Developmental Disabilities Waiver (DDW) Service Standards

Effective Date: November 1, 2012
Revised: April 23, 2013 and June 15, 2015

Developmental Disabilities Supports Division

http://nmhealth.org/dds
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CHAPTER I

INTRODUCTION

The Developmental Disabilities Medicaid Waiver (DDW) approved by the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2011, provides an array of 1915 (c) Home and Community Based Services (HCBS) to increase and promote independence of individuals with developmental disabilities receiving services and to decrease dependence on paid supports. These standards govern the provision of services for all eligible individuals receiving services through the DDW.

Services approved and provided through the DDW are required to comply with the CMS final rule that became effective on March 17, 2014. This new rule requires that eligible recipients served through 1915 (c) waivers must receive services in the community with the same degree of access as people not receiving HCBS.

DDSD has established these standards to guide service delivery and promote the health and safety of individuals served by DDW Provider Agencies. All Provider Agencies that enter into a contractual relationship with DOH to provide DDW services shall comply with all applicable standards, federal and state rules.

These standards apply to all services provided through the DDW program for individuals with developmental disabilities. These standards interpret and further enforce the New Mexico Human Services Department (HSD), Medicaid Policy Manual for Developmental Disabilities HCBS Waiver (8.314.5) and the CMS requirements for HCBS Waivers. Pursuant to the approved DDW, under no circumstances may a parent (or guardian) receive payment for services delivered to their minor child under age eighteen (18). Also, under no circumstances may any individual receive payment for services delivered to their spouse.

These standards acknowledge that many individuals and the families of children served by the DDW program have the ability to direct their own services and supports. However, planning must occur through an Interdisciplinary Team (IDT) process, in accordance with the Service Plans for Individuals with Developmental Disabilities Living in the Community (7.26.5 NMAC). Within the IDT process, these standards promote self-determination through flexible types and amounts of services provided. In addition, new service options to promote independence and community integration for individuals with developmental disabilities are available to address each individual’s unique ISP requirements.

The objective of these standards is to establish provider policy, procedure and reporting requirements for the DDW Medicaid Program. These requirements apply to all provider agencies and staff whether directly employed or subcontracting with the approved provider agency.
DD Waiver Standards

Each approved DDW provider is responsible for ensuring that it initially and continuously meets all of the qualifications specified in the DDW service standards. Additionally, providers that meet the qualifications and are approved by the DDSD to provide waiver services must comply with the freedom of choice requirement that Medicaid beneficiaries be allowed to choose from any qualified provider.

As outlined in the quality assurance/quality improvement section in each of the service standards, all approved DDW providers are required to develop and utilize a quality assurance/quality improvement (QA/QI) plan to continually determine whether it operates in accordance with program requirements and regulations, achieves desired outcomes and identifies opportunities for improvement. CMS expects states to follow a continuous quality improvement process to monitor the implementation of the waiver assurances and methods to address identified problems in any area of non-compliance.

Providers are required to verify Medicaid eligibility for services to assure eligibility of the individual on the date(s) of services. Providers are required to verify current prior authorization for services prior to delivery of service to ensure reimbursement for services provided.

All provider agencies shall permit the DOH to review quality of care and services in accordance with the Quality Management System and Review Requirements for Provider Agencies of Community Based Services (7.14.2 NMAC).

All provider agencies shall submit to and cooperate with announced and unannounced inspections and survey and complaint investigations conducted by DOH or HSD in order to receive or maintain a DOH provider agreement. The provider agency shall give the DOH and HSD reasonable access to all records; both electronic and paper versions required by these standards and program rules. The provider agency shall permit the DOH or HSD to have private interviews with individuals and staff.

Failure to correct any deficiency(s) or to submit a required plan of correction to DOH within the prescribed timelines regarding the provision of services outlined in these service standards, may lead to the immediate imposition of sanctions and/or penalties as outlined in the contract management policy and procedures.

