NEW MEXICO
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HEALTH

DDW Standards

Effective March 2018

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Agenda

- Introduction
- Section I – Planning
  - Chapters 1 - 9
- Break
- Section II – DD Waiver Services
  - Chapter 10 -14
  - Lunch Break
- Section III – Quality Assurance & Continuous Quality Improvement
  - Chapters 16 – 22
  - Break
- Roll Out
- Final Questions

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Introduction

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Organization of DD Waiver Standards

Chapters are organized and grouped into sections:

- Section I: Planning;
- Section II: DD Waiver Services; and
- Section III: Quality Assurance and Continuous Quality Improvement.

Updates and Enhancements

- Strengthened language around PCP, informed choice, Employment First, Human Rights, and Settings Requirements
- Policies previously incorporated by reference are now detailed in one place
- Director's Releases and other instructions are included
- Improved readability

Updates and Enhancements

- Supplements, corrections, and page replacements may be issued as needed.
- DD Waiver Provider Agencies will be notified through e-blasts, website postings, and/or direct mailings.
- DDSD will provide for a public feedback period before any substantial changes are issued.

Using DD Waiver Standards

- Providers must use entire document, can no longer just go to one chapter.

- Common responsibilities among all providers are outlined in new chapters (e.g. Billing, Person Centered Planning, Individual Service Plan).

- Shared understanding of Program Requirements is intended to help with team work.

Integration of Policy and DR's

- New to standards but not new requirements.
- Refer to applicable required trainings for more details.
- Placement in standards underscores importance and provider accountability.

Language That Moved

- ANS and Bundled Nursing → Nursing Services Chapter 13
- Staffing Qualifications → Qualified Provider Chapter 16
- Staff Training Requirements → Training Requirements Chapter 17
- Employee Abuse Registry → Qualified Provider Chapter 16

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Language That Moved (cont.)

- General Events Reporting → Provider Reporting Requirements Chapter 19 and Appendix B GER
- Consumer Records Policy → Provider Documentation and Client Records Chapter 20 and Appendix A Client File Matrix
- Billable/Non-Billable Activities → Billing Chapter 21
- QA/QI Reporting → Quality Improvement Strategy (QIS) Chapter 22

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Initial Allocation and Ongoing Eligibility

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Initial Allocation

Chapter Includes:

- Definition of Developmental Disability
- Central Registry and Waiting List
- Allocation Process
- Expedited Allocations
- Annual Recertification of Eligibility

Annual Recertification of Eligibility

- 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.
- Shared awareness of the process can assist IDTs to adequately support the person to complete recertification timely.
- A DD Waiver budget cannot be processed, and Provider Agencies cannot bill for services without a current 096 COE indicating DD Waiver eligibility.

Annual Recertification of Eligibility

- Client Information Update (CIU) is the mechanism to assure the correct information is on record including contact information to receive notices about recertification.
- The CIU/MAD 054 is available with instructions for completion on the NM Medicaid Portal (https://nmmedicaid.acs-inc.com/webportal/home).
- The CIU is completed by the CM, DD Waiver participant, legal guardian, authorized representative, or other partnering state agencies.

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Chapter 2: Human Rights

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CMS Final Rule

- Provider Agencies must ensure they are meeting the new requirements and be in full compliance with all CMS settings requirements by 2022.
- New applicants must fully meet the CMS Final Rule Settings Requirements to be approved as a DD Waiver provider.
- Additional guidance on settings validation and coming into compliance will continue to be issued by DDSD.

Settings Requirements Highlights

- Be integrated in and facilitate full access to the greater community.
- Ensure the person receives services in the community to the same degree of access as people not receiving HCBS services.
- Be chosen by the person (in consultation with the guardian if applicable) from all available residential and day options, including non-disability specific settings.

CMS Final Rule

DD Waiver Provider Agencies are required to comply with CMS Settings requirements. Provider Agencies:

- Monitor settings for compliance;
- Monitor that waiver recipients are being given choices; and
- Ensure rights are being respected.

Consumer Rights and Freedoms

- HCBS Statement of Rights is new.
- Annual review required (in a way that accommodates preferred communication style).
- Signed Acknowledgement is required for file.

  (See also Appendix A Client File Matrix)

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Chapter 3: Safeguards

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The Safeguards Chapter

- Information about healthcare decisions, provides an overview of HRC requirements, incorporates previous policies, & processes on these topics.
  - 3.1 Decision Consultation and Team Justification
  - 3.2 Financial Rights and Responsibilities
  - 3.3 Human Rights Committee
  - 3.4 Emergency Physical Restraint

3.1 Decision Consultation and Team Justification

- The decision consultation and team justification processes assist participants and their health care decision makers and guardians to receive information and document these decisions.
- **Health issues -> Decision Consultation Process**
- **Non-Health issues -> Team Justification Process**
- For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/

3.2 Financial Rights & Responsibilities

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 reflects a plan to increase this skill when appropriate.

3.3 Human Rights Committee

- Exists to protect DDW participants' rights & freedoms through the review of proposed rights' restrictions.
- The ***RIGHTS RESTRICTION*** must be based on a documented health & safety concern.
- HRCs monitor implementation of certain time-limited restrictive interventions designed to protect a DDW participant and/or the community from harm.

3.3 Human Rights Committee

- Now required of all Living Supports, Customized Community Supports (CCS) and Community Integrated Employment (CIE) Providers.
- All committee members must receive training on human rights, HRC requirements, and other pertinent topics ***prior to voting participation.***
- HRCs will appoint a chairperson to a two-year term & each chair may serve only two consecutive two-year terms at a time.

3.3 Human Rights Committee

- Aversive interventions (restrictions) may be included temporarily as a part of a person's support and need to be reviewed prior to use, ***except in emergency situations.***
- In general, changes to these lists include adding clarifying language or defining examples.
- A complete list of interventions requiring HRC approval is found in section 3.3.4; a list of *PROHIBITED* interventions are in 3.3.5.

3.3 Human Rights Committee

- HRC members directly involved in the services provided to the person (e.g. service coordinator) must excuse themselves from voting in that case.
- The HRC with primary responsibility for implementing the restriction will record all minutes on an individual basis.
- Provider Agencies 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 process*** regarding the restriction, and their (the person's) timely participation in the review.

3.4 Emergency Physical Restraint

Every person shall be free from the use of unnecessary restrictive physical crisis intervention measures

The use of EPR:

- Is permitted when non-physical interventions & de-escalation strategies have failed;
- Shall be discontinued as soon as the safety of each person in the immediate area is reasonably assured;
- Should not be entered into lightly, nor without a ***comprehensive understanding*** of reasons for its use & each team members' role in its plan development & implementation.

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Chapter 4: Person Centered Planning

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Person Centered Planning

Person Centered Planning is a Waiver requirement.

This Chapter breaks Person Centered Planning into three parts:

- Person Centered Thinking,
- Person Centered Planning, and
- Person Centered Practice.

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Person Centered Thinking Example

Interviews documenting:

- what is working/not working.
- specific aptitudes, skills, and abilities.
- Good Day/Bad Day for the person.
- what is important to/important for the person.
- what the person does and does not want in his/her overall employment or retirement life.

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Person Centered Planning

- PCP is facilitated by the CM.
- The person is encouraged and supported to direct the process as much as possible.
- Requirements are listed for all provider types to understand.

Informed Choice

- Standards expanded on Informed Choice as previously defined and related to Employment First in NM.

- Shared responsibilities among providers are listed in this chapter.

Informed Choice – Highlights

- Increase a person's experiences with options.
- Listen and respect choices.
- Support people to speak openly about their services without being fearful of retaliation.
- Support and not replace use of natural and non-disability specific resources available.
- Work with the CM to document efforts demonstrating choice of non-waiver and non-disability specific options in the ISP.
- Be aware of guardianship.

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Chapter 5: Health

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Health Chapter

New chapter with standards that promote and protect the person's health, safety and well-being. Incorporates multiple policies and practices.

