



Guidance for Selected Licensing Regulations

February 2015

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General note: References to participation by individuals receiving services also include persons who have legal standing to participate (e.g., a guardian, durable power of attorney, or authorized representative who has been granted decision making authority in the particular area) and others invited by the individual to participate.

12VAC35-105-580. Service description requirements

- A. The provider shall develop, implement, review, and revise its descriptions of services offered according to the provider's mission and shall make service descriptions available for public review.
- B. The provider shall outline how each service offers a structured program of individualized interventions and care designed to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meet the objectives of any required individualized services plan.
- C. The provider shall prepare a written description of each service it offers. Elements of each service description shall include:
1. Service goals;
 2. A description of care, treatment, training, or other supports provided;
 3. Characteristics and needs of individuals to be served;
 4. Contract services, if any;
 5. Eligibility requirements and admission, continued stay, and exclusion criteria;
 6. Service termination and discharge or transition criteria; and
 7. Type and role of employees or contractors.
- D. The provider shall revise the written service description whenever the operation of the service changes.
- E. The provider shall not implement services that are inconsistent with its most current service description.
- F. The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served.
- G. The provider shall provide for the physical separation of children and adults in residential and inpatient services and shall provide separate group programming for adults and children, except in the case of family services. The provider shall provide for the safety of children accompanying parents receiving services. Older adolescents transitioning from school to adult activities may participate in mental retardation (intellectual disability) day support services with adults.
- H. The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders).
- I. If the provider plans to serve individuals as of a result of a temporary detention order to a service, prior to admitting those individuals to that service, the provider shall submit a written plan for adequate staffing and security measures to ensure the individual can be served safely within the service to the department for approval. If the plan is approved, the department will add a stipulation to the license authorizing the provider to serve individuals who are under temporary detention orders.

Evidence of compliance:

- Providers shall demonstrate that their service description policies and procedures and written service descriptions are accessible to staff assigned to implement service descriptions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that the current service description corresponds to the needs of the population receiving services.

Note:

- When a provider is serving an individual whose needs have changed over time and those needs are now beyond the program description, if that individual's needs AND the services to meet those needs are documented in the individual's ISP and the provider has made arrangements to address them (e.g., arranging for specialized services) for that individual only, the provider would not have to change the program description; BUT
- If the provider plans to admit people with needs that do not match the current service description, then the service description would have to be changed.

- Providers shall demonstrate that they are not admitting individuals who are beyond the scope of their license.
- Providers shall demonstrate how staffing levels in its staffing plan support the current service description.
- Providers shall provide evidence of admission, discharge and exclusion criteria.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your service description policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Would you provide a written description of each service you offer (12VAC35-105-580 c 1-7)?
- What are the critical characteristics of the service you are providing?
- Are the services you deliver consistent with your written service description?
- Are the individuals being served by your program consistent with your service description?
 - What are the characteristics of the people you intend to serve?
- How do you utilize your service description to screen participants into your program (e.g., scope of services; comparison of scope to individuals' need profiles and admission, discharge and exclusion criteria)?
- Is there physical separation of services for adults and children?
- Do you have appropriately qualified staff to provide that service (as demonstrated by job descriptions and staff resumes and by professional licenses, as applicable)?

Examples that may clarify how this regulation would be applied:

Compliance:

- There is a current description of services that includes a description of the characteristics of the people that are being served by the provider and what service is being provided.
- The individuals who are being served match the description of the characteristics and the service delivered matches the description of the service being provided.
- An ID service provider that admits an individual with both ID and a serious MI has the staffing complement with experience and training to serve the individual in the home or service location.

Noncompliance:

- The people being served do not match the characteristics that are described in the service description.
 - A provider “expands” the population it serves without submitting a proposed new service description and request for service modification. For example, an Intensive Outpatient Program is licensed as an “Intensive Outpatient Program for geriatric adults” but when the specialist makes an unannounced visit, he determines that one of the participants is 45 years old. The provider explains that it had to admit younger individuals to make the program more viable because “we didn’t have enough older folks attending.” (Violation of 580.C.3)
 - The provider has not updated its service descriptions as the program evolved and as regs were updated. For example, the provider may have updated relevant Policies and Procedures to comply with revised regs but it failed to revisit the service descriptions or change staff qualifications. Or the provider may have revised its Policies and Procedures manual and its staff qualifications is compliant with the current regs but its service description still shows staff qualifications that are now obsolete. (Violation of 580.D)

- Essential elements of the service are not being provided. Examples include:
 - A detox program does not have a medical doctor;
 - A MH crisis stabilization program has no psychiatrist;
 - An Intensive In home service has no therapist; or
 - An ID residential provider admits an individual with primary MH needs but it does not have any MH experience (e.g. an individual with DAP funds who has clear history of MI is receiving congregate residential services from an ID provider).

Parking lot for future regulatory consideration:

- Change C.2 “A description of care, treatment, or other supports provided reference to training”

12VAC35-105-590. Provider staffing plan

A. The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the:

1. Needs of the individuals served;
2. Types of services offered;
3. The service description; and
4. Number of people to be served at a given time.

B. The provider shall develop a written transition staffing plan for new services, added locations, and changes in capacity.