All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of payment, until ongoing audits are settled, or until involvement of the state Attorney General is completed in regard to settlement of any claim, whichever is longer. All records pertaining to Jackson Class members must be retained permanently and be available upon request, and upon provider agreement termination, expiration or withdrawal of provider agreement, to DDSD.
## RESOURCE ALLOCATION AND RESOURCE ALLOTMENTS

### A. Resource Allocation for Eligible DDW Recipients Ages Eighteen (18) Years and Older:

The DDSD Resource Allocation system uses a standardized assessment tool, the Supports Intensity Scale® (SIS), to identify an individual’s pattern and intensity of support needs. Based on the information from the SIS results, supplemental questions (SQ) and when applicable a SQ verification review process used to verify extraordinary medical and/or behavioral support needs, the DDW participant is assigned to one of seven NM DD Waiver Groups, A-G. Group H is reserved as a safeguard for extremely complex needs or extenuating circumstances.

This standard seven level system is based on decision making rules applied and developed in collaboration with the Human Services Research Institute (HSRI) during a NM pilot study. NM decisions regarding service package options corresponding to each group assignment are based on a validation study conducted in 2011, public input, rate study and utilization history. The decision rules for NM DDW Group assignments and service package options are in accordance with Developmental Disabilities Home and Community Based Waiver Services (NMAC 8.314.5). Periodically, DDSD conducts additional validation activities to ensure the resource allocation system meets individuals’ needs for covered waiver services. The decision rules are outlined in the table below.

<table>
<thead>
<tr>
<th>NM DDW Groups</th>
<th>SIS Sum Scales ABE</th>
<th>SIS Section 3A Extraordinary Medical Support Needs Score</th>
<th>SIS Section 3B Extraordinary Behavior Support Needs Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Mild Support Needs and low to Moderate Behavioral Challenges</td>
<td>( \geq 0 ) to ( \leq 24 )</td>
<td>( \geq 0 ) to ( \leq 6 )</td>
<td>( \geq 0 ) to ( \leq 6 )</td>
</tr>
<tr>
<td>B: Low to Moderate Support Needs and Behavioral Challenges</td>
<td>( \geq 25 ) to ( \leq 30 )</td>
<td>( \geq 0 ) to ( \leq 6 )</td>
<td>( \geq 0 ) to ( \leq 6 )</td>
</tr>
</tbody>
</table>
### DD Waiver Standards

<table>
<thead>
<tr>
<th><strong>C</strong>: Mild to Above Average Support Needs and Moderate to Above Average Behavioral Challenges</th>
<th>≥ 0 to ≤ 36</th>
<th>≥ 0 to ≤ 6</th>
<th>≥ 7 to ≤ 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D</strong>: Above Average Support Needs and Low to Moderate Behavioral Challenges</td>
<td>≥ 31 to ≤ 36</td>
<td>≥ 0 to ≤ 6</td>
<td>≥ 0 to 6</td>
</tr>
<tr>
<td><strong>E</strong>: High Support Needs and Mild to Above Average Behavioral Challenges</td>
<td>≥ 37 to ≤ 55</td>
<td>≥ 0 to ≤ 6</td>
<td>≥ 0 to ≤ 10</td>
</tr>
<tr>
<td><strong>F</strong>: Extraordinary Medical Challenges</td>
<td>Any</td>
<td>≥ 7 to ≤ 32 or Extraordinary medical risk determined by SQ’s</td>
<td>≥ 0 to ≤ 10</td>
</tr>
<tr>
<td><strong>G</strong>: Extraordinary Behavioral Challenge;</td>
<td>Any</td>
<td>Any</td>
<td>≥ 11 to ≤ 26 or Dangerousness to others or extreme self-injury risk determined by SQ’s and a verification</td>
</tr>
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**B. Covered waiver services by NM DDW group assignments**

Each NM DDW Group service package is divided into three budget categories and services outlined in the table below:

<table>
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<th>NM DDW GROUP</th>
<th>BASE BUDGET ELIGIBILITY</th>
<th>PROFESSIONAL SERVICES</th>
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<td><strong>A</strong>: Mild support needs and low to moderate behavioral challenges</td>
<td>case management customized in-home supports: independent or family/natural supports including respite Community Integrated Employment -including employment, customized community supports</td>
<td>physical therapy, speech therapy, occupational therapy- prioritize one discipline behavior support consultation</td>
</tr>
</tbody>
</table>
## DD Waiver Standards

### B: Low to moderate support needs and behavioral challenges
- Case management customized in-home supports: independent or family/natural supports including respite Community Integrated Employment, customized community supports
- Physical therapy, speech therapy, occupational therapy, prioritize one discipline, behavior support consultation

