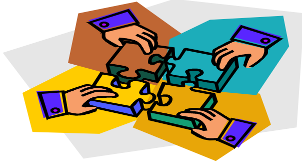

2016 Community Practice Review

Protocol #1: General Information

Jackson v. Ft. Stanton

Date:
Person's Name:

Reviewer's Name:
Provider Name:

General Information from Case Management Record

Diagnoses

Neuroleptic Meds

Assessments

Team Meetings

Case Management Contacts

Progress & Regression

ADAPTIVE EQUIPMENT

Questions for Nurses

Questions for PT

Questions for SLP

Questions for OT

Other Information Notes

Procedures for Data Collection: Record Review

In advance of the review, you are to have received and reviewed the individual's current ISP, previous ISP and assessments. **Assessments that are not sent to you in advance are to be provided by the case manager during your record review and/or interview.** The record review conducted during the review includes the individual's primary record kept by the case manager.

The record review is intended to be the means to gather readily accessible, useful information about the Participant assigned. The information sought in the protocol should be available in the Participant's current/active/working record. The record review is not intended to be an exhaustive document search. The Reviewer is not required to search the historical/inactive/"dead" records or files for information unless such a search is needed to substantiate a specific issue discovered during the review.

If you cannot find a document or information, ask the case manager and/or relevant provider staff. If knowledgeable staff says the document or record does not exist, note this, along with the name of the person who told you this, in the protocol book.

The week prior to the review start date, you should have received a copy of the current and previous ISP and all current assessments. You are expected to review this file in advance of the onsite or early bird start date. If the copies have not been provided, please identify the documents and ask the appropriate Regional Program Manager for copies to be made available to you in advance of the on site review. NOTE on the Document Request ALL requests for document. If there are problems securing copies of the needed documents during the review, notify your Case Judge immediately.

The Reviewer **MUST finish the initial record review and complete the documentation in the protocol booklet prior to proceeding** to the next phases of the protocol. It is the Reviewer's responsibility to acquire the information necessary to complete the protocol.

I. General Information (from Case Management Record)

YOU MUST PR OVIDE AN ANSWER TO EVERY QUESTION.

* 1. Social Security Number	2. Date of Birth	* 3. Current Age	* 4. Gender	* 5. Current Address (Include Zip Code)	* 6. Telephone	* 7. Ethnicity
/ / Source	Source		***Choose***		- -	***Choose*** If Other, specify:

* 8.a. Preferred language:	* 8. b. Preferred means of communication:	* 9. Does this Participant have a legal guardian? ***Choose***	9.a. Legal Guardian Name: Address: City, State: ZIP Code:	9.b. Telephone: (Address if no phone): - -

* 10. Guardianship Status (based on legal documents found in record). **Check the <u>one</u> that applies**	☐ a. Full (plenary)	☐ b. Limited (specify) ____	☐ c. None, this person is his/her own guardian and the team feels this is appropriate.	☐ d. Could Not Determine	☐ e. This person does not have a guardian but the team feels the person needs a guardian.

NOTE: Limited guardianship will state specifically what the guardian has authority to do, such as make financial and medical decisions. Full or Plenary guardianship papers may not specify what authority the guardian has, or may list many general things, such as all financial, medical, treatment, and placement decisions. If the document only states the guardian cannot make decisions for the person regarding marriage, children, and voting, that is NOT a limited guardianship; it is a Plenary Guardianship.

NOTE Questions #11 to #14: Do not rely on any one document for this information. This information can often be found in psychological evaluations, the Level of Care form, and many assessments.