C. The provider shall meet the following staffing requirements related to supervision.

1. The provider shall describe how employees, volunteers, contractors, and student interns will be supervised in the staffing plan and how that supervision will be documented.
2. Supervision of employees, volunteers, contractors, and student interns shall be provided by persons who have experience in working with individuals receiving services and in providing the services outlined in the service description.
3. Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented.
4. Supervision shall include responsibility for approving assessments and individualized services plans, as appropriate. This responsibility may be delegated to an employee or contractor who meets the qualification for supervision as defined in this section.
5. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.
6. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, mental health supports shall be provided by a QMHP-A. An individual who is QMHP-E may not provide this type of supervision.
7. Supervision of mental retardation (intellectual disability) services shall be provided by a person with at least one year of documented experience working directly with individuals who have mental retardation (intellectual disability) or other developmental disabilities and holds at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement.
8. Supervision of individual and family developmental disabilities support (IFDDS) services shall be provided by a person possessing at least one year of documented experience working directly with individuals who have developmental disabilities and is one of the following: a doctor of medicine or osteopathy licensed in Virginia; a registered nurse licensed in Virginia; or a person holding at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, or psychology. Experience may be substituted for the education requirement.
9. Supervision of brain injury services shall be provided at a minimum by a clinician in the health professions field who is trained and experienced in providing brain injury services to individuals who have a brain injury diagnosis including: (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a psychiatrist who is a doctor of medicine or osteopathy specializing in psychiatry and licensed in Virginia; (iii) a psychologist who has a master's degree in psychology from a college or university with at least one year of clinical experience; (iv) a social worker who has a bachelor's degree in human services or a related field (social work, psychology, psychiatric evaluation, sociology, counseling, vocational rehabilitation, human services counseling, or other degree deemed equivalent to those described) from an accredited college or university with at least two years of clinical experience providing direct services to individuals with a diagnosis of brain injury; (v) a Certified Brain Injury Specialist; (vi) a registered nurse licensed in Virginia with at least one year of clinical experience; or (vii) any other licensed rehabilitation professional with one year of clinical experience.

D. The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

E. Providers of brain injury services shall employ or contract with a neuropsychologist or licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial assessments, development of individualized services plans, crises, staff training, and service design.

F. Direct care staff who provide brain injury services shall have at least a high school diploma and two years of experience working with individuals with disabilities or shall have successfully completed an approved training curriculum on brain injuries within six months of employment.

Evidence of compliance:

- Providers shall demonstrate that their staffing plan/schedule policies and procedures are accessible to staff assigned to implement those functions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that the staffing plan/schedule is based on the needs of individuals receiving its services.
 - There is a process in place that examines and incorporates the needs of individuals receiving services (e.g., assessed medical needs or behavioral challenges) when determining staffing requirements rather than just relying on a pre-defined staffing ratio;
 - Staffing schedules are formulated by using the general requirements of the service and level, acuity and needs of individuals receiving services as reflected in their ISPs;
 - Staffing plans/schedules meet requirements in 12VAC 35-105-660 and 12VAC35-105-665); and
 - Changes are made to the staffing plan/schedule to respond to the needs of individuals receiving services that are not within the provider's capacity under the existing staffing plan.
- Providers shall demonstrate that staff with specific expertise was brought in or other arrangements were made, as necessary, to address the needs of individuals receiving services that are beyond the provider's capacity (e.g., skilled nursing, behavioral, REACH, or hospice services).
- Providers shall demonstrate that the staffing plan/schedule addresses the availability of staff required to maintain the health and safety of all individuals receiving services, including consideration of staffing required to transport individuals to medical or other appointments and to address emergencies and other staff absences.
- Providers shall demonstrate that direct care staffing is sufficient to address physical environment considerations and mobility limitations of individuals during an evacuation.
- Providers shall demonstrate that staff on duty at any time is of sufficient number and has the skills to provide all of the services designated in all of the individuals' service/care plans.
- Providers shall demonstrate that there are adequate numbers of direct support staff available to supervise individuals during periods of time when other direct support staff are unavailable (e.g., breaks, meals, meetings, training, etc.).
- Providers shall demonstrate that the staffing policy and plan/schedule clearly reflects all phases of supervision required in 12VAC35-105-590.C and includes required **modes** of supervision (observation, record review, interview, staff meetings, in-services) and **frequency** of supervision (how often is each mode implemented per position).
 - Each position description should include specific competency levels and supervision needed.
Note: Generally, direct care staff should have frequent supervision in a variety of modes.
- Providers shall demonstrate that basic elements in supervisors' job descriptions reflect required skills and knowledge requirements, including experience working with individuals receiving services, developing ISPs, and managing people.
 - Supervision of ID services shall be provided by persons who have at least one year of documented experience working directly with individuals who have ID or DD and who hold at least a bachelor's degree in a human services field such as sociology, social work, special

education, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement. (Refers to a QIDP)

- Providers shall demonstrate the availability of a written staff schedule indicating shifts to be worked and shall provide evidence of changes in the schedule (e.g., timesheets or payroll documents).
- Observation by the licensing specialist of the services being delivered in accordance with individuals' ISPs.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your staffing plan/schedule policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Would you provide a written copy of your staffing plan/schedule?
- Does the staffing plan indicate the types, roles, and numbers of staff that will be providing services and supports?
- Is there evidence to support that the indicated staffing plan was implemented?
- Would you describe how you allocate staff to ensure that you meet the needs of the individuals you are serving?
- When all the services and supports being provided to all the individuals receiving services are laid out on a daily/weekly schedule, is there enough staff with the appropriate qualifications to deliver those services and supports?
- Do you have sufficient staff available to effectively respond to a crisis, illness, or emergent event in the home or service location, including events that may require staff to transport or accompany individuals?
- What on-call arrangements or schedule adjustment protocols are in place to provide flexibility to respond immediately to a crisis, illness, or emergent event in the home or service location?
- How much and what kind of supervision do you provide?

Examples that may clarify how this regulation would be applied:

Compliance:

- Each individual has been provided all supports/interventions listed in his ISP at the frequency and intensity specified.
- There are no delayed or missed appointments due to insufficient staff.
- If an urgent/emergent event occurs, staff was available to transport and/or accompany the individual, if applicable.

For Sponsored Residential Services

- *Examples of **SUFFICIENT** coverage:* (1) A sponsor home is located a few miles from another sponsor home provider. Each home has two adults fully background checked, trained, and named as a sponsor provider. They have agreed to provide back-up for each other. (2) A sponsor's sister lives nearby and has a part-time job with flexible hours. She agreed to be a back-up, has been successfully background checked, and has completed all required training including behavior intervention and medication administration. She visits the home regularly and the individual(s) receiving services know and are comfortable with her.

