NEW MEXICO DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD)

DIRECTOR'S RELEASE **EFFECTIVE DATE:** July 1, 2016

Signature Date:	June 13, 2016
FROM:	**Cathy Stevenson, DDSD Director** *(Signature on file)*
TO:	Living, Day, Employment and Case Management providers and DDSD staff
SUBJECT:	Jackson Remedial Plan and Implications for Providers and DDSD Staff related to Health and Healthcare

Background:

On April 3, 2015, Honorable Judge Parker issued a final order on the Jackson Remedial Plan. The Remedial Plan consists of 3 focused areas for disengagement: Health, Safety and Supported Employment. These requirements are termed *Evaluative Components*, or "ECs."

Many of the activities ordered in the plan are already part of current services, but need to be documented and demonstrated to the Court in order to disengage from court oversight. Other requirements reflect work that will be done directly by NMDOH staff. However, in order for the New Mexico Department of Health to demonstrate substantial compliance and ultimately end the court oversight in the Jackson litigation, there are also new communication and reporting requirements that Class Members must receive from community providers.

This Director's Release establishes these new requirements related to health and health care. These are outlined in this Director's Release. DDSD needs the collaboration of service providers in documenting these elements of care so that compliance with the court's order can be established.

New Requirements: The following are new health-related communication and reporting requirements. These will be monitored by the DDSD to ensure compliance with the court order. [*Note*: *Italics* indicate text from the court order; normal font shows the new required actions.]

A) Accurate Health Records.

1) Objective: Teams use accurate health records for Jackson Class Members.

a. **Specific Required Actions**:

1) Nurses must monitor the accuracy of each JCM's health record, including the JCM's current healthcare plans, CARMPs and MERPs. Healthcare plans, DSP notes and other health records (*e.g.*, weights,

blood pressures) should be dated and reviewed at each required nursing visit and appropriate actions taken accordingly.

2) To assure that all individuals' ISPs reflect their current health needs, the eCHAT must be completed no more than 45 days before the IDT meeting is held to develop the ISP.

3) Individual-specific information on pain management may be included in the individual's HCP or MERP unless a specific plan is required by the eCHAT.

B) Assuring a trained and competent workforce.

1) Evaluative Component: Nurses, DSP, front-line supervisors, ancillary providers, and case managers must satisfactorily complete the mandatory competency based training program.

a. Specific Required Actions:

1) All persons who are required to receive training must:
   a) Satisfactorily complete all required trainings in a manner that meets criteria established by DDSD
   b) Complete all new and additional required trainings within the timeframes defined by DDSD.

C) Monitoring and assuring that JCM's health needs are met:

1) *Objective*: *Nurses routinely monitor Jackson Class Members' individual health needs through (1) oversight, (2) communication with DSP (Direct Support Professionals), and (3) corrective actions in order to implement the Jackson Class Members' health plans, to ensure that the Jackson Class Members' health needs are being met, and to timely respond to changes in Jackson Class Members' health status.*

a.Specific Required Actions:

1) Nurses and/or designated trainers must train Direct Support Professionals (DSPs) and their supervisors so that they are able to competently and correctly implement each JCM's healthcare plan (HCPs, CARMP, MERPs, etc.)

2) Nurses must visit each JCM in accordance with JCM acuity requirements. These are based on assessment of the eCHAT Acuity level and the Aspiration Risk level. The required frequencies are:
   a) *Semi Annual*: Low eCHAT Acuity AND Low Aspiration risk
   b) *Quarterly*: Moderate eCHAT Acuity OR Moderate Aspiration risk
   c) *Monthly*: High eCHAT Acuity OR High Aspiration risk

3) Nurses must meet with DSPs as needed to assure that DSPs are implementing health care plans and health monitoring in accordance

with health care plans, the nurse's assessment of the JCM and changes in the JCM's health status.