Includes:

- 5.1 Healthcare Coordination
- 5.2 Medical Stabilization
- 5.3 Promoting Healthy Relationships and Sexuality
- 5.4 Use of Psychotropic Medication
- 5.5 Aspiration Risk Management (ARM)

5.1 Healthcare Coordination Requirements

- Support the delivery of safe, appropriate, and effective care and involves organizing care and sharing information.
- The person's needs and preferences are known ahead of time and communicated at the right time, to the right people.
- Actions are taken to:
  - monitor and manage health related needs;
  - respond proactively to health changes and concerns; and
  - facilitate the appropriate delivery of healthcare services and support the process of Care Coordination in the larger Health Care System.

5.1 Healthcare Coordination in the DD Waiver requires:

- Communicating and coordinating between the IDT and medical providers in a timely manner.
- Ensuring that a qualified person who knows the person well and who can communicate their needs attends appointments in order to clearly address needs with the medical/dental provider.
- Tracking implementation of recommendations made by a medical provider for assessments, treatment and other services in addition to tracking the outcomes of those recommendations.

5.1 Healthcare Coordination in the DD Waiver requires:

- Ensuring healthcare needs, conditions, and risk factors are accurately documented in the healthcare record including use of Therap. Refer to Chapter 20.
- Actively managing care transitions, including changes in acuity levels, hospital discharge, Out of Home Placement (OOHP) or other.
- Ensuring that the Decision Consultation Process (DCP) as described in Chapter 3 is utilized when needed.
- Coordinating with the MCO Care Coordination staff and the DD Waiver CM to assure continuity and access to healthcare services as well as availability of medications, medical equipment and healthcare supplies.

5.1.1 Designation of a Health Care Coordinator (HCC)

The HCC is the *designated individual on the IDT* who arranges for and monitors health care services for the person in services.

- The person or guardian may choose to designate themselves or another member of the team to be the HCC.
- 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.

NOTE- The HCC does not HAVE to be a nurse!

5.1.2 Roles and Responsibilities

All DDW Providers have a role and must:

- Review, update and follow up on health related information (Chapter 20).
- Hold (and participate in) IDT meetings for:
  - Change in condition
  - Health concerns
  - Health and safety issues or risks to health and safety.
- Know and comply with your health related Service Standards.
- Budget Nursing assessment and consultation if the person receives supports from non-related DSP who require training and oversight by a nurse (in non-bundled services).
- Provide and support IST for subtle or acute signs of change.
- Screen for Aspiration Risk and provide ARM supports.

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 his/her parent, guardian or designated healthcare decision maker.
- These are professional decisions and do not require review by a HRC of the supporting agency.
- If medication is ordered by the physician or dentist to be given before the procedure, the medication must be delivered according to the order and must be documented on the MAR.

5.3 Use of Psychotropic Medication: Important Highlights

- A psychotropic medication is any medication that alters the chemicals in the brain & thus impacts a person's emotions and behaviors.
  - Used to treat a variety of psychiatric conditions
  - These medications can improve behavioral symptoms, but may not improve quality of life.
  - Effective pharmacological intervention & support considers many things.

5.3 Use of Psychotropic Medication: Important Highlights

Requirements for psychotropic medication use:

- Persons receiving psychotropic medication should have an assessment through the Medicaid State Plan &/or BSC services.
- Use should be:
  - In response to treatment of a diagnosed psychiatric condition;
  - In line with all laws, regs & standards of acceptable practice; and
  - Reviewed at a schedule established by the prescriber & person in services or healthcare decision-maker.

5.3 Use of Psychotropic Medication: Important Highlights

Requirements for psychotropic medication use (continued):

- Is *PROHIBITED* if the administration of the medication is:
  - for a chemical restraint
  - for substitution of meaningful support services
  - in the absence of a comprehensive treatment plan

5.3.2 Exceptions to Requirements: Psychotropic & PRN Psychotropics

- People receiving psychotropic or PRN psychotropic medications & their IDT may ask for an exception to have BSC &/or behavioral health treatment by:
  - Conducting a meeting to discuss the use of behavioral health treatment and/or BSC; and
  - Demonstrating conditions that may make behavioral health treatment or BSC unnecessary.
  - For specific procedures, see additional information addressed in section 5.3.2.

5.4 Promoting Healthy Relationships and Sexuality: Important Highlights

DD Waiver offers a continuum of behavior support services (BSC, SSE, & PRSC) to promote healthy relationships and sexuality by:

- addressing sexuality education.
- addressing community safety needs when persons engage in sexually inappropriate and offending behaviors.
- reducing the impact of interfering behaviors (such as trauma from sexual victimization) that may compromise a person's quality of life.

5.4 Promoting Healthy Relationships & Sexuality: Important Highlights

- Specific roles & responsibilities (R & R) are found in sections: 5.4.1 IDT, 5.4.2 BSC, 5.4.3 CM, and 5.4.4 DSP.
- Section 5.4.1 on IDT contains important highlights for promotion of healthy relationships for ***all providers–the key ones are:***
  - Listen to the person's wants & needs about relationships & sexual expression.
  - Respect the right to privacy & confidentiality.
  - Assure that a person's right to relationships & sexual expression is protected!

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5.5 Aspiration Risk Management

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ARM

5.5 Aspiration Risk Management (ARM)

- Information is the same but is organized differently.
- ***Steps are more defined.***
- 5.5.1 ARST
- 5.5.2 Collaborative Aspiration Risk Assessment,
- 5.5.4 Decision Consultation Process

5.5.6 Roles and Responsibilities (R&R)

- 5.5.6.1 Similar R&R grouped together and sorted into:
  - 5.5.6.1.1 Initial CARMP
  - 5.5.6.1.2 Existing CARMP review
  - 5.5.6.1.3 General CARMP R&R
- Includes discipline specific R&R and all IDT Members' R&R.
- Tables and timelines remain the same!

Important changes

- 5.5.6.3 Additional Nursing Responsibility
  - When an SLP diagnoses dysphagia with a bedside swallow evaluation or radiological diagnostic studies, the Nurse updates the diagnosis list; refers to this diagnosis during the ARST assessment and informs the Primary Care Practitioner of the risk level and CARMP development or revision.
  - Everyone is responsible to ensure the CARMP is available in all settings during visits.

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Chapter 6: Individual Service Plan

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Preparation for Meetings

- 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.
- 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.
- The CM and IDT shall make every effort to ensure that the person has input in decision-making and does not fear repercussions.

ISP Development

- DD Waiver Provider Agencies participate in the development of the ISP.
- Providers must submit assessments and reports timely so information can be used in planning.
- DD Waiver Services and Individual Specific Training must be provided in accordance with the ISP.

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Revisions

- The ISP is a dynamic document.
- The ISP should change 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.

Revisions
Examples of when needed

- When immediate action is needed after a report of ANE is made or if ANE is substantiated.
- Within ten days of an ANE Closure letter if issues still need to be addressed.
- Within ten days of a person's life change in order to take appropriate actions to minimize a disruption in the person's life.

ISP Template

- DDSD has been working on an ISP redesign and will continue to elicit stakeholder involvement.
- No changes to the ISP template have been issued with the 2018 Standards.
- Addendum A will be reissued to include information about ANE reporting.

ISP Template

Contains specific instructions to:

- Document Employment First in the ISP. (Chapter 6.6.3.4)
- Document Aspiration Risk Management in the ISP. (Chapter 6.6.3.5)

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Chapter 7: Available Services and Individual Budget Development

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Service Availability and Exclusions

- Requirements support the need to use the DD Waiver to enhance, not replace, natural and generic community supports.

- DD Waiver services cannot duplicate services available through the EPSDT benefit or Medicaid State Plan.

Clinical Justification and Outside Review Process

- JCMs transition into these Standards by ISP date beginning with ISPs effective 6/1/2018.
- JCMs do not submit to the Outside Review.
- Clinical Criteria is adjusted to align with these Standards (SL Category 4 and CCS).

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Chapter 8: Case Management

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Overview

Organized differently to underscore essential elements of Case Management in the DD Waiver system:

- Advocacy
- Annual recertification
- Assessment
- Linking
- Person Centered Planning
- Submissions
- Monitoring

Linking

- Know the available resources within the community of the person.
- Link people and families to resources that will assist in achievement of the person's vision.
- Aligns with CMS Final Rule.