For Children's Therapeutic Day Treatment*Summer Services**

- *An example of **SUFFICIENT** coverage:* A provider uses the same five staff to serve 20 children and also pulls from other programs or hires part time staff to manage transportation in the morning and evening. The provider also has struck an agreement with the school system to operate at the school where a 12 month school nurse will be present on the premises. Summer interns work every day and have primary responsibility for operational support of the program (e.g., preparing materials and classrooms, gym, etc for activities, setting up and cleaning up lunch, making calls that are not of a clinical or sensitive nature) in addition to their inclusion in group counseling sessions and some individual therapy sessions to gain clinical exposure/experience.

Noncompliance:

- Services are not delivered.
- There are repeated events of peer-to-peer aggression.

For Sponsored Residential Services

- *Examples of **INSUFFICIENT** coverage:* (1) A provider consistently advises the specialist that it receives back-up coverage from another licensed home and when asked for the name of the back-up, the specialist finds the same one or two names are being given by numerous sponsors for back-up coverage over a broad area. The provider advises the specialist that it has agreements with a few of its sponsors to serve as back-up for others. (2) An individual served by sponsor home has been living with an elderly parent who is in poor health and no longer able to provide his care. The sponsor home is a family member that lives within sight of the parent’s house and has identified the parent to provide back-up coverage. However, the parent has not had nor is he able to complete all the required training (e.g., behavioral intervention, med admin, etc.). Note: the individual is free to visit family members whenever he likes; however there must be clear evidence of qualified and trained back up staff and of the appropriate use of those back up staff. The intent is to ensure that appropriately trained and supervised staff is providing back-up.

For Children’s Therapeutic Day Treatment*Summer Services**

- *Example of **INSUFFICIENT** coverage:* The program is using the same staffing ratios for summer services as for those delivered during the school year when individuals were in a concurrent with educational program. During the school year, the provider has 25 students and five therapeutic day treatment counselors at XYZ Elementary. The children are in a structured environment and the counselors are surrounded by supportive resources such as the school nurse, teachers, school administrators, resource officers, guidance counselors, and cafeteria staff. The same five counselors are assigned to provide summer services to the 20 children attending the summer program, representing a 4:1 ratio, without the supportive resources provided in the structured school environment. A specialist arrives to see 18 -20 children engaged in a therapeutic outdoor activity with only one staff supervising because (1) one staff is out sick that day, (2) one staff is inside setting up for lunch, (3) one staff is in the office providing first aid for a scraped knee, and (4) one staff is in the front parking lot with an emotional 5th grader that has left the activity and is threatening to leave the grounds alone and walk the five miles home.

Parking lot for future regulatory consideration:

- Need to revise 12VAC35-105-590. –item C. 7. - Supervision – How supervision is being provided and documented and to clarify that experience only in provision of direct care would not meet experience that may be substituted for the education requirement. Rather, substitution has to be for like responsibilities.
- Need to change section title and appropriate text to “staffing plan/schedule”

- Need to include specifics related to IHH and MHSS services related to supervision.
- Need to spell out the supervision component of a QIDP. QIDP should be able to supervise the implementation of staff delivering the services spelled out in the person-centered plan (PCP).

12VAC35-105-620. Monitoring and evaluating service quality

A. The provider shall implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality assurance system. The provider shall implement improvements, when indicated.

Evidence of compliance:

- Providers shall demonstrate that their service quality monitoring and evaluation policies and procedures are accessible to staff assigned to implement those functions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that written policies and procedures specify how service quality and service effectiveness will be monitored and evaluated. This may include QS checklists, on-site supervision forms, critical incident tracking forms, and plans for remediation of critical incidents.
- Providers shall demonstrate that they collect and utilize objective (verifiable and quantifiable) and subjective data to assess the quality of services delivered.
- Providers shall demonstrate that they compile ISP (individual level) and program/environmental level data on service effectiveness annually and, if the data indicates that any one individual receiving services is not on track, that there has been a review/assessment of factors that were responsible for his insufficient progress and that a plan to address those factors has been developed and agreed to by the individual (and/or any substitute decision maker).

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your written policies and procedures for monitoring service quality and service effectiveness?
 - Are these policies and procedures being implemented?
- What do your quality review checks consist of and how do you to conduct quality review checks?
 - What is the frequency of your quality review checks?
 - Would you provide a copy of the most recent quality review check (e.g., the last quarterly review)?
- What are the qualifications of the people performing reviews of service quality and reviews of service effectiveness?
 - Do your written policies specify those qualifications?
 - Would you provide documentation that the persons performing quality reviews meet required qualifications?
- Are the results of service quality and service effectiveness review reviewed by program and/or agency administrators?

- Would you provide documentation of any services that were changed (if needed) based on a review of service effectiveness and service quality?
- How do you track and document service effectiveness in the short term and in the long term?
 - Would you provide the most recent data analyses/report that you compiled to determine service quality and effectiveness (short term and the long term)?
- Do your policies include provisions for obtaining input from individuals receiving services, as well as from anyone who is designated to speak on the individuals' behalf (authorized representative (AR), guardian, person designated by durable power of attorney, or person to whom the individual has given informed consent receive information)?
 - Are these provisions being implemented?
- How do you track and document the rate of progression by individual in achieving the stated goals/objectives by the date indicated for accomplishing that goal/objective as indicated in the ISP/PCP? (12VAC35-105-620)
 - Would you provide documentation or evidence that individuals are achieving the stated goals/objectives within timeframes established in their ISPs?

Examples that may clarify how this regulation would be applied:

Compliance:

- Written policies are in place and documentation is consistent with the policies being followed;
- When issues were identified a plan was devised and implemented to correct those issues;
- Actual data collected;
- Evidence of regular and ongoing analysis of the overall program data;
- Evidence of regular and ongoing analysis of each individuals data;
- Evidence that any issues identified, including a lack of sufficient progress to meet individual or overall program goals or objectives have resulted in actions being taken to remediate the identified issues;
- Evidence of ongoing evaluation of the effectiveness of those changes in remediating the identified issues.

Noncompliance:

- Lack of documentation of service review check and systems in place to monitor and evaluate service quality and effectiveness.
 - When provider is asked about their monitoring and evaluating systems, he pulls out the P&P and says “We really haven’t been following this.”