4) If there is a change in the JCM's health status, providers must ensure that the JCM's healthcare plan is revised to reflect the new health needs and plans within five (5) business days of admission, readmission or change of medical condition (2015 Standards)

D) Situational Increased Nursing Services.

1) *Objective: Jackson Class Members receive increased intensity of services during acute episodes of illness*. Providers must ensure that, whenever an individual has an acute illness or a significant health episode, that the individual's nurse take prompt and appropriate steps to monitor, assess and oversee the individual's care. This includes nursing assessments and oversight.

a. **Specific Required Actions**: *Assurance of nursing assessment and follow-up:*

1) If an acute condition or other significant change of condition occurs, providers must ensure that the individual is promptly assessed in accordance with prudent nursing practice.
   a) This assessment can be done by either:
      a) Assuring that the nurse promptly conducts a face-to-face assessment. (This visit must include a nursing assessment, monitoring and management of the JCM's acute illness or episode)
      or by:
      b) Assuring that the nurse directs, and the JCM receives, care from either:
         1. A physician or other prescribing healthcare practitioner,
         2. Urgent care services, or
         3. Emergency department services.

   b) If the JCM does receive care from a Healthcare Practitioner, urgent care or emergency services, the provider must assure that the nurse promptly re-assesses the JCM's status and health care needs at the conclusion of that care.
      a) The nurse must reassess the health needs of the individual within 24 hours of the individual returning from physician, ER or hospitalization.
         1. Note that this is a shorter timeframe than the current *Standards*.
         2. The assessment after an individual receives assessment and/or treatment is not required to be face-to-face. The nurse should determine the appropriate type of assessment using her/his professional judgment, taking into consideration the individual's condition and the nature of the

health-care practitioner's recommendations/orders.

3. This assessment, as all nursing assessments, should be documented in the individual's health records.

b) Nurses must update the eCHAT after hospitalization or with significant change within 5 business days, in condition in accordance with the *2015 DDW Standards*.

c) Failures in compliance with DOH requirements regarding a JCM's significant health status change must be reported to IMB.

E) Acuity Driven Nurse Monitoring and evidence of communication with DSP

1) *Evaluative Component: Nurses must meet with DSPs as needed based upon the JCM's eCHAT acuity level and any significant change in health status to monitor the individual.*

a. **Specific Required Actions**:

1) *Assurance:* Whenever there is a change in an individual's health status, whether by worsening of the individual's existing condition(s) or by a new condition, providers need to assure that effective communication occurs between the nurse and the individual's DSPs in order to:
   a) assure that all orders and recommendations are documented
   b) assure that all orders and recommendations are implemented, and
   c) assure that appropriate monitoring and follow-up take place.

F) Recognizing and monitoring an individual's subtle signs of pain or illness.

1) Evaluative Component: Each JCM's healthcare plans and MERPs must contain individual-specific information on how provider agency staff can identify subtle signs of change or acute symptoms.

a. **Specific Required Actions**:

1) *Training:* Providers must ensure that individual-specific training for DSPs and DSP supervisors include training so that:
   a) the DSP and supervisor are competent to identify the JCM's subtle and/or individualized signs of pain or illness in a timely manner, and
   b) the DSP or his/her supervisor is able to document, communicate and report these signs to the individual's nurse.

G) Assuring communication and collaboration with healthcare providers and out-of-home providers

1) *Evaluative Component: A JCM's provider must ensure a JCM's current healthcare information is provided to treating and evaluating healthcare professionals and the case manager must verify that through review of the Physician Consultation Form.*

    a. **Specific Required Actions**:

        1) Provider's policies, procedures and practices need to assure:
            a) that the individual's Health Passport is current,
            b) that staff deliver the documents to the healthcare practitioner, and
            c) that internal review and documentation is maintained as explained below.

        2) The following documents should be stapled together and must accompany the individual whenever he or she is seen by a healthcare practitioner.
            a) *Health Passport*
            b) *Physician Consultation Form*
            c) Advance Healthcare Directives (If applicable)

        3) The documents should be physically delivered either to the nurse or to the treating healthcare professional.