Person Centered Planning

- The CM is responsible for leading the PCP process and ensuring the ISP addresses all the participant's needs as determined by any assessments and personal goals, either through DD Waiver services or other means.

- Other Providers have requirements detailed throughout the Standards. (See Human Rights, Safeguards, Budget Submission, PCP, ISP, Transitions, etc.)

Conflict of Interest

- Case Mangers who are contracted under the DD Waiver are identified as agents who are responsible for the development of the ISP.

- Additional language emphasizes principles of Conflict Free Case Management in DD Waiver system.

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Chapter 9: Transitions

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Transitions

- New chapter consolidates procedural requirements for various transitions.
- Appropriate planning and information sharing must occur to facilitate a smooth transition and informed choices.
- The CM plays a critical role in all types of transitions.
- Providers must cooperate, collaborate for smooth transition, accurate proration of units.

Transitions

Requirements common to most transitions:

- Transition Meeting
- Use of Individual Transition Plan template from DDSD
- Transfer of Documentation including sharing of records in Therap

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Chapter 10:
Living Care Arrangements (LCA)

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Living Care Arrangements

- 10.1 Living Care Arrangements are available to adults age 18 and older based on individual preferences, needs, and clinical justification.
- There are five (5) types of Living Care Arrangements.
  - Customized In-Home Supports (Independent Living)
  - Customized In-Home Supports (Family/Friends)
  - Living Supports-Family
  - Living Supports-Supported Living
  - Living Supports-Intensive Medical Living Services

Family Living

- 10.3.8 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.
  - Includes 750 hours of Substitute Care
  - Includes 1000 hours of Substitute Care for Jackson Class Members.
- Family Living includes up to 12 hours (48) units of Adult Nursing Services for assessment and consultation services.

Supported Living

- 10.3.9 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.

- There are four (4) types of Supported Living:
  - Supported Living Category 1 (Basic Support)
  - Supported Living Category 2 (Moderate Support)
  - Supported Living Category 3 (Extensive Support)
  - Supported Living Category 4 (Extraordinary Medical/Behavioral Support).

Supported Living Category 4

10.3.9.2 Supported Living Category 4 (Extraordinary Medical/Behavioral Support)

- Accommodates the needs for more than 28 hours a week of individualized staff attention apart from shared staffing.
- Staffing Grid no longer required to be submitted as clinical justification (for all SL categories 1-4).
- For Jackson Class Members receiving Residential Behavior or Medical Outlier services; this service would replace Residential Behavior or Medical Outlier services.

Supported Living Category 4 Cont.

- **10.3.9.2 Supported Living Category 4 (Extraordinary Behavioral 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, etc.
- Provider must have documentation detailing the level of DSP intervention needed to assure the health and safety of the individual and/or to assure the health and safety of others. The documentation must provide evidence that additional DSP had to intervene.

Supported Living Category 4 (Cont.)

- Cannot be provided unless the person also receives services from a BSC.
- The enhanced 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 and BCIP.

Supported Living Category 4 Cont.

- **10.3.9.2 Supported Living Category 4 (Extraordinary Medical Support)** is for people who have medical support needs defined as a chronic physical or medical condition requiring prolonged dependency on medical treatment for which skilled nursing intervention is necessary.
- Provider Agency must have documentation and evidence that the IDT discussed additional means of addressing the extraordinary medical support needs other than increasing the level of staffing support, the reasons why increasing staff is necessary, why the current level of staffing is not sufficient, and what the IDT has already pursued and exhausted.

Supported Living Category 4 Cont.

- Enhanced staffing is required to implement the applicable HCPs and MERPs Plans to ensure the health and safety of the person.
- Cannot be provided unless the person receiving this service receives frequent nursing oversight including at a minimum, monthly nursing assessments.
- For those individuals who would not qualify for Intensive Medical Living.

Intensive Medical Living Services

10.3.10 IMLS are for persons with complex medical needs who require intensive DSP supports & nursing care and oversight.

- Daily Nursing face to face visits are required.
- Weekly RN oversight must be performed.
- At least one DSP or Nurse must remain awake throughout all night shifts.

Must score 20 points on parameter tool.

Short Term: increased to 90 days.

Review Criteria Changes.

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Contact your respective **Regional Office** or

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Chapter 11: Community Inclusion

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11.2 Employment First

Informed Choice:

- Assessment: PCA.
- Experience: No volunteer or employment history.
- Opportunity for Trial Work or Volunteering: If the individual and guardian are interested.
- Once first three steps –individual/ guardian, determine if employment pursued.
- If employment, then discuss potential impact to benefits, using community resources.
- If a person is retired, information in the ISP.

11.3 Implementation of a Meaningful Day

Meaningful Day activities should be developed with the four guideposts of CLE in mind. The four guideposts of CLE are:

- Individualized supports for each person.
- Promote community membership and contribution.
- Use human and social capital to decrease dependence on paid supports.
- Provide supports that are outcome-oriented and regularly monitored.

Adopted CLE Guideposts from the ThinkWork project from the Institute of Community Inclusion from the University of Massachusetts in Boston.

11.4 PCA and Career Dev Plans

- Removed language about Vocational Assessment Profiles (VAPs).
- Minimum Requirements – Same.
- Timelines for completion:
  - Initial PCA - first 90 calendar days.
  - Reviewed and updated annually.
  - New PCA must be completed every five years.
  - Significant change - a new PCA may be required.
- Changes to PCA - Should be signed and dated.

11.5 Settings Requirements for Non-Residential Settings

Current Language: All individuals have the right to choose where they receive services. ~~The following may not be provided in an agency operated building and must be provided in the community:~~

~~1. Individual CCS (CCS-I),~~
~~2. Small Group CCS,~~
~~3. Community Inclusion Aide,~~
~~4. Job Maintenance,~~
~~5. Self-Employment,~~
~~6. Intensive Community Integrated Employment (ICIE), &~~
~~7. Community Integrated Employment- Group models.~~

11.6 Customized Community Supports (CCS)

- General Service Requirements - individual, small group & group
- Removed ratios of time in community – fullest extent possible
- Individualized schedules -needs, preferences & circumstances - activities per day, week and month including date, time, location & cost
- In-home supports:
    - Non-JCM - two-hour period
    - JCMs - Up to 30 hours a week

11.6.5 Customized Community Supports (CCS) – Group

Added Tiered Rate language – Removed references to SIS/group assignments:

- CCS - Group Category 1 - not to exceed one-to-six (1:6).
- CCS - Group Category 2 – Extensive Support - not to exceed one-to-four (1:4).

- Removed language about classroom setting.
- Not vocational or pre-vocational activities.

Jackson CCS-Group Information

- Within the CCS Group model, there are three categories of service: CCS Group Category 1, CCS-Group Category 2 Extensive Support, and CCS-Group, Jackson Only. The three categories are based on intensity and nature of individual support needs.
- CCS-Group Jackson Only-is not to exceed one-to-four (1:4).
- JCMs may receive the CCS-Group Jackson Only service in order to maintain the same level of Adult Habilitation Outlier services received under the 2007 DD Waiver Standards.