Note Axis Definitions: Axis I: Major psychiatric disorders; Axis II: Level of mental retardation; secondary psychiatric disorders; Axis III: Physical health

* 11. Please list the person's Acuity Level as identified in Therap.	Choose

Source for Question #11:

	DIAGNOSIS	WHERE DID YOU FIND THIS INFORMATION?	DATE OF THE DOCUMENT	NAME OF TITLE OF AUTHOR
*12. Axis I				
Major Psychiatric Disorders				
* 13. Axis II				
Level of MR, Secondary psychiatric disorders				
* 14. Axis III				
Physical health				
* 15. Other conditions				

* 16. Does this Participant currently take medications? ***Choose One***

Note: A list of current medications is to be recorded in Residential Services Provider Interview, page 83. Be sure that all current medications are listed on page 83 so you can check them at this person's home.

For questions 17-19, the Reviewer is asked to rate each item as either 0, 1, 2 or N/A. The meaning of each rating is as follows:
0 - Information not present or not adequate (non-compliance)
1 - Information is not completed or partially adequate (partial compliance)
2 - Information present and found to be adequate (full compliance)
N/A - Item not applicable to this Participant

*17. If Participant is on a neuroleptic medication, is there evidence of involuntary movement screening and follow-up? (choose **one**)	***Choose***
*18. If needed, is there evidence of ongoing tracking of seizures? (choose **one**)	***Choose***
* 19. If needed, is there evidence of required blood work? (choose **one**)	***Choose***

*20. Name of Case Management Agency: _____

*21. Name of Residential Agency: _____

*22. Type of Residential Model: Choose One

NOTE DDSD Definitions: If the Participant lives in own home with non-paid family but receives personal care/respite services, record that provider information in Question #25. New service titles for individuals who have converted to the new DD Waiver are indicated in parenthesis.

☐ **Family Living:** Services are provided to Participant in a family setting. (Actual family or surrogate foster-type family).

☐ **Independent Living: (Customized In-Home Supports)** More independent environment. Staff support is available when needed and furnished on a planned, periodic schedule. Such intermittent

support may occur in a home they share with other family members or non-disabled friends or may occur in their own apartment/home where they live alone or with a peer roommate.

☐ **Supported Living**: Services are provided to an individual or in groups of 4 or less. Service is provided 24 hours with the exception of time spent in education/employment setting.

☐ **(Intensive Medical Living):** Similar to Supported Living, but includes a daily nursing visit and expanded support for highly complex medical needs. This service is based upon a higher reimbursement rate for the extra medical oversight, but does not indicate a certain location. Individuals receiving Intensive Medical Living may have roommates that receive regular Supported Living. This rate is also available short term in certain circumstances such as post-hospital stabilization.

☐ **Other:** If a class member is not in a service described above, please put other and describe what type of service the class member is receiving.

If Other, please describe:

*23. Number of residences in which the individual has lived within the last year (Count the current home, too):

*24. Day/Employment Program(s):

a) Name of Agency/Agencies:

____

____

____

____

b) Type of Program(s):
(Note day activity v. sheltered workshop v. supported employment)

NOTE DDSD definitions

☐ **Individual Supported Employment: (Community Integrated Employment - Individual):** Face-to-face support of Participant placed in community-based employment. Supervision and support is furnished in response to the Participant's needs and preferences.

☐ **Intensive Individual Supported Employment:** Direct on-the-job job coaching of persons placed in community-based employment. Utilized for persons when supported employment services are not sufficient to adequately support an individual in a community placement. (Note: as people switch into the new DD Waiver, the Supported Employment reimbursement is based upon a fifteen minute unit instead of a monthly rate making this service unnecessary.)

☐ **Group Supervised Employment: (Community Integrated Employment - Group):** On-site supervision of persons working as part of an integrated group in community-based employment.

Supervision is furnished on a continuous, full-time schedule by a provider.

☐ **Self Employment:** assistance with the development of business plans, marketing, banking, and other services relating to the implementation of their business plan;

(Job Development): activities to assist an individual to plan for, explore and secure Community Integrated Employment.

☐ **Community Access: (Customized Community Supports - Individual and/or Small Group):** Is designed to: promote maximum participation in community life; support individuals in achieving their personal outcomes; promote self-advocacy; and enhance an individual's ability to control their environment.