        4) Providers must document that these forms 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*.
            b) Scan the signed *Physician Consultation Form* into Therap after the individual returns from the healthcare visit.

        5) The *Physician Consultation Form* has been modified to include a place for the healthcare practitioners to affirm that they received the *Health Passport*.
            a) The agency nurse must review this form and implement any orders and recommendations contained therein.
            b) Case Managers must review this as part of their monthly visit to JCMs

2) *Evaluative Component: The out-of-home provider must receive a JCM's* ***Health Passport*** *from the residential provider, along with information concerning the JCM's* ***mobility, comfort, safety, and sensory*** *items within 24 hours of the JCM's placement with an out-of home provider.*

    a. **Specific Required Actions**:

        1) Providers must ensure that information on mobility, comfort, safety, and sensory items and/or any durable medical equipment is current in the Individual Data Form, the eCHAT, and medication history.

        2) The provider must document that this information and the *Health Passport* were received by the out-of-home provider.

a) Delivery and receipt of this information should be documented in the ***Event Detail*** section of the *Therap Out of Home Placement General Event Report* (GER).
b) The DDW agency staff person who approves the GER must assure that this information has been entered into the GER ***Event Detail*** section.

3) *Evaluative Component: The necessary **adaptive supports*** already used *by a JCM must be offered to the out-of-home provider within 24 hours of the JCM's placement with an out-of-home provider.*

a. **Specific Required Actions**:

1) Information on assistive technology devices and other adaptive supports that the individual uses must be current in the Individual Data Form and eCHAT.

2) The provider must document that the information was received by the out-of-home provider and that the supports have been offered to the out-of-home provider.

3) Delivery and receipt of this information should be documented in the ***Event Detail*** section of the Therap Out of Home Placement General Event Report (GER).

4) The DDW Agency staff person who approves the GER must assure that this information has been entered into the GER ***Event Detail*** section.

4) *Evaluative Component*: *The JCM's ECHAT and other healthcare records must be promptly updated by appropriate healthcare providers to indicate healthcare and adaptive supports that the JCM <u>received from</u> the out-of-home provider in order to ensure a safe and smooth transition back to the JCM's home.*

a. **Specific Required Actions**:

1) When the Jackson Class Member returns from an out-of-home placement, the following must occur:
a) The eCHAT must be updated per existing *2015 DDW Service Standards*
b) If the individual received new healthcare or adaptive supports, then the health records must also be updated:
(i) *Individual Data Form* (IDF) in Therap: update the *Medical Information Section Adaptive Equipment* portion.
(ii) eCHAT: update appropriate sections.

H) Planning a smooth transition from an out-of-home setting back to the JCM's home.

1) Objective: When a JCM is receiving healthcare in an out-of-home setting, the IDT will plan for a smooth transition back to the JCM's home as soon as medically feasible.

a. Specific Required Actions

1) Providers must assure that the JCM's case manager(s), Agency Nurse(s) and, as appropriate, DDSD Regional Office staff will

coordinate with appropriate staff at the hospital or other out-of-home setting to plan for a JCM's safe and smooth discharge.

2) Providers must assure that nurses and other appropriate healthcare providers update the JCM's e-CHAT and other health records in accordance with the 2015 *Standards*.

3) Healthcare recommendations and adaptive supports that the JCM received from the out-of-home provider should be implemented in order to ensure a safe and smooth transition back to the JCM's home.

    a) If the individual received new healthcare recommendations or adaptive supports, then the health records must also be updated:
        a) *Individual Data Form* (IDF) in Therap: update the *Medical Information Section Adaptive Equipment* portion.
        b) eCHAT: update appropriate sections.

I) Assuring that health care recommendations are reviewed and are either implemented in a timely manner or are documented to have been declined.