Individual Intensive Behavioral Customized Community Supports

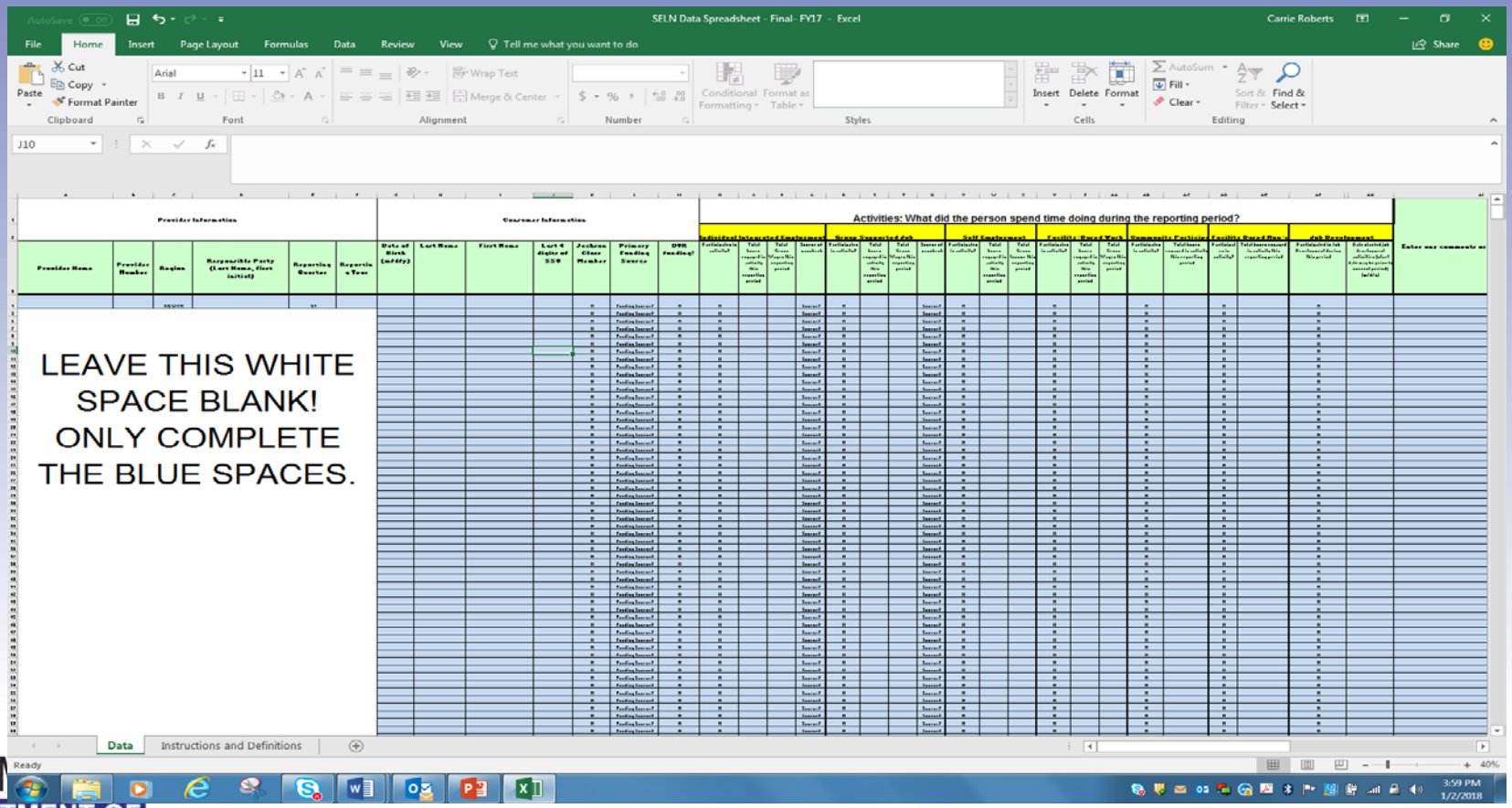
- Removed reference to Group G and SIS
- Clarified the language

Fiscal Management for Adult Education Opportunities

- Stand alone service – It does not require supports or has natural supports.

11.6.9 Agency Requirements

- State Employment Leadership Network (SELN) Data Spreadsheet



Community Integrated Employment (CIE)

11.7.2. - General CIE Requirements – Similar to CCS

- Ensuring and implementing a system to minimize any disruption to a person's employment when an individual suffers a "life change".

- Attending an IDT meetings within 10 days of a life change to take appropriate actions to minimize a disruption to employment.

11.7.2.2. Job Development

- Job development services through this 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).

Service Criteria V4

- **Job Development (Service Code includes Job Maintenance)**
- Desire to work, newly acquired job, or a job offer pending job coaching: Work section of the ISP to include a Vision Statement for “Work/Learn” and a related desired outcome for employment.
- Prior approval from DDSD demonstrating the need for job development through the DD Waiver because job development/short term job coaching through Division of Vocational Rehabilitation (DVR) is not available or is due to end within 90 days.

Tentative Plan for VR Funding

- Creation of a rate for CM to work with VR – Incentive payment
- Hourly rate for employment providers – Similar to DD waiver monthly rate
- Presumptive eligibility for VR – Shorter lead time to obtain services
- DVR to fund discovery for people who wish to work and need this type of assessment

More guidance to the forthcoming in the next few months.

11.7.2.3. Job Maintenance

- Moved natural supports and communicating with co-workers from job development to maintenance
- Use DVR first – Should only be used for long-term supports – Same language as Job Development
- In special circumstances only, short-term job maintenance (job coaching generally lasting up to 4 months) services through the DD Waiver can be accessed when services are not otherwise available…

11.7.2.4 CIE - Group

- Removed SIS Language
- Two categories are based on intensity and nature of individual support needs.
- Approved category of service:
  - a. CIE Group Category 1 are not to exceed one-to-six (1:6).
  - b. CIE – Group Category 2 – Extensive Support are not to exceed one-to-four (1:4).

11.7.2.6. Self Employment

- Self-employment services through 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).

Service Criteria V4

CIE Self-Employment:

- Desire to work: Work section of the ISP to include a Vision Statement for “Work/Learn” and a related desired outcome for employment.
- For an initial request, written documentation from DVR demonstrating that self-employment services are not available.
- Business Plan, unless this is an initial request for services.

Language Removed

- Service Requirements
  - o …75% of the employees do not have developmental disabilities and where an individual has consistent (throughout the work day) opportunities to interact with non-disabled workers…

- Obsolete - Maintain and comply with all provisions of the annual Performance Contract…

SE Qualified Providers pilot

- Changes to FY19 Provider Application
- Currently working with 6 pilot agencies
- Application and Scoring Guide in development
- More guidance to the field – April 2018

For further questions, please contact:

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Chapter 12: Professional and Clinical Services

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Clinicians and Provider Agencies

This chapter contains requirements for Clinicians and Provider Agencies for the following services:

- 12.2 Behavior Support Consultation (BSC)
- 12.3 Preliminary Risk Screening and Consultation (PRSC)
- 12.4 Therapy Services
- 12.5 Nutritional Counseling

Note: Nursing is addressed in Chapter 13 2.4

12.2 Behavior Support Consultation: Important Highlights

BSC identifies skills & capacities that contribute to a person's ability to experience success & satisfaction. Support includes all efforts to teach, strengthen, and expand positive behaviors. **A quality foundation for BSC has several components**:

- Assessment of the person and his/her environment, including barriers to independent functioning;
- Design and testing of strategies to address concerns and build on strengths and skills for independence;
- Writing and training plans in a way that the person and Direct Support Personnel (DSP) can easily understand and implement; and
- Evaluating progress to determine if plan strategies are successful.

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12.2 Behavioral Support Important Changes/Highlights

- Attend annual ISP & any IDT meetings needed for behavioral support planning
- Develop timely assessments & plans with required components in the “Beyond the ABCs”
- Support effective implementation of the CARMP by complying with all relevant requirements
- Train DSP &/or an agency designated trainer
- Attend HRC meetings (initial, annual, substantial changes to a plan containing restrictions)
- Attend psychiatric appointments in certain circumstances

12.2 Behavioral Support Important Changes/Highlights

12.2.5 Agency Requirements

- BSC agencies & services provided by employees or subcontractors are subject to oversight & monitoring by BBS.
- Each BSC Provider Agency must employ or subcontract with at least one professional with an independent practice license.
- Ensure BSC meeting attendance, site visits, and telephone coverage during regular business hours.
- Provide information regarding arrangements for vacations and/or extended absences to CMs & other IDT members when the BSC is not able to respond within 24 hours (regular business hours).

12.3 Preliminary Risk Screening & Consultation: Important Highlights

- Is part of a continuum of behavioral support (including BSC & SSE) that promote community safety & reduce the impact of interfering behaviors that compromise the person's quality of life
- Is provided by a licensed mental health professional that has been trained and approved as a Risk Evaluator by the BBS
- Currently we have 3 providers of the service with risk evaluators in training statewide!