☐ **Personal Support: (Community Inclusion Aide):** A non-medical service assisting the individual with activities of daily living to maintain personal care, self help and independent living skills. These services take place in the individual's Customized Community Supports, Employment or Customized In-Home and/or settings and are provided on a one-to-one staff-to-person served ratio.

☐ **Adult Habilitation: (Customized Community Supports - Group):** Daily program of group activities designed to increase the individual's skills in performing routine functions. Services take place outside the individual's residential setting.

Note: Individuals can receive combinations of services. For example, an individual might receive Supported Employment part time and Community Membership. If individuals are receiving combinations of services, check all the services the person receives.

*25. Other major providers (e.g., behavior management, specialized or generic psychotherapy, PT, SLP, Adult Nursing, etc.):

Providers	Services/Dates Receiving That Service
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

5. _____ _____

BEFORE PROCEEDING PLEASE INSURE THAT YOU HAVE ANSWERED ALL OF QUESTIONS 1-25.

Documentation of Relevant Information (from Case Management Record)

The following pages are provided for the Reviewer to record information found in the case management file that is relevant to the Summary Questions to be answered at the end of the protocol. The Reviewer should be very familiar with the specific questions in the Summary Questions Section prior to reviewing the primary record/case management file. To assist the Reviewer in recording and finding information needed to complete the Summary Questions Section, the following pages have been formatted by subject area with a brief guide to the information to be recorded in each section.

This space is "working paper" for the Reviewer. Information recorded here will be used as evidence to support determinations made in the Summary Questions Section of the protocol. Record the date and source of any information recorded on these pages. The Reviewer may summarize or paraphrase the information found in the record or may record the information verbatim.

Notes on Assessments. Copies of all current assessments should have been provided with the initial packet of information. If not, they must be requested and, if possible, obtained by the Reviewer. Use this space to record information about assessments indicated as needed but not found, efforts to arrange any missing assessments, and any pertinent information found in the case manager's notes about the assessments.

Consider the following types of assessments: physical health; dental; psychological; behavioral; psychiatric; physical therapy; occupational therapy; daily living skills; vision; hearing; communication/speech; social/recreational; vocational/employment; other: i.e., neurological; self-administration of medications; nutritional; etc.

For each assessment, the Reviewer needs to review the Professional Judgment Standard in this document and Reviewer's Guide.

ASSESSMENTS THAT ARE NOT DATED AND/OR NOT SIGNED BY THE EVALUATOR CANNOT BE CONSIDERED. An assessment cannot be considered adequate if it does not include clear information that can be used for planning. The mere presence of a piece of paper titled an assessment does not automatically warrant a "1" rating if the contents do not approach the Professional Judgment Standard.

***Note to Reviewer: Please be sure to include information on,** Behavioral, Career/Vocational Assessments and Aspiration Screens.

If you find that recommendations made in an assessment are not followed or are followed incorrectly, be sure to provide detail regarding the source document of the recommendation not being followed so teams can refer back to them. Use the back of this page if necessary.

Note assessments completed in the past year.

These assessments are required annually: History & Physical Exam—required for everyone; e-CHAT)—required for everyone; Medication Administration Assessment Tool (MAAT) is required annually for everyone, Comprehensive Individual Assessment (CIA)—required for everyone. The Aspiration Risk Screening Tool is only required annually for those individuals who previously scored as low aspiration risk and who, therefore, are not required to have a Comprehensive Aspiration Risk Management Plan.

NOTE: Jackson class members may have a Mealtime Plan, but only if they are not at moderate or high risk for aspiration but they have special dietary/eating needs unrelated to aspiration risk such as no-gluten for those with Celiac's or chopped soft for an elder with several missing teeth. If they have additional factor(s) in addition to aspiration risk - everything should be incorporated into the CARMP and there should not be a separate MTP. (JTL)

Assessments requirements should be identified in the ISP: Positive Behavior Supports Assessment; Occupational Therapy (OT) Assessment; Physical Therapy (PT) Assessment; Speech Therapy (SLP) Assessment; Vision Exam; Dental Exam; Neurological Exam; Psychiatric Exam; Vocational Assessment; Aspiration Screens; TEASC, SAFE clinic, and other clinic exams/assessments.