Parking lot for future regulatory consideration: None identified.

12VAC35-105-645. Initial contacts, screening, admission, assessment, service planning, orientation, and discharge

- A. The provider shall implement policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services and designate staff to perform these activities.
- B. The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the:
1. Date of contact;
 2. Name, age, and gender of the individual;
 3. Address and telephone number of the individual, if applicable;
 4. Reason why the individual is requesting services; and
 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service.
- C. The provider shall assist individuals who are not admitted to identify other appropriate services.
- D. The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service.

Evidence of compliance:

- Providers shall demonstrate that its policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services are accessible to staff assigned to perform those functions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that its policies and procedures contain specific instructions regarding:
 - How referrals will be received,
 - How initial contact will be made,
 - Specific admission criteria for each licensed service,
 - Specific admission processes and forms to be used,
 - Specific staff title and qualifications of positions that will implement applicable policies and procedures, and
 - Process that will be used to refer individuals to other services providers if applicable.
- Providers shall demonstrate that current practices are consistent with applicable policies and procedures.
- Providers shall demonstrate completion of 12VAC35-105-645 items B through D to demonstrate compliance with item A.
- Providers shall demonstrate that they have a system in place to document information specified in 12VAC35-105-645 item B and retain documentation of individuals' initial contacts and screening for six months.
 - There is written documentation on file for each individual who contacted the provider and was screened for services, to include each element listed in 12VAC35-105-645 item B.
 - Individuals calling for assistance may not provide all specified items (e.g., age). In those instances, the program shall note in writing that the information was not provided.

- Providers shall demonstrate the disposition, specifically whether the person was admitted to a service, placed on a waiting list for a specific service, or received assistance to identify or obtain other appropriate services.
 - For individuals who were admitted, the provider shall document that the individual met the criteria for admission.
 - For individuals who were not admitted, the provider shall document the reason or reasons why the person was not admitted and the actions it took to assist individuals identify other appropriate services.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services?
 - Are provider practices consistent with applicable policies and procedures?
- What happened to the individual after he or she contacted the provider? Have you documented what happened?
- Was the individual placed on a waiting list for services? Have you documented this?
- If an individual was not admitted or placed on a waiting list for services, what did the staff do to help the individual identify other appropriate services? Have you documented what happened?

Examples that may clarify how this regulation would be applied:

Compliance:

- A provider reviewed a referral, gathered information, determined that the individual did meet its criteria for admission, and, based on the preliminary information, that it had the facilities and expertise to provide the services and supports that were likely to be needed.

Noncompliance:

- The provider reviewed a referral, gathered information, determined that the individual did meet its criteria for admission, and, based on the preliminary information, that it did not have the facilities or the expertise to provide the services and supports that were likely to be needed. Even with this information, the provider decided to admit the individual to their service.

Parking lot for future regulatory consideration:

- Recently, some providers have not been determining the disposition to admit an individual until after submission to Magellan. This is not appropriate and providers continue to get cited. This area is clearer for ID services than for MH services.

12VAC35-105-650. Assessment policy

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual and authorized representative, if applicable, in the preparation of initial and comprehensive assessments and in subsequent reassessments. In these assessments and reassessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate employees or contractors who are responsible for conducting assessments. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tool or tools being utilized, and the provision of services that the individuals may require.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history.

E. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's:

1. Diagnosis;
2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;
3. Current medical problems;
4. Current medications;
5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and
6. At-risk behavior to self and others.

F. A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address:

1. Onset and duration of problems;
2. Social, behavioral, developmental, and family history and supports;
3. Cognitive functioning including strengths and weaknesses;
4. Employment, vocational, and educational background;
5. Previous interventions and outcomes;
6. Financial resources and benefits;
7. Health history and current medical care needs, to include:
 - a. Allergies;
 - b. Recent physical complaints and medical conditions;
 - c. Nutritional needs;
 - d. Chronic conditions;
 - e. Communicable diseases;
 - f. Restrictions on physical activities if any;
 - g. Past serious illnesses, serious injuries, and hospitalizations;
 - h. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and
 - i. Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs.
8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues;
9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;
10. Legal status including authorized representative, commitment, and representative payee status;
11. Relevant criminal charges or convictions and probation or parole status;
12. Daily living skills;
13. Housing arrangements;
14. Ability to access services including transportation needs; and
15. As applicable, and in all residential services, fall risk, communication methods or needs, and mobility and adaptive equipment needs.

G. Providers of short-term intensive services including inpatient and crisis stabilization services shall develop policies for completing comprehensive assessments within the time frames appropriate for those services.

H. Providers of non-intensive or short-term services shall meet the requirements for the initial assessment at a minimum. Non-intensive services are services provided in jails, nursing homes, or other locations when access to records and information is limited by the location and nature of the services. Short-term services typically are provided for less than 60 days.

I. Providers may utilize standardized state or federally sanctioned assessment tools that do not meet all the criteria of 12VAC35-105-650 as the initial or comprehensive assessment tools as long as the tools assess the individual's health and safety issues and substantially meet the requirements of this section.

J. Individuals who receive medication-only services shall be reassessed at least annually to determine whether there is a change in the need for additional services and the effectiveness of the medication.

Evidence of compliance:

- Providers shall demonstrate that assessment policies and procedures are accessible to staff assigned to perform this function.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).

Note: Sponsored home locations are not expected to have these materials in each location.