12.3 PRSC
Important highlighted topics:

The PRSC Risk Evaluator (RE):

- Provides screening, consultation & periodic case review for persons who have exhibited sexually inappropriate & offending behaviors
- Technical assistance related to the management of risk including:
  - Recommendations of reduction to levels of supervision for risk
  - Writes consultation note &/or PRS report as needed

**Individuals may NOT receive BSC services from the Risk Evaluator

12.4 Therapy Services

OT/COTA, PT/PTA, SLP:

- Minimal changes to therapy requirements.
- *Service Requirements* (12.4.7) contain former therapy "Scope of Service".
- Two additional required therapist trainings and revised timelines:
  - *ANE* and
  - *Indications of Illness and Injury.*

12.4 Therapy Services

- Therapy Documentation Guidelines moved to the Standards.
- Watch for upcoming changes to Therapy Criteria and submissions to the Outside Review.

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Therapy for Jackson Class Members

- Therapy no longer divided as clinical or integrated services.
  - All therapy will be billed under same code.
- Continue to use:
  - Therapy Exception when exceeding 58 hours.
  - Super Exception when exceeding 72 hours.
- All Jackson Class Member services, in standard and incentive counties, will be reimbursed at the incentive rate.

12.5 Nutritional Counseling

- Nutritional Counseling Services (NCS):
  - Provides nutrition/dietary supports; and
  - May be added to budget for persons who do not reside in FL, SL or IMLS.

12.5 Nutritional Counseling

- Participate in collaborative assessment for people who are identified at moderate or high risk for aspiration;
- Monitor the nutrition portion of the CARMP a minimum of four times a year, revise and retrain as necessary; and
- Monitor the effectiveness of nutritional plan, adjusting plan content and strategies as indicated.

For further questions, please contact:

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OR your Therapy Consultant

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Chapter 13: Nursing Services

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Background Reminders:

- Reimbursement for Nursing services is bundled into the rates for:
  - Supported Living
  - Intensive Medical Living Services (IMLS); and
  - Customized Community Supports- Group (CCS-G)
- Budget Adult Nursing Services for
  - Family Living; and
  - All other settings.

Review all other chapters!

Chapter 13: Nursing

- Stand alone chapter
- Divided into 2 sections

13.2 Part 1 General Nursing Services Recruitments

- Requirements for ALL DDW nurses

13.2 Part 2 Adult Nursing Services (ANS)

- Deliverable tasks under ANS
- Adult Nursing Services Provider requirements

13.2.2 Collaboration

Nurses must routinely and professionally communicate and collaborate with one another for the benefit of the person's health and safety.

- In Residential and Day settings:
  - Share e-CHAT assessment information and care plans including CARMP.
  - Each nurse is responsible for creating and training plans pertinent to their service setting.
- In Hospice/Palliative services, DD Waiver plans must:
  - reflect the person's decisions and wishes; and
  - provide clear guidance to the DSP, including who to contact in specific circumstances.

13.2.4 Documentation Requirements highlights

- Out of sequence notes/late entry notes are addressed.
- Electronic signatures must have credentials.
- Content of Semi annual reports:
  - Current heath status
  - Significant changes to date
  - Progress toward health related goals

eCHAT and Planning

13.2.5 Includes eCHAT, ARST and MAAT policies

13.2.6 – eCHAT – NEW

- Face to face to assessment
- Review and update the electronic record
- Complete ALL questions: No Blanks!

- LPN contribution: RN required to review, edit, and approve within three business days.
- Non-nurses data entry from paper eCHAT by RN.
  - Data entry within three business days of completion.
  - RN is required to review and approve within three business days after data entry.

eCHAT and Planning

- Dates for HCPs and MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created or revised.
- HCPs (including the CARMP) and MERPs must be linked and attached in the Therap system.
  - Link HCP/CARMP on the Summary Sheet.
  - Link MERPs on the IDF.

13.2.9 Health Care Plans

- Interim Health Care Plans may be developed for new admission or change of condition.
  - 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.

13.2.9 HCP - New Elements

- HCPs/MERPs should include person-specific subtle or atypical signs of illness or pain so that DSP are able to promptly identify, notify the nurse and access medical care.

- Interventions that may prevent a medical emergency must be addressed in HCP.

13.2.10 MERP

- Removed measures to prevent a life-threatening condition from requirements.
  - These are now addressed in the HCP.
- Instructions to DDW nurses from CSB:
  - Make these edits according to the person's ISP cycle or for new HCPs/MERPs.
  - You do not need to edit all of these plans immediately!

13.2.10 More on MERP

The MERP must be written in clear, jargon-free language and include at a minimum the following information:

- A brief and simple description of the condition with the most likely life-threatening complications that might occur.
- How those complications may appear to an observer.
- Clear, jargon free, step-by-step instructions in an emergency, including when to call 911 directly.
- List of emergency contacts with phone numbers.
- Note if the person has advance directives or not, and if so, where the advance directives are located if pertinent to the MERP.

- The nurse is not required to create a MERP for persons in respite services

13.2.11 HCP and MERPs

- Nurses are responsible for providing training on the HCP and MERP to DSP and anyone else listed in the IST section of the ISP.
- The nurse may designate an alternate, competent trainer to provide education about the HCP and MERP.
  - Nurses may not designate a trainer for delegated tasks.

13.2.12 PRN Medications - NEW

- Now allow exception to prior consultation with the agency nurse to administer selected PRN emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website.
- Meds must be ordered, in MAR and MERP and trained.
- Use of 911 is likely needed.
- DSP must notify the nurse as soon as possible after delivery of the medication.

https://nmhealth.org/about/ddsd/pgsv/clinical/

Emergency Medications Examples

- Medications may include but are not limited to:
  - EpiPens and/or antihistamines for anaphylaxis;
  - Intranasal and rectal benzodiazepines for seizure control; and
  - Rescue inhalers for status asthmaticus.

Website content being finalized.

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13.2.13 Visit Schedules - NEW

- Minimum, face-to-face home visit schedule based on the person's e-CHAT acuity level that is required in all service settings (except in IMLS and for JCMs)

  a. Low acuity – at least annually
  b. Moderate acuity – at least semi-annually
  c. High Acuity – at least once per quarter
  d. High Aspiration Risk – at least monthly

Frequency of Nursing Visits for JCMs

	Low eCHAT Acuity	Moderate eCHAT Acuity	High eCHAT Acuity
Low Asp Risk	Semi annual	Quarterly	Monthly
Mod Asp Risk	Quarterly	Quarterly	Monthly
High Asp Risk	Monthly	Monthly	Monthly

13.2.13 Change of condition - NEW

Change of condition: If the nurse identifies or is notified of any change of condition, the nurse may (based on prudent nursing practice):

a. complete a face-to-face assessment
b. refer the person for immediate emergency care
c. work with the CM to coordinate an IDT meeting
d. All actions will be documented

13.2.13 On Call Nursing

An on-call nurse is required to :

- be available to DSP.
- must be able to respond within 15 minutes by phone.
- within 30 minutes in-person to make an on-site visit to assess the person if deemed necessary per prudent nursing judgment.

- The on-call nurse is not obligated to make an onsite visit if, based on prudent nursing practice, they determine it is preferable to refer for immediate access to urgent care or ER.
- An LPN on duty or on-call must have access to their RN supervisor by phone in case consultation is required.
- On-call nurses are required to document the calls they receive, the actions they take.

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Part 2 of Chapter 13
13.3 Adult Nursing Services

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13.3 Adult Nursing Services

- Contains tasks to be performed by the ANS Nurse in specific service categories
  - Nurses follow the General Nursing Requirements.

- ANS Provider Requirements.

13.3 Adult Nursing Services – NEW

13.3.2.6 Coordination of Complex Conditions now Required in Host- Surrogate Families

- 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 surrogate/host families but is optional for all others.