Date of Source Document	Name of Source Document	Type of Assessment Provided	Recommendations Made	Recommendations made by: give name and title.	If needed documents are not available, give name & title of who you ask for this information?

Notes on Team Process. Record information found on the frequency of IDT meetings; topics discussed during any IDT meetings; any communication among the IDT members outside of formal meetings including the "topic" of any communication; information about unusual incidents and any IDT follow-up; or any information pertinent to how the team is functioning for this Participant.

Note: The IDT shall consist of: person served, case manager, guardian (if applicable), direct service staff from each provider agency and ancillary service providers (if applicable) such as therapists, nurses, vocational specialists, behavioral support consultant, etc. The team may also include a friend advocate, physician, psychiatrist, psychologist, family member and/or legal representative. Participation of ancillary service providers does not require the provider's physical presence at the IDT meeting. Their participation can be accomplished through the submission of assessments/progress reports, through conference call, or through meeting with another team member prior to the meeting to discuss issues/concerns/recommendations. This is also true for nurses in cases where urgent health needs of another individual prohibited their attending in person.

If you find specific meeting/incidents which resulted in a score of a "0" or "1", be sure you document information. ***Note all IDT meetings held in the past year, including Annual ISP meetings (6 month ISP reviews are no longer required) and all interim IDT meetings held to review and/or revise the ISP...*** If other relevant meetings have been held you may note them here as well e.g. Aspiration Reviews.

Date of Meeting	Type of Meeting or Incident	Follow Up Required or Agreed Upon	Evidence that Follow Up Was done/not? Cite Source.

Notes on Monitoring and Coordination of Services by Case Manager. Record information on case manager contact with the person; the frequency and outcome of case manager visits and telephone calls to the person's home and day program/work site; case manager contacts with ancillary providers; information about the outcomes and/or recommendations of physician/dental visits; case manager efforts to locate and secure needed services.

Note: Case Managers are to see class members at least 2 times per month. Note contact with other team members. Look for patterns… when the Case Manager visits is the person always in bed? Is there progress on Outcomes/Action Plans? Does the Case Manager always visit at the same time and same place (their visits are to be at different times and in multiple places)? IDT meetings do count as a face-to-face meeting for that month.

If you find problems, e.g., inadequate number of contacts, inadequate follow up, inadequate attention to issues when visiting, etc; please note those details.
ALSO: Note home visits and site visits as well as contacts with providers, the individual, the guardian, and others such as the individual's healthcare providers, follow-ups for appointments and exams, etc. within the past year. Also note Aspiration Quarterly Reviews done by the Case Manager. Note: If you see exemplary intervention please note in Individual Summary and Good News Section of the Findings and Recommendations.

Contact Date & Time of Day	Location of Contact	Issue	What happened as a result of the lack of meaningful contacts/follow up?	Source Documents (Evidence verifying your findings)

Contact Date & Time of Day	Location of Contact	Issue	What happened as a result of the lack of meaningful contacts/follow up?	Source Documents (Evidence verifying your findings)

Notes on Progress/Regression Information. Record information related to the person's progress/growth. This may include information (progress reports) generated by service providers and/or ancillary providers that was found in the person's record. Use this space to make notes about the type (data only, data and written summaries) of information found specific to outcomes on the ISP. Include information about growth/progress that may not be specific to outcomes in the ISP. If you find problems such that you will score either a "0" or a "1", note those details. **ALSO:** List provider reports for the past year which may include but not be limited to: Residential monthly/quarterly/semi-annual progress reports; Day/Employment monthly/quarterly/semi-annual progress reports; BSC quarterly/semi-annual reports; OT 6-month reports; PT 6-month reports; SLP 6-month reports; Psychiatric visit reports/notes. Nurses are required to provide quarterly reports for people who score a moderate or high on the e-CHAT. Once the individual comes under the new standards the frequency of such reporting will be reduced from quarterly to semi-annually unless the individual receives Intensive Medical Living Services. Intensive Medical Living Services requires quarterly nursing reports.