1) *Objective: The team assures recommendations from healthcare professionals are reviewed with the individual and guardian in a manner that supports informed decision making and [are] either implemented, or documented in a Decision Consultation Form if recommendation is declined.*

a. **Specific Required Actions**:

1) A JCM's IDT must ensure that a healthcare professional's recommendations and assessments:
    a) are promptly communicated to the nurse, guardian, DSP, and entire healthcare team, as needed, and
    b) are implemented, unless the individual or their healthcare decision maker has declined the healthcare professional's recommendations by completing a Decision Consultation Form.

2) The JCM's nurse must assure that the JCM's healthcare records accurately identify and reflect all recommendations and assessments of the JCM's treating and evaluating healthcare professionals.
    a) Records should be reviewed and updated whenever new orders or recommendations are made by a healthcare professional.
    b) All healthcare recommendations must be implemented within the timeframe prescribed by the treating professional, unless the recommendation has been declined by the individual or his/her healthcare decision maker.
    c) If a healthcare professional's recommendation has been declined by the individual or his/her health decision maker, this must be documented by the JCM's case manager using the

DDSD Decision Consultation Form, as appropriate, for use by the JCM's healthcare professionals.

a) The signed *Decision Consultation Form* must be kept in the JCM's healthcare records.

J) Pain management

1) *Evaluative Component*: *The DDW agency nurse must implement effective pain management strategies for addressing a JCM's chronic and acute pain. The Nurse will note evidence of implementation of pain management strategies from HCPs in regular visit documentation.*

2) *Evaluative Component*: *The pertinent agency must communicate these effective pain management strategies to the JCM's treating healthcare professionals.*

[Note: The intention is that the effectiveness of the pain management strategies is evaluated and communicated to the healthcare provider so that any necessary adjustments can be made. This is especially important when pain management strategies are ***not*** effective so that changes can be made promptly.]

3) *Evaluative Component*: *The DDW Agency Nurse will evaluate the effectiveness of pain management strategies and record the effectiveness in nursing notes or on the Medication Administration Record.*

[Note: Pain management strategies include orders from health care Practitioners as well as non-prescription, but planned, measures that promote comfort such as positioning, ice or massage.]

a. **Specific Required Actions:**

1) Pain management strategies prescribed or recommended by a healthcare practitioner must be implemented and their effectiveness monitored.

2) The MAR should indicate the individual's response to as-needed (*p.r.n.*) interventions whenever utilized.

3) DSP notes and Nurses notes may also be used to indicate the individual's response to both standing and as-needed (*p.r.n.*) interventions whenever appropriate.

4) The Nursing quarterly report must reflect the individual's overall health status and progress to care planned goals including acute or chronic pain management strategies.

5) The nurse should communicate to the treating health care professional whenever interventions are not effective.
    a) The nurse should document this communication in a nursing note.

b) Both the presence of pain and the response to pain management interventions should be recorded in the eCHAT, DSP notes and nursing notes.

6) Any new orders and/or revision of plans must be implemented promptly and in accordance with the new orders.

7) If needed, the JCM's healthcare record and medication records must be promptly updated.

K) Advanced care planning and palliative care

1) *Evaluative Component*: *The DOH must identify, and must document on an annual basis in the pertinent healthcare records, those JCMs who want advanced care planning, including palliative care, and those JCMs who decline advanced care planning.*

a. **Specific Required Actions**:

1) The questions about whether the JCM or guardian wants information about advanced directives can be found in the last few pages of the ISP.

2) If the JCM or the individual's guardian chooses advance care planning, the Case Manager should inform the individual or the individual's guardian that assistance is available from *UNM Continuum of Care*.

3) Discussions and follow-up about advance care planning and referrals to *UNM Continuum of Care* should be documented in the IDT meeting minutes. This documentation needs to include:
   a) Whether the discussion regarding advanced care planning/palliative care occurred; and
   b) Whether the JCM/guardian wanted advanced care planning, including palliative care.