- Providers shall demonstrate that assessment tools incorporate elements required for assessments.
- Providers shall demonstrate that staff conducting assessments have the qualifications and experience to conduct the type of assessment provided by that professional discipline (e.g., licensed medical professional for health assessment, licensed psychologist for assessment of intellectual functioning, licensed behavioral analyst for assessment of the function of behavior). (12VAC35-105-650 item C)
- Providers shall demonstrate current assessment practices are consistent with the provider's policies and procedures and that they have a system for documenting information specified in 12VAC35-105-650 items B through J to demonstrate compliance with item A. This includes written documentation in individuals' records that contain a substantial portion of the following elements:
 - The provider followed its procedures in the performance of assessments, including specific documentation of individuals' input to the process (12VAC35-105-650 item B);
 - Contacts requesting previous assessments (12VAC35-105-650 item D);
 - Evidence in the initial assessment includes all immediate service, health, and safety needs and required information, including the reasons for medications and any contraindications/side effects and ramifications in persons' lives (12VAC35-105-650 item E).
 - Evidence in the comprehensive assessment (12VAC35-105-650 item F) that includes a substantial portion of elements listed in item F. Additional guidance for certain elements follows:
 - § Onset and duration of current issues for which the individual is seeking services includes stated issues for which the individual is seeking services or what's needed to help the individual realize his vision of a good life;
 - § Social, behavioral, developmental, and family history and supports includes a brief listing of historic events in the individual's lives and what supports have been provided in the past;
 - § Cognitive functioning includes psychological testing results as well as any previous determinations of capacity to make decisions, and cognitive strengths and weaknesses as determined by psychological assessment;
 - § Employment, vocational, and educational background includes the individual's education and work history;
 - § Previous interventions and outcomes includes a listing of all known previous interventions and supports and what effects those interventions and supports provided;
 - § Financial resources and benefits includes a listing of all known assets, income, and debts;
 - § Health history and current medical needs includes a description of any restricted diets and choking risks;
 - § Daily living skills can be assessed using a standardized instrument or through direct systemic observation and written documentation of the individual's skills;
 - § Housing arrangements refers to a description of the individual's current home and all who live in the home with the individual;

- § Ability to access services including transportation needs refers to an assessment of both the individual's skills to use transit and the availability of those services in the individual's environment; and
 - § Fall risk, communication methods or needs, and mobility and adaptive equipment needs refers to assessments by a licensed professional of areas in their scope of practice resulting in a written report of the assessment process and findings.
- Providers shall demonstrate that the comprehensive assessment contains enough detail to be sufficient for services and supports to be designed and provided.
 - Providers shall demonstrate that changes in assessment policy and/or forms are submitted to licensing for approval prior to implementation.
 - Providers shall demonstrate that assessments and annual reassessments include the following five risk areas (based on review of incidents, reports, etc. from the year) in addition to a review of effectiveness data:
 - Health - Inclusion of new diagnoses, medications, and concerns and how they will be addressed;
 - Nutrition - Documentation of choking concerns, dietary changes, liquid consistency and food texture requirements;
 - Behavior - Documentation of behavior plan/guidelines that are in place, are working, or are needed, including any new behavior concerns and how are they will be addressed;
 - Falls – Documentation of fall risks and concerns, and whether a prevention plan in place and working or whether changes are needed;
 - Restrictive protocols or special supervision requirements – Inclusion of any restrictive protocols or special supervision requirements already in place are clearly defined to ensure consistent implementation and are assessed to determine if:
 - § They still are needed,
 - § They are meeting the needs of individual,
 - § The team has discussed risk and documented agreement, and
 - § All providers/services are utilizing the same protocol or any differences are explained.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your assessment policies and procedures?
 - Does your policy specify what assessment(s) will be done, by whom, and how the results will be documented?
 - Does your policy identify how you will attempt to obtain previously completed assessments?
- How are your practices consistent with applicable policies and procedures?
- Is there evidence that your comprehensive assessments contain enough detail to allow for the development of an ISP that is effective in addressing identified needs and realizing the individual's stated desired outcomes?

Examples that may clarify how this regulation would be applied:

12VAC35-105-650 – examples to clarify expectations regarding assessment instruments (e.g., regulations do not require a single tool assessment elements should focus on the needs of the individual)

Compliance:

- A person who is suspected to have swallowing issues has his swallowing assessed by a speech pathologist.
- A person with significant behavior issues has that behavior assessed by a licensed behavior analyst.
- A person determined to have an intellectual disability has his basic skills assessed to determine his basic self help needs.
- The provider provides documentation of significant efforts to obtain services if they have not been obtained.

Noncompliance:

- A person who is suspected to have swallowing issues has their swallowing assessed by a chart review of events of choking.
- A person with significant behavior issues has that behavior assessed by completing an instrument that is not appropriate for that purpose, e.g., the FAST (Functional Analysis Screening Tool).
- A person determined to have an intellectual disability has his basic skills assessed by a review of daily notes to see what he does on his own.

12VAC35-105-650 item C – examples to clarify training/expertise that would meet the requirement for “experience in working with the needs of individuals, etc.”

Compliance:

- Assessments using tools or techniques that fall under a particular profession licensed by the Commonwealth that are conducted by professionals in those disciplines.
- Assessment tools that are designed to be utilized by others are completed by people who have been trained and have documented demonstration of competency in that assessment tool.

Noncompliance:

- Assessments using tools or techniques that fall under a particular profession licensed by the Commonwealth conducted by a person who is not a professional in those disciplines.
- Assessments that are designed to be utilized by others are completed by people who have not been trained and do not have documented demonstration of competency in that assessment.

12VAC35-105-650 item E – examples to clarify:

- Item E. 1 - diagnosis can be “as reported by” – Diagnosis that were made by an appropriately credentialed professional can be used and listed in this document as long as there is a reference as to where the diagnosis came from (e.g. he was given the diagnosis of bipolar disorder by Dr. Doolittle in 1974);
- Item E. 2. - definition of needs – Items targeted for intervention/support;
- Item E. 3. - current medications to include reasons if available, medication contraindications/side effects and ramifications in persons’ lives - Information from the prescribing doctor (Lithium 300mg BID for bipolar disorder), Medication information regarding side effects, adverse reaction and interactions for each medication prescribed to the individual from a pharmacy or information contained on the medication reference section of medscape.com <http://reference.medscape.com/>.

12VAC35-105-650 item F – examples that incorporate needs into assessment and tie back to ISP:

- Clinical assessment to support mobility and adaptive equipment needs;
- Consideration of physical environment needs (e.g. evacuation considerations).