Please contact your respective Regional Office Nurse or any nurse in Clinical Services Bureau

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Chapter 14: Other Services

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Chapter 14.4: Environmental Modifications

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Environmental Modifications

- 14.4 Environmental Modifications includes physical adaptations identified in the person's ISP, which provide direct medical or remedial benefits to the person's physical environment.
- 14.4.1 Examples of Environmental Modifications include but are not limited to:
  - Ramps.
  - Roll-in shower.
  - Bathtub, sink, and/or toilet modifications.
  - Widening of doors.

Environmental Modifications

- 14.4.1 Examples of items not covered by Environmental Modifications:
  - Carpeting except for repairs to carpet needed due to permitted modification, such as carpet repair due to door widening.
  - Vehicle modifications.
  - Remodeling.
  - Outdoor fences.
  - General household repairs.

Environmental Modifications

- 14.4.2 Environmental Modification Service Requirements.
  - Administrative costs of the Environmental Modification cannot exceed 15% of the total cost of the project.
  - The DDSD Verification of Benefit Availability form must be obtained from the Regional Office prior to approval of this service.
  - Jackson Class Member Environmental Modification requests will no longer be reviewed and approved by the Regional Office. All submissions must go to Qualis Health.

Other Services
Maximum $ Amounts & Administrative Fees

- **AT** $250 per ISP year inclusive of 10% fees and no more than **$40 for batteries**.
- **FMAE** $550 per ISP year, inclusive of 10% fees.
- **Environmental Modifications** $5,000.00 every five (5) years inclusive of any 15% administrative fees.
- **Independent Living Transition Service** $1,500.00 inclusive of 15% fees.
- **PST** $5,000.00 per ISP year inclusive of 15% fees.
- **Non-Medical Transportation** $750 at $0.41/mile AND $460 inclusive of 10% for passes per ISP year.

Other Services

Supplemental Dental

A Fiscal Agent processes payment for:

- One preventive examination and cleaning each ISP year that is in addition to the benefit provided through the Medicaid State Plan.

- Available to adults (over age 21).
- Children receive all care through EPSDT.

For further questions, please contact:

Your local **Regional Office or Scott Doan**,

Regional Office Bureau Chief

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Chapter 14.8: Respite

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Respite

- 14.8 Respite is a flexible family support service. The primary purpose of respite is to provide support to the person and relieve the primary-unpaid caregiver.
  - Available to a person of any age living with an unpaid primary caregiver including CIHS with unpaid family members.
  - Use and location of Respite is decided by the primary caregiver in consultation with the IDT.
  - Medication administration is not a support in Respite and must be arranged for separately by the primary caregiver.
  - 100% of the total dollars available (excluding Case Management) may be accessed in the service package for Respite services.

For further questions, please contact:

Your local **Regional Office or Scott Doan**,

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Chapter 14.9: Socialization & Sexuality Education

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Socialization & Sexuality Education: Important Highlights

Sexuality is an essential part of anyone's health, well-being, and identity. Through the Friends & Relationships curriculum (FRC) the SSE service:

- provides concrete, interactive instruction that teaches people the skills needed to form & maintain relationships; and
- also helps people to make the strongest connection possible between their own personal values & informed choices about relationships & sexuality

To support the FRC student, the IDT is required to:

- Provide services & supports in such a way that the skills being learned are being practiced, reinforced, & expanded in all settings; and
- Integrate these skills and supports into the person's Desired Outcomes & TSS where and when appropriate.

- People taking the classes may take up to 2 series of classes each ISP year; there is no lifetime cap on the service.

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For further questions, please contact:

Your local **BBS Staff**.

https://nmhealth.org/about/ddsd/pgsv/behavior/staff/

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Chapter 15: Provider Enrollment Unit

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Provider Enrollment Unit

The Provider Enrollment Unit (PEU) has a new chapter in the standards. There are no new requirements however, the chapter outlines information about:

1. Enrolling new provider agencies and ensuring current provider agencies remain active.
2. Ensuring providers have an active Medicaid number.
3. Ensuring providers have an active Provider Agreement with the Department of Health.
4. Processing Amendments, Moratoriums and Waivers of Accreditation.
5. Tracking accreditation, insurance, licensure and QA/QI reports.
6. Processing expiration or termination of Provider Agreements, as well as withdrawals from the waivers.

For further questions, please contact:

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Chapter 16: Qualified Provider Agencies

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Overview

- DD Waiver services must be delivered by qualified DD Waiver Provider Agencies.
- This chapter consolidates what it means to be a Qualified Provider and the review processes built into the system.
- Most details are not new but consolidated in one place e.g. CHHS and EAR, licenses and education.)

16.6-Conflict of Interest

- Conflict Free Case Management is required.
- Case Manager requirements are in more detail in Chapter 8.
- Mitigation of Conflict of Interest is required.
- Clarifying language is added to the Standards about guardianship and Power of Attorney.

16.7-Compliance with the Standards and Exceptions

Two types of exceptions may be approved:

- Exceptions that directly impact a person in service, i.e., Exception Authorization Process, formerly known as the H Authorization Process; and
- Exceptions related to service and/or agency requirements.

All exceptions must be approved prior to implementing.

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Qualified Provider
16.9 Quality Management Bureau Surveys

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Changes to Survey Tools

- DDSD and DHI have worked together to revise Survey tools.
- QMB will not begin surveying on the 2018 DDW standards until April 1, 2018.
- Beginning April 1st QMB will review on 2018 standards for administrative requirements.
- QMB will continue to review individuals on the 2012 DDW standards until they transition to the 2018 DDW standards based on their ISP renewal date.
- QMB Community Programs Compliance Surveys will not include Jackson Class Members seen by the Individual Quality Review during the same review year.

Changes to Conditions of Participation (Essential Standards)

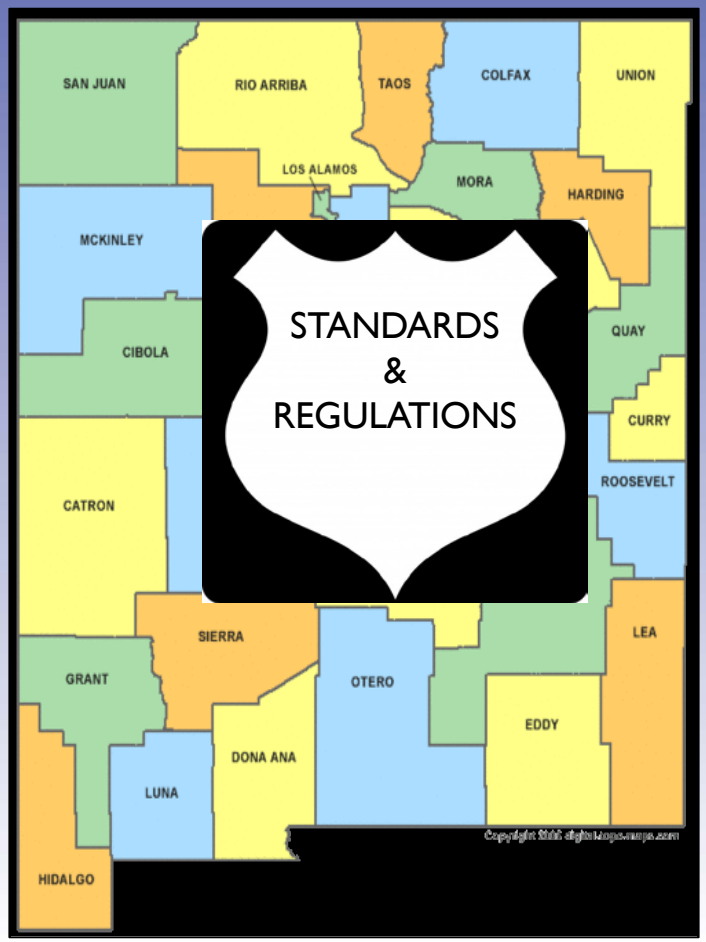
- DDSD and DHI have worked collaboratively to revise Conditions of Participation for Case Management, Living Care Arrangements and Community Inclusion Services.
- Conditions of Participation (CoP) are essential standards that must be followed by providers. We have revised them to be stand alone tags, which allows us to isolate the area of concern and the specific CoP citation.
- Visit the DHI website at https://nmhealth.org/about/dhi/ for updates to CoP listing and survey tools *(available 4/1/2018).*

Changes to Compliance Determination Process

- After a QMB compliance survey each DD Waiver provider will receive a determination of:
  - Compliance;
  - Partial Compliance with Standard Level tags;
  - Partial Compliance with Standard Level tags and Condition of Participation Level tag; or
  - Non-Compliance.