Date of Report	Type of Report	Completed by (Give name and title)	Related to what ISP (date) and Outcome (list)	List type of growth, progress or regression … use exact quotes from reports when possible

Notes on Adaptive Equipment and Augmentative Communication Devices:

Equipment	Who will Obtain	Who will Maintain	Title and Date of Document Source Here	Title and Date of Document Source Here	Title and Date of Document Source Here	Title and Date of Document Source Here	Title and Date of Document Source Here

Note: The following tables are for use with interviewing nurses or therapists. The questions are general, but additional, more specific questions can be added for the individual class member's unique issues. Just insert rows as needed by tabbing from the end of the appropriate table.

Questions for Nurses:	
1.	Are there any concerns regarding the individual's health? Is he/she having issues with incontinence, falls, constipation, aspiration, weight issues, etc.? Please explain
1A	
2.	What specialists does the individual see? How often does he/she see the specialists? Are there any issues? What does he/she see the specialists for?

Questions for Nurses:	
2A	
3.	How is he/she doing with his seizures? Are those being monitored by his day hab and residential staff? Are seizures being tracked by day hab and residential staff?
3A	
4.	How are the meds given? Are there physician orders for how the medications are to be given?
4A	
5.	Does he/she have a healthcare/crisis plans? What are they? What are staff to do? How often do you review the plans?
5A	

Questions for Physical Therapist:	
1.	What are you working on with ______? Has the staff been trained? How often and where do you visit?
1A	
2.	Has s/he made progress or regression? What progress has been made? If none, why not?
2A	
3.	What adaptive equipment does s/he use? Is the equipment in working order and being utilized? Does he need additional equipment? If yes, what does s/he need? What is being done to obtain it?
3A	
4.	Is the equipment used in all environments? If no, why not? Are staff trained on the used of the equipment? What are you requiring staff to do for the individual?

Questions for SLP:	
1.	How often and where do you visit the client? What are you working on?
1A	
2.	Has he/she made progress in the past year? What progress has he/she made?
2A	
3.	Does he/she have a mealtime plan and is he/she at risk for aspiration? Is the staff trained on his mealtime plan? Are there any issues related to aspiration?

Questions for SLP:	
3A	
4.	What adaptive/assistive equipment does he/she use? Is the equipment in working order and being utilized? Does he/she need additional equipment? If yes, what does he/she need? What is being done to obtain the additional equipment?
4A	
5.	Is the equipment used in all environments? If no, why not? Are staff trained? What are your recommendations for staff to follow and how often are they to implement?
5A	

Questions for OT:	
1.	What are you working on with ______? Have the staff been trained? What are you having the staff work on and how often are they working on strategies? How often and where do you visit?
1A	
2.	Has s/he made progress or regression? What progress has been made? If none, why not?
2A	
3.	Does he/she have a mealtime plan and is he/she at risk for aspiration? Is the staff trained on his mealtime plan? Are there any issues related to aspiration?
3A	
4.	What adaptive equipment does s/he use? Is the equipment in working order and being utilized? Does s/he need additional equipment? If yes, what does s/he need? What is being done to obtain it?
4A	
5.	Is the equipment used in all environments? If no, why not? Are staff trained on the used of the equipment? What are you requiring staff to do for the individual?
5A	

Notes on Other Information Found in the Record. Use this space to record information that is relevant to the review of this person's services but does not fit into any of the categories above. Be specific in terms of document you are referencing, date, author and issue.

#	Question	Score
17.	If Participant is on a neuroleptic medication, is there evidence of involuntary movement screening and follow-up?	***Choose***
18.	If needed, is there evidence of ongoing tracking of seizures?	***Choose***
19.	If needed, is there evidence of required blood work?	***Choose***