Compliance:

- Assessment, both those done by licensed professionals and those done by the provider identifies the needs of the individual. (assessment therefore necessarily includes talking with the individual or someone selected by the individual to speak for him regarding why they are seeking services and to determine what they would like to have happen as a result of services).

Noncompliance:

- Providing services to the individual based on a predetermined program regardless of their assessed or stated needs.

Parking lot for future regulatory consideration:

- “One size fits all assessment” should be revisited
- 12VAC35-105-650 add legal guardian in definitions, look at competency/capacity to give informed consent, explore supportive decision making
- 12VAC35-105-650 item F – timeframe for comprehensive assessment
- 12VAC-105-650 item I. – standardized state or federally sanctioned assessment tools

12VAC35-105-660. Individualized services plan (ISP).

A. The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.

B. The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first.

C. The provider shall implement a person-centered comprehensive ISP as soon as possible after admission based upon the nature and scope of services but no later than 30 days after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services.

Evidence of compliance:

Providers shall demonstrate that their ISP policies and procedures are accessible to staff assigned to develop and implement ISPs. (12vac35-105-580 paragraph B)

- Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that a process is in place to involve the individual and anyone who is designated to speak on the individuals’ behalf, as appropriate, in the development of the ISP and there is written documentation in individuals’ records:
 - That the individual was present and participated in ISP planning meetings;
 - Of any additional assistance that was provided to the individual in making decisions;
 - That the ISP was developed in collaboration with the individual, based on the individual’s preferences, choices, and stated objectives;
 - That cultural preferences and practices were incorporated in the ISP; and
 - The settings, services, and providers that were considered and those chosen by the individual.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your ISP policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Is there evidence that ISPs are developed within the specified timelines?
 - Are initial ISPs being developed within 24 hours of admission?
 - For short term services, are initial ISPs comprehensive enough to address the needs of individuals seeking services? (Note: For individuals needing acute services, the initial ISP may be the only plan to stabilize the person)
- Is there evidence that initial ISPs include goals/objectives/interventions? (Note: typically initial ISPs, especially in MH services, do not contain interventions associated with indicated goals/objectives, which has and continues to be an issue.)
- Is there evidence that the ISP process complies with HIPAA requirements, e.g. persons involved in the development of the ISP were invited by the individual, agreed to by the individual at the meeting or who had legal standing to participate?
- Is there evidence that ISPs are being implemented as soon as possible after admission?

Examples that may clarify how this regulation would be applied:**Compliance:**

- Individuals' ISPs are consistent with both the assessed and self identified needs of the person being served.

Noncompliance:

- The ISPs for all the individuals in the service are identical or very similar even though the individuals have widely divergent strengths, needs and preferences.
- People who have not invited by the individual and who no legal standing attending the ISP meeting

Parking lot for future regulatory consideration:

- Incorporate CMS regulations

12VAC35-105-665. ISP requirements.

A. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment. The ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need;
2. Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports;
3. The role of the individual and others in implementing the service plan;
4. A communication plan for individuals with communication barriers, including language barriers;
5. A behavioral support or treatment plan, if applicable;
6. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;
7. A crisis or relapse plan, if applicable;
8. Target dates for accomplishment of goals and objectives;
9. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies; and
10. Recovery plans, if applicable.

B. The ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document his attempt to obtain the necessary signature and the reason why he was unable to obtain it.

C. The provider shall designate a person who will be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual or authorized representative, as appropriate.

D. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP.

E. Providers of short-term intensive services such as inpatient and crisis stabilization services that are typically provided for less than 30 days shall implement a policy to develop an ISP within a timeframe consistent with the length of stay of individuals.

F. The ISP shall be consistent with the plan of care for individuals served by the IFDDS Waiver.

G. When a provider provides more than one service to an individual the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.

H. Whenever possible the identified goals in the ISP shall be written in the words of the individual receiving services.

Evidence of compliance:

- Providers shall demonstrate that their ISP policies and procedures are accessible to staff assigned to develop and implement ISPs.
 - Staff access to ISP policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that ISP planning meetings occur within timeframes specified in 12VAC35-105-660 item B and implementation was initiated within the timeframes specified in 12VAC35-105-660 item C.
- Providers shall demonstrate that ISPs include information specified in 12VAC35-105-665 items A through C.
 - The ISP has been developed by the individual with support from the treatment/support team that may include the individual, the provider, the case manager/support coordinator, the individual's authorized representative as applicable, and other individuals who have been selected by the individual; and

- Target dates for completion of goals/objectives are the actual date by which the goal/objective is expected to be completed. Note: Setting the dates to correspond with the end of the plan year or authorization period is not an acceptable practice.
- Providers shall demonstrate that parties have agreed to the ISP (e.g., completed signature page).
- Providers shall demonstrate that a process is in place to ensure that ISPs are clearly related to individuals' stated reasons for seeking services and to their assessed needs for specific services and supports to achieve his or her desired outcomes. This includes the following written documentation that:
 - The ISP includes the individual's reasons for seeking services and his or her desired outcomes and reflects services and supports (paid and unpaid) that will assist the individual to achieve his identified goals;
 - Individuals receiving services have been provided the opportunity to make informed choices about the services and supports identified in their ISPs (e.g., completed consent for treatment/choice forms);
 - Each service and support identified in the ISP is clearly related to the listed desired outcomes, derived from an assessed clinical and/or support need, and tied specifically to a specific written goal and objective;
 - The ISP reflects risk factors and measures that will be in place to minimize them in applicable plans (e.g., behavioral support or treatment plan, safety plan, or crisis response or relapse plan). This includes individualized back-up plans and strategies when needed;
 - The ISP includes a description of how services or supports will address assessed clinical/support needs, the target dates for completion of each goal and objective and related services of supports, and data to be collected that will verify that an outcome has been achieved;
 - § Data that is gathered may vary in type, intensity, methodology, and frequency according to the description in the individual's ISP (dependent on the need and intervention but must be object and verifiable data); and
 - Each specific written goal and objective has a specific targeted outcome that will trigger the discontinuation of that goal or objective and related services or supports when achieved.
- Providers shall demonstrate working knowledge of the objectives and strategies contained in an individual's ISP either by providing the support to the individual or via role play.
- Providers shall be responsible for ensuring that staff are trained to be able to implement, document and evaluate individuals' plans.
- Providers shall make sure that documentation clearly demonstrates the opportunity to work on individuals' outcomes/goals.
- Providers shall demonstrate that they use objective data to clearly indicate that each individual receiving services is meeting, or is on track to meet, the objectives and outcomes by the date identified in his ISP.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your ISP policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Is there evidence that ISPs contain the items listed in 12VAC35-105-665 items A through C?
- Do individuals' ISPs reflect their wishes (as evidenced by the language in the ISP and by discussion with individuals receiving services)?