QMB Overview & Training

- The two major changes to the QMB survey process:
  - ➢CoPs and Compliance Determinations.
- QMB conducts Survey Process and Survey Expectations Training.
- We are here to help.
- Visit our website https://nmhealth.org/about/dhi/ or contact QMB directly.



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For questions regarding the QMB, please feel free to contact:
Valerie V. Valdez, Quality Management Bureau Chief at
Valerie.valdez@state.nm.us

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Qualified Providers
16.10 Individual Quality Review

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Individual Quality Review

- The name of the Community Practice Review (CPR) has changed to the Individual Quality Review (IQR).
- The IQR is conducted for Jackson Class Members only and will eventually be solely conducted by DHI Reviewers.
- The revised standards outline provider responsibilities during the IQR such as document production and follow up on the noted findings and recommendations.

Individual Quality Review Cont.

- The protocol is available on the Community Monitor's website:

  http://www.jacksoncommunityreview.org/

- The IQR protocol includes questions from the CPR as well as additional questions added by DOH, the Community Monitor and Plaintiffs' Counsel in order to ensure the questions are relevant and produce data that depicts a current picture of the class.

Individual Quality Review Cont.

- Please be sure to visit the Community Monitor's website to view the new protocol as new additions to the protocol include an in depth look at the following:
  - Informed Choice requirements in regards to Community Integrated Employment.
  - Healthcare coordination- for example, timely follow up on physician recommendations/orders and assessments.

For questions regarding the IQR, please feel free to contact:

Shadee Brown, DDSD Litigation Management Bureau Chief
(505) 841-5505 Shadee.Brown@state.nm.us or
Valerie Valdez, QMB Bureau Chief at
Valerie.Valdez@state.nm.us (505) 528-5037

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Chapter 17
Training

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Important Changes to Training

- Overall structure of the training chapter has been revised. All training requirements are broken down by position type (ie: Case Manager, DSP, DSP Supervisor, etc.).
- Competency % requirements have been removed from the standards and are available at the time of training.
- Change in timelines for Therapists and BSC's.
- CMs must attend ARM training.
- Three training policies and procedures have been incorporated into the standards.
- New Trainings -
  - *Indications of Injury and Illness; and*
  - *ANE.*

Policy and Procedure Integration into Standards

- T-001 Provider Training Reporting and Documentation Requirements-moved to Chapter 17.9.
- T-002 Training Requirements for CMs moved to Chapter 17.2.
- T-003-Training Requirements for DSP and Service Coordinators-moved into position specific section.

Changes to DSP and Service Coordinator Requirement Section

- Change in language related to any staff being used in an emergency situation to fill in or cover a shift.
  - Covering staff must have at a minimum the DDSD required Core Trainings and be on shift with another staff who has had the relevant Individual Specific Training for the individuals.
  - Pre-Service for DS/DSS & Foundation for Health & Wellness is now required 30 days from the date of hire & before working alone with any person receiving DD Waiver Services.

New Trainings

Indications of Illness and Injury - New requirement for **all** service providers.

- Online training which takes approximately 6 hours to complete and providers will access the training on the CDD web portal.
- **DSP and SC**-within 30 days of hire and before working alone with any person.
- **Therapists, BSCs and Nurses**-within 90 days of hire and before working alone with any person.
- Director's Memo will be sent in the near future indicating roll out and grace period for providers already in the system.

New Trainings Cont.

Abuse Neglect and Exploitation (ANE) face to face and online refresher.

- DDSD classroom training (face to face)-must be completed within 30 days of hire and prior to working alone for **all service providers.**
- ANE Trainers must be certified and must utilize the DOH-DDSD approved Core Curriculum.
- DDSD ANE On-line Refresher training renewed annually, within one year of successful completion of the DDSD ANE classroom training.

For further questions, please contact:

Chris Futey, Bureau Chief of Systems Improvement at Christopher.Futey@state.nm.us or 505-841-5507

OR

Your Regional Trainer Coordinator

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Chapter 18: Incident Management System

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Abuse Neglect & Exploitation

- New Chapter in the standards. No new requirements, however the 2014 NMAC changes are now included in the Standards.
- Incident Management Abuse Neglect Exploitation (ANE) training has been moved to the DDSD training unit.

ANE Training Changes

- The ANE training was transferred to the DDW Training Unit.
- The ANE training is now part of the required core competency trainings.
- There is an initial face to face training to be completed within 30 days and an online refresher that must be completed annually.

Case Management & DD Waiver Provider Agency Responsibilities for Risk Management

- 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.
- In situations where DHI substantiates the ANE report, the CM must:
  - Convene the DD Waiver participant's IDT to review the DHI findings.
  - Modify the person's ISP, if necessary.
  - Submit the IDT meeting minutes with a signature page to DHI within 10 business days of receiving the DHI IMB letter. The IDT meeting minutes must address all the concerns identified in the IMB closure letter.

Case Management & DD Waiver Provider Agency Responsibilities for Risk Management Cont.

When 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.

CM Responsibilities Related to IMS

Interim training on new requirements

New Case Managers must contact DD Waiver Unit to get training on requirements in previous slides within 30 days of hire and prior to working with alone with a person.

This supplemental training must be scheduled until the new Case Management training is developed.

For further questions, please contact:

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Chapter 19: Provider Reporting Requirements

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Reporting Overview

Provider Agencies are responsible for tracking and reporting to DDSD in several areas on an individual and agency wide level. Areas are:

- GER,
- OOHP,
- Aspiration,
- Client Census and Service Summary,
- Employment First,
- Semi Annual Reporting, and
- RORA.

Consumer Census and Service Summary

- All Providers must keep data that is readily available to DDSD or other state agencies as needed.
- DDSD Bureaus may establish routine timelines to request data related to specific services e.g. CM Agencies provide data semi annually.
- DDSD may request information on an ad hoc schedule.
- Required data elements help all providers track important information related to other program requirements (e.g. ISP and COE.)

Consumer Census and Service Summary

Important data points include:

- Consumer demographics including guardianship information,
- ISP begin and end dates,
- COE effective dates,
- Services provided by the specific DD Waiver Provider Agency,
- Setting of service and address, and
- Assigned lead (e.g. CM, BSC, Therapist).

Consumer Census and Service Summary

Important sources of information:

- Case Managers;
- Historical ISP Dates;
- Medicaid Provider Portal; and
- Use of CIU for Notifications.

Semi Annual Reporting Requirements

- After much input about usefulness of semi annual reporting, DDSD made no changes to the requirements.

- The second semi- annual report does not cover an entire 6 months due to the timing of ISP meeting. This is ok!

Regional Office Request for Assistance (RORA)

RORA is a request submitted by any entity involved in the provision of DD Waiver Services formally requesting assistance from the respective Regional Office.

- Significant changes from RORI to RORA:
  - Name change, was called RORI (**Intervention**), now called RORA (**Assistance**).
  - No longer required for the Regional Office to request authorization from the submitter to close the RORA.
  - Regional Office Director has the authority to close all RORAs.
  - A revised RORA template will be issued to reflect name change and new language.
  - A revised set of RORA instructions will be issued to reflect name change, new language, and minor process changes.

19.2 General Events Reporting (GER)

- GER reporting is now the Standards.
- The following providers are responsible for entering specified information into the GER section in Therap.
  - Customized In- Home Supports
  - Family Living
  - IMLS
  - Supported Living
  - Customized Community Supports
  - Community Integrated Employment
  - Adult Nursing
  - Case Management
- Entry must follow the GER Reporting Requirements in Appendix B.

