------|--|------------|
| 5 | Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group . | \$ 69,901 |
| | Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite. | \$ 85,813 |
| | Family Living: 365 days of residential support.,5 hours per week of CCS-I and 20 hours per week of CCS-Group. | \$ 72,415 |
| | Supported Living: 365 days of residential support including 120 hours of nursing support per year, 10 hours per week of CCS-I and 20 hours per week of CCS-Group. | \$ 154,263 |
| 6 | Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group. | \$ 74,661 |
| | Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite. | \$ 85,813 |
| | Family Living: 365 days of residential support. Day service assumptions include 10 hours per week of CCS-I and 15 hours per week of CCS-Group. | \$ 74,385 |
| | Supported Living: 365 days of residential support including 120 hours of nursing support per year, 10 hours per week of CCS-I and 20 hours per week of CCS-Group. | \$ 154,263 |
| 7 | Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group. | \$ 74,661 |
| | Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite. | \$ 85,813 |
| | Family Living: 365 days of residential support, 10 hours per week of CCS-I and 15 hours per week of CCS-Group. | \$ 74,385 |
| | Supported Living: 365 days of residential support including 120 hours of nursing support per year. Day service assumptions include 10 hours per week of CCS-I and 20 hours per week of CCS-Group. | \$ 154,263 |

¹ Dollar amounts may change based on current published fee schedule. Check budget worksheets for current amounts.

DDSD Contact Information:

DDSD Community Programs Bureau

DD Waiver Unit
810 San Mateo, suite 104
Santa Fe, NM 87505
505-476-8913

DDSD Regional Offices

Metro Regional Office

5301 Central Ave NE, Suite 1700
Albuquerque, NM 87108
505-841-5500 (Phone)
800-283-5548 (Toll-Free)
505-841-5554 (Fax)

Southeast Regional Office

726 South Sunset, Suite B
Roswell, NM 88203
575-624-6100 (Phone)
866-895-9138 (Toll-Free)
575-624-6104 (Fax)

Northeast Regional Office

224 Cruz Alta, Suite B
Taos, NM 87571575-758-5934 (Phone)
866-315-7123 (Toll-Free)
575-758-5973 (Fax)

Southwest Regional Office

1170 North Solano Drive, Suite G
Las Cruces, NM 88001
575-528-5180 (Phone)
866-742-5226 (Toll-Free)
575-528-5194 (Fax)

Northwest Regional Office

2910 East Route 66
Gallup, NM 87301
505-863-9937 (Phone)
866-862-0448 (Toll-Free)
505-863-4978 (Fax)
or
355 S. Miller Avenue
Farmington, NM 87401
505-326-3148 (Fax)