- Do goals and objectives in ISPs match what individuals indicate they want to accomplish as a result of the ISP?
- Is there evidence that all identified service needs are addressed in the ISP?
 - Are the needs/wants identified in individuals' assessment addressed in their ISPs?
 - Is there evidence of clear service needs that were not assessed/included in the ISP?
 - Do ISPs include needs that have been identified but are not currently a focus of intervention due to prioritization of needs?
- Is there evidence that individuals receiving services received a complete description of the risks, benefits, processes, and timelines associated with proposed supports/interventions?
 - Do individuals receive information about alternatives to proposed supports/interventions, including the same information for the option of receiving no support/intervention?
- Would you provide your specific criteria for discontinuing ISP objectives/goals and the specific timeframes by which the team is expected to have accomplished those criteria?
- Is there evidence that ISPs have been signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative?
 - If the signature of the individual receiving services or the authorized representative was not obtained, has the provider documented its attempts to obtain the necessary signature and the reason why it could not be obtained?

Examples that may clarify how this regulation would be applied:

Compliance:

- Individuals receiving services identify that their current ISP strategies are working well for them; the data supports progress is on track to meet specified outcomes/timelines; and staff demonstrate the application of ISP interventions/ supports as written in the ISP (when asked or observed).

Noncompliance:

- Staff are unable to demonstrate the application of the interventions/supports in the ISP.

Parking lot for future regulatory consideration:

- Incorporate CMS regulations
- For most services, change annual review requirement to require reviews based on the complexity/ needs of individuals
- Informed choice/consent requirements

12VAC35-105-675. Reassessments and ISP reviews

A. Reassessments shall be completed at least annually and when there is a need based on the medical, psychiatric, or behavioral status of the individual.

B. The provider shall update the ISP at least annually. The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. These reviews shall evaluate the individual's progress toward meeting the plan's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.

Evidence of compliance:

- Providers shall demonstrate that their ISP reassessment and review policies and procedures are accessible to staff assigned to implement those functions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).
- Providers shall demonstrate that a process is in place to ensure that ISP reviews are being updated at least annually and when individuals' needs change. This includes the following written documentation:
 - That goals and objectives and related services and supports are reviewed and updated to reflect changing needs of individuals receiving services.
 - That accomplished ISP goals/objectives were discussed with the individual receiving services, were removed from the ISP, and any new or modified goals/objectives were developed using an informed choice process.
 - That goals/objectives that are not on track to be accomplished by the targeted date were discussed with the person being served and removed or modified using an informed choice process
 - That, for goals/objectives that were not accomplished by the identified target date, the team met to review the reasons for lack of progress and to provide the individual an opportunity to make an informed choice of how to proceed.
- Providers shall demonstrate that timely reassessments were conducted based on a change in status of the person served.
- Providers shall demonstrate that changes were made to the ISP as a result of the assessments.
- Providers shall demonstrate that an informed choice process is being implemented when changing the ISP.
- Providers shall demonstrate that data related to goals, objectives in ISPs is being reviewed at least every 3 months and that determinations are being made that individuals meet or are on track to meet the outcomes/objectives by specified dates.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your ISP reassessment and review policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Is there evidence to support the items listed above were completed?
- When asked, do individuals being served identify that the ISP is addressing their desired outcomes?

- When asked, do individuals being served identify that they were presented a complete description of the risks, benefits, processes and timelines involved in the proposed supports/interventions as well as alternatives to those supports/interventions to include the same information regarding no support/intervention, and that they were able to understand the information being presented?

Examples that may clarify how this regulation would be applied:

Compliance:

- There are four quarterly reviews of the implementation and effectiveness of the ISP that describe current status/revisions to the plan, as needed. If changes identified, during quarterly review, the individual is aware and has signed the review

Noncompliance:

- There is no demonstrated progress or progress will not meet the designated timelines and there is no indication of discussion with the individual as to how they want to proceed and/or no changes were made to the current ISP implementation strategies

Parking lot for future regulatory consideration: None identified

12VAC35-105-1240. Service requirements for providers of case management services.

A. Providers of case management services shall document that the services below are performed consistent with the individual's assessment and ISP.

1. Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
2. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment;
3. Assessing needs and planning services to include developing a case management individualized services plan;
4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the ISP;
5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments;
7. Monitoring service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual;
8. Providing follow up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;
9. Advocating for individuals in response to their changing needs, based on changes in the individualized services plan;
10. Planning for transitions in the individual's life;
11. Knowing and monitoring the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and
12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

Evidence of compliance:

- Providers shall demonstrate that their case management policies and procedures are accessible to staff assigned to implement those functions.
 - Staff access to applicable policies and procedures may be provided through paper copies at the service delivery site or by electronic access to applicable documents. If the provider chooses to

make policies and procedures available electronically, appropriate staff must have access to a computer and applicable link(s).