19.2 General Events Reporting (GER) Important Changes

- The GER Requirements were updated September 15, 2017. This is now Appendix B.
- Reminder of major changes:
  - See ANE guide for all incidents reportable to DHI.
    - GER does NOT replace reporting to DHI.
  - All low and moderate medications errors are required to be reported at least monthly in the GER.
    - You can no longer use an alternative reporting system to report medication errors. You must use Therap GER.
  - Definitions were refined for consistency.
  - Document is organized alphabetically by event type.

19.2 GER and Appendix B Continued

- The major changes in the document:
  - All low and moderate medications errors are required to be reported at least monthly in the GER. You can no longer use an alternative reporting system to report medication errors. You must use Therap GER.
  - Definitions have been refined for consistency.
  - Document is now organized alphabetically by event type.

19.3 Out of Home Placement Reporting (OOHP)

- Providers must insure that information about the individual's mobility, comfort, safety, sensory items, communication supports and any durable medical equipment is current in the Individual's Data Form (IDF), e-CHAT and Medication History.
- The provider must document that this information listed above and the Health Passport were received by the Out of Home Placement provider.
- Delivery and receipt should be documented in the Event Detail section of the OOHP GER.

19.3 Out of Home Placement Reporting (OOHP)

- Living Support agencies must communicate the need for existing assistive technology (AT), adaptive equipment and communication supports, and offer the person's AT devices to the Out of Home provider. This also needs to be documented in the GER.
- Upon discharge, the Living Supports provider must promptly update the e-CHAT, IDF in Therap: the medical information section Adaptive Equipment portion or other healthcare records to indicate any supports received from the Out of Home provider.
- Provider Agencies must report an OOHP; within 48 hours of the placement. The Provider will enter the placement via Therap GER, categorized as "Out of Home Placement."

Statewide Aspiration Risk List (SARL) Reporting

- There are no changes to the reporting process for adults and young adults (18-20 yrs. old) who are found to be at moderate or high risk for aspiration.

- The Case Manager must submit the SARL form to the Kotie Viljoen, ARM Coordinator :
  - Within 7 calendar days following the IDT meeting
  - For significant changes (see list on form)
  - Via SCOMM or Fax 505-841-2987

For further questions, please contact:

Your local Regional Office or

Betsy Finley, RN, Clinical Services Bureau Chief

(505) 841-2907 or Elizabeth.finley@state.nm.us

Kotie Viljoen, ARM Coordinator, Clinical Services Bureau

(505)841-6188 or Jacoba.Viljoen@state.nm.us

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Chapter 20: Provider Documentation and Client Records

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Creating and Maintaining Records

- 20.5 Creating and Maintaining Records in Therap was previously a DDSD Policy. The Policy has been incorporated into the 2018 DD Waiver Standards.
- The Client File Matrix is expanded to include Therapy, Adult Nursing Services and Behavior Support Consultation. (See Appendix A)
- Required records per service type and setting are updated.

Therap Records

- If providers have documentation in Therap, they do not have to produce the documents for surveys (QMB, IQR, etc.).

Policy-Procedure Integration into Standards

- Therap Usage Policy was moved to Chapter 20.5 and 20.5.1.
- Use of Health Tracker Components was moved to Chapter 20.5.2.
- Electronic Health Passport was moved to Chapter 20.5.3.

Changes to Structure

- In Chapter 20, Section 20.1, HIPAA requirements are explained and referenced.
- 20.2 Client Records Requirements-General Requirements for DD Waiver Provider Agencies are listed in this chapter, the specifics for each service is delineated in Appendix A Client File Matrix.
- 20.3 Record Access for Direct Support Personnel (DSP) during Service Delivery-Delineates what records, Plans and forms DSPs should have access to, in order to complete necessary documentation and implementation of services being provided.
- 20.4 Timely Distribution and Sharing of Records.

20.6 Medication Administration Records – NEW

- Creating and maintaining an electronic or paper MAR in their service setting.
  - Provider Agencies may use the MAR in Therap, but are not mandated to do so.
- Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety.
- MAR must have prescribed dose, frequency and route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments including over the counter (OTC) or “comfort” medications or treatments and all self-selected herbal or vitamin therapy.

For further questions, please contact:

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Kathy Baker, Therap Supervisor (505) 841-5524 Kathy.Baker@state.nm.us

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Chapter 21: Billing

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505-476-8836

Prior Authorization Requirements

- Providers share responsibility to assure all requirements are met.
- Work with the Case Manager.
- Use the NM Medicaid Portal. https://nmmedicaid.portal.conduent.com/static/index.htm.
- Retroactive start dates can only be approved in extenuating circumstances.

Billable Activities/ Non- Billable Activities

- Billable activities must be consistent with service scope and requirements, and the individual's approved ISP.

- Non-Billable Activities are consolidated in this chapter.

Billable Units

- Units are defined.
- Chapter describes the process to share and prorate units when transitions between agencies occurs.
- Providers must work together.

For further questions, please contact:

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(505) 476-8836 or Christina.hill@state.nm.us

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Chapter 22 Quality Improvement Strategy (QIS)

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Important Areas to Highlight

- This is a new, separate chapter in the standards.
- Previous requirements were entered into each service provider chapter.
- Chapter is data focused and includes examples of data sources to be utilized when creating Quality Assurance and Improvement plans.
- Distinction between Quality Improvement vs. Quality Assurance
- DDSD Required Key Performance Indicators (KPI) related to Quality Assurance and Improvement

Preparation of Report and QA Requirements

- Same requirement to submit report to PEU on February 15th.
- Must track the following QA KPI in your annual report:
  - Compliance with DDSD Training Requirements, CCHS, EAR and licensing requirements as applicable.
  - Compliance with reporting requirements including ANE.
  - Timely submission of documentation for budgets
  - Presence and completeness of required documentation
  - Summary of all corrective plans implemented over the last 24 months.

Requirements Related to QI

- Must also have a QI plan in addition to QA plan explained on previous slide.
- The KPI are determined by DDSD on an annual basis.
  - May be discipline specific

Questions/Contact info for further support

Please contact Chris Futey Bureau Chief of Systems Improvement for questions at Christopher.Futey@state.nm.us or 505-841-5507.

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Roll Out

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Important Dates

1. *March 1, 2018*:

DD Waiver Services Standards, along with any associated changes to Clinical Criteria and the Budget Worksheet are effective. New Clinical Criteria is applied to any revisions coming in after March 1, 2018.

2. June 1, 2018:

New Version 4 Clinical Criteria will be applied for use with annual budget submissions for Individual Service Plans that begin on and after June 1, 2018.

Budget Worksheet

- BWS for Non-Jackson Class Members for submission to the OR
  - Updates to be issued on or before March 1, 2018
  - V-OR 2018 xx
  - Removal of SL IIBS and addition of SL Category 4 Extraordinary Support

OR Clinical Review Process

- Streamlined process for clinical review;
- Expansion of services which never require a clinical review e.g. case management;
- Typical review schedule of every 3 years;
- Services characterized by intensive levels of support may be reviewed annually;
- Elimination of SPARS and Staffing Grid;
- Elimination of evaluation units; and
- Number of units requested triggers clinical reviews for specific services.

REVIEW SCHEDULE & MORE INFORMATION COMING SOON!

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Budget Worksheet for Jackson Class Members

- **BWS for Jackson Class Members are submitted directly to Qualis Health**
  - o V-JCM 2018 XX
  - o Proposed Budget Levels field is auto populated with “JCM”.
  - o Family Living code accommodates 1000 hours of Substitute Care.
  - o Customized Community Supports Group Jackson Only code accommodates Adult Habilitation Medical Outlier.
  - o Customized In Home Supports will accommodate Independent and Intensive Independent Living.
  - o JCMs will receive PT, OT, and SLP incentive rates regardless of county.
  - o JCMs will receive BSC incentive rates regardless of county
  - o DDSD will issue a crosswalk of all 2007 services and codes to the 2018 services and codes.

Questions/Contact info for further support

Please contact

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(505) 476-8836 or Christina.hill@state.nm.us
Your local **Regional Office or Scott Doan**,
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