- Providers shall demonstrate that initial and subsequent assessments are conducted utilizing an informed choice and consent process in which individuals being served have opportunities to consider and make informed choices among options available to them and receive information about any specific risks and benefits of associated with those options.
- Providers shall demonstrate that information about potential services and supports is discussed with individuals being served; that ISPs are tied to descriptions of what individuals' say they would like their life to look like or to the specific areas in their life for which they would like assistance; and that ISPs identify all areas of support/services.
 - The support coordinator/case manger clearly identifies the capabilities of services to meet the identified needs and preferences and ensures that services do not place an individual, other participants, or staff at risk of serious harm.
- Providers shall demonstrate that additional assessments are conducted and included in ISPs in response to changes in individuals' status or their lack of sufficient progress toward meeting stated goals/objectives information.
- Providers shall demonstrate that case management services performed are consistent with the individuals' assessments and ISPs. This includes written documentation of:
 - Reasons why particular community supports offered to individuals and included in ISPs are the most likely to promote their life goals and desired outcomes;
 - Specific assistance provided to assist individuals' locate, develop, or obtain needed services, resources, and appropriate public benefits;
 - Discussion of and planning for known transitions that are expected to in the person's life.
- Providers shall demonstrate that individuals being served have increased their integration into the community as demonstrated by an increased number of natural supports, use of resources available to the general public and a decrease in the use of/reliance on paid supports.
- Providers shall demonstrate contacts with people who are important to individuals' achieving their desired outcomes and becoming an integral part of their local community. This includes written evidence that there are legally valid releases to allow for these contacts.
- Providers shall demonstrate efforts to assure that provider agencies, as well as other human services agencies and systems, are providing services consistent with the individuals ISP/PCP and that all provider agencies services, are both compatible and focused on achieving the outcomes the person served had identified as their desired outcome. This includes evidence that:
 - Providers, the CSB, and individuals receiving services (and anyone who speaks for an individual) have been in contact with each other and have had ongoing discussions about accomplishments, issues, needs and changes;
 - Service delivery monitoring has occurred and has involved contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual;
 - There is evidence in the individual's record of any aspect of their life that is not working for them and what they are requesting in order to meet that need;
 - There is evidence in support coordinators/case manager's notes that individuals' needs have been communicated to them and that a plan of action has been implemented to review and address that need; and

- There are sufficient notes to determine if the support/service has been provided as planned.
- Providers shall demonstrate that objective (quantifiable and verifiable) data has been recorded in the records of individuals being served. (e.g., number of psychiatric hospitalizations, number of events of self injury, number of non-paid people in the individuals life, number of times the person used a new skill, amount of time between positive urine drug screens, or number of days on the job). This includes:
 - Summaries of that data in the support coordinator's /case manager's notes;
 - Analyses of the likelihood that the desired outcome target will be met in the time frame specified for that outcome;
 - Evidence of any aspects of individuals' lives that are not working for them and what they are requesting in order to meet those needs;
 - Evidence in the support coordinator's/case manager's notes that the need has been communicated to them and that a plan of action has been implemented to review and address that need
- Providers shall demonstrate that the support coordinator/case manager has provided follow up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP. This includes evidence of any changes in the status or previously available services/supports that are no longer available or needed.
- Providers shall demonstrate knowledge and monitoring the individual's health status, any medical conditions, and medications and potential side effects, and of assistance to the individual in accessing primary care and other medical services, as needed. This includes evidence in appropriate records or notes:
 - Of any incidents/events that have occurred;
 - That the incident/event was communicated to them;
 - That the support coordinator and the individual reviewed the incident/event and made an informed decision of how to proceed;
 - That the individual's support team had met to discuss any changes the individual had decided to pursue.
 - Of ongoing monitoring to assure incident/event and any changes made in response to that event are working for the individual.

Examples of questions that may be asked to determine compliance with this regulation:

- Would you provide your case management policies and procedures?
 - Are provider practices consistent with applicable policies and procedures?
- Is there evidence that your case managers have completed DBHDS case management modules?
- Is there evidence that applicable case management reporting requirements for individuals under the DOJ settlement agreement are met, if applicable?
- When asked, what do individuals being served say about opportunities they have had to:
 - Consider and make informed choices among options available to them;
 - Understand any specific risks and benefits of associated with those options;
 - Express their reasons for choosing or not choosing specific options.
- What do you do when the individual receiving services does not have anyone who can assist him to consider and make informed choices among options available to them?

- How does the support coordinator/case manager determine that the individual is progressing in the plan?

Examples that may clarify how this regulation would be applied:

Compliance:

- An individual has had multiple events of self injurious behavior, the case notes indicate that the support coordinator/case manager had been informed of the events; had authorized additional services to be provided to the individual; and had initiated a meeting with the support team to review, discuss and develop a plan of action. The effectiveness of that plan was reviewed by the support coordinator/case manager and changes to the plan were made until the events of self injurious behavior had resolved.
- An individual had been taking psychotropic medications as prescribed. A new medication was added and within 4 weeks the individual seemed more symptomatic and began refusing to take any medications. The support coordinator/ case manger met with the individual and talked with her about her medications and her refusal to take the current regimen. The individual identified experiences that were consistent with the side effects of the new medication. The support coordinator/case manager assisted the individual in meeting with his psychiatrist and facilitated the individual communicating her concerns about the current meds. Following the appointment the case manger provided extra contact and additional supports until medication changes could be made and the medication could take effect. The support coordinator/case manager also helped the individual to obtain some classes to teach her how to monitor her symptoms and side effects as well as how to effectively communicate that information to her

Noncompliance:

- Two individuals living in a group home stated that they really disliked each other and both said they would like to move away from each other. The provider has been working with them to try to get them to be civil to each other and has added staff to try to help support them. Even with these efforts the two individuals end up in physical altercations with each other about once per week. The support coordinator/case manager notes the events in their monthly note and indicates that they will address the issue at the annual ISP meeting.
- An individual had been taking psychotropic medications as prescribed. A new medication was added and within 4 weeks the individual seemed more symptomatic and began refusing to take any medications. The support coordinator/case manager waited until her symptoms are at emergent levels and then has emergency services respond and she is admitted to the psychiatric hospital. The support coordinator/case manager does not meet with the individual and waits for the psychiatrist to send her a report about the individual's status.

Parking lot for future regulatory consideration:

- Separate ID case management section that would be more specific and directive and include DOJ Agreement ID case manager qualifications, duties and responsibilities, required trainings, supervision, reporting requirements
- Incorporate CMS regulations