### C: Mild to above average support needs and moderate to above average behavioral challenges
- Case management customized in-home supports, family living or supported living: independent or family/natural supports including respite Community Integrated Employment, customized community supports
- Physical therapy, speech therapy, occupational therapy, prioritize one discipline, behavior support consultation, increase to core hours

### D: Above average support needs and low to moderate behavioral challenges
- Case management customized in-home supports, family living or supported living: independent or family/natural supports including respite Community Integrated Employment, customized community supports
- Physical therapy, speech therapy, occupational therapy, prioritize two disciplines, behavior support consultation

### E: High support needs and mild to above average behavioral challenges
- Case management customized in-home supports, family living or supported living: independent or family/natural supports including respite Community Integrated Employment, customized community supports
- Physical therapy, speech therapy, occupational therapy, prioritize three disciplines if clinical criteria met for each, behavior support consultation

### F: Extraordinary medical challenges
- Case management customized in-home supports, family living or supported living: independent or family/natural supports including respite, intensive medical living services Community Integrated Employment, customized community supports
- Physical therapy, speech therapy, occupational therapy, prioritize three disciplines if clinical criteria met for each, behavior support consultation

### OTHER SERVICES:
- Are available to all NM DDW groups with applicable prior authorization processes and service caps:
  1. Environmental modifications every five years;
  2. Personal support technology
  3. Assistive technology
  4. Independent living transition
  5. Supplemental dental care, one visit per year;
  6. Non-medical transportation, with caps applicable by mileage of passes
  7. Adult nursing
  8. Nutritional counseling
  9. Initial assessment for therapies and behavior support consultation
  10. Preliminary risk screening
  11. Socialization and sexuality education, six classes per lifetime: and
  12. Crisis supports.

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**NM DOH – 2012 DDSD Service Standards**

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**CHAPTER 1**

**RESOURCE ALLOCATION AND RESOURCE ALLOTMENTS**

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The total budget amount for selected services may not exceed the annual resource amount for the individual’s ISP year, unless the individual receives prior approval for additional covered services. If the individual uses all funding in their budget prior to the end of their ISP year, funding for services will terminate until the beginning of the next ISP year.

C. Annual Resource Allotment for Eligible DDW Recipients Ages Birth through Eighteen (18):

1. General Services from the Children’s Category. Children’s Category services are only available to individuals from birth to the age of eighteen (18). At the annual Individual Service Plan (ISP) meeting in the year the individual turns eighteen, he or she may choose to continue receiving services through the Children’s Category until the next regular ISP date; or the individual may choose to transition to the Resource Allocation system in section A above.

Services from the Children’s Category must be coordinated with and shall not duplicate other services such as: the Medicaid School Based Services Program, the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, services offered by the New Mexico State Department of Education, or the DOH Family Infant Toddler Program.

The child’s Level of Care (LOC) assessment is used to determine the Annual Resource Allotment (ARA) within the Children’s Category. The IDT is responsible for using the ARA to achieve the individual’s ISP outcomes and to support the family in caring for the child in the home.

The budget for all services shall not exceed the ARA. The child’s family may shift the amount or number of units, as well as drop and add units throughout the year, to accommodate changing needs within the ARA. Revisions to the budget must be approved by the Medicaid Third Party Assessor (TPA)

2. Service Options funded with the ARA. The family of an eligible child, in conjunction with the IDT, may choose any or all of the following service options; however, the total budget for the selected services may not exceed the ARA. Each service must be provided in accordance with the corresponding DDW regulations, standards, and applicable DDSD policies:

   a. Behavior Support Consultation;

   b. Customized Community Support, Individual;

   c. Respite;

   d. Non-Medical Transportation;

   e. Case Management; (minimum 4 units per year )

   f. Supplemental Dental Care; and

   g. Nutritional Counseling.
4. **Service Options Outside of ARA.** The only services available outside of the ARA for children under age eighteen (18) are the Environmental Modifications, Assistive Technology, Personal Support Technology and Socialization and Sexuality Education.
DD Waiver Standards

GENERAL AUTHORITY

The following laws and standards, policies, and procedures governing the provision of services under the DDW include, but are not limited to:

CMS requirements for HCBS Waivers

CMS Rulings such as decisions of the Administrator, precedent final opinions, orders and statements of policy and interpretation

Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the CMS Administrative Simplification Provisions

HSD Medicaid Policy Manual for Developmental Disabilities HCBS Waiver (8.314.5)

HSD Medicaid Program Policy Manual

HSD Medicaid Billing Instructions for the Medically Fragile, and Developmental Disabilities Waivers (8.314 BI)

HSD Medical Assistance Division Provider Participation Agreement (MAD 335)

Fair Labor Standards Act of 1938 (FLSA), as amended 29 USC §201 et seq.; 29 CFR Parts 510 to 794

Pharmacy Act (Chapter 61, Article 11 NMSA 1978)


New Mexico Nursing Practice Act, Chapter 61, Article 3, New Mexico Statute Authority (NMSA)

Certified Medication Aide Rules – Title 16, Chapter 12, Part 5 New Mexico Administrative Code (NMAC)

The DDSD HCBS Waiver Provider Agreement

HSD/DOH Medicaid Waiver Case Management Code of Ethics

DOH/DDSD Service Plans for Individuals with Developmental Disabilities Living in the Community (7.26.5 NMAC)

DOH/DDSD Rights of Individuals with Developmental Disabilities Living in the Community (7.26.3 NMAC)

DOH/DDSD Client Complaint Procedures (7.26.4 NMAC)

DOH/DDSD Requirements for Developmental Disabilities Community Programs (7.26.6 NMAC)

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DD Waiver Standards

DOH/DDSD (Appendix A) Individual Transition Planning Process (7.26.7 NMAC)

DOH/DDSD (Appendix B) Dispute Resolution Process (7.26.8 NMAC)

DOH/DHI Statewide Incident Management System Policies and Procedures

DDSD Developmental Disabilities Supports Division [formerly Developmental Disabilities Division (DDD) and Long Term Services Division (LTSD)] Policies, Procedures, Director’s Releases, Interpretive Memos, Guidelines or other current published rules including, but not limited to DDSD Policies and Procedures.

DOH/DHI Caregivers Criminal History Screening Requirements (7.1.9 NMAC)

DHI/DOH Quality Management System and Review Requirements for Provider Agencies of Community Based Services (7.14.2 NMAC)

DOH/DHI Employee Abuse Registry (7.1.12 NMAC)

DOH/DHI Requirements for Home Health Agencies (7.28.2 NMAC)

DOH/DDSD Requirements for Family Infant Toddler Early Intervention Services (7.30.8 NMAC)

Individuals with Disabilities Education Act (IDEA), Part C

Education Department General Administrative Regulations (EDGAR)

Abuse, Neglect, Exploitation, and Death Reporting, Training and Related Requirements for Community Providers 7.1.14 NMAC

DOH/DHI Statewide Mortality Review Policy and Procedures

State and Local regulations for operating a business
I. Assistive Technology Purchasing Agent

The use of Assistive Technology (AT) is valuable in supporting individuals with disabilities through a “Participatory Approach,” which presumes that all persons, regardless of the degree of disability, can participate in daily activities and achieve individual goals.

1. SCOPE OF SERVICE

   A. The Assistive Technology purchased must:

      1. Be utilized in a functional activity;

      2. Have a specific adaptation or feature that assists in compensating for a disability experienced by the individual; and

      3. Meet a desired outcome in the Individual Service Plan (ISP), such as: increasing functional participation in employment, community activities, and activities of daily living, personal interactions, or personal safety during these types of activities. The Case Manager must provide justification for this purchase in the health and safety section the ISP or relevant action steps.

2. SERVICE REQUIREMENTS

   A. AT Purchasing Agent Providers: Acts as a fiscal agent to either directly purchase, or reimburse team members who purchase devices or materials to fabricate custom AT items, on behalf of a Developmental Disabilities Waiver (DDW) recipient.

   B. General: The AT Purchasing Agent may either purchase approved items directly, or issue a check payable to the person or entity responsible for making the purchase. The check cannot be made to any individual or provider who is not a member of the individual’s Interdisciplinary Team (IDT).

   C. Service Limitations:

      1. AT covered by the individual's state plan benefit, Division of Vocational Rehabilitation (DVR), the public schools, or other funding sources shall not be covered by the DDW.

      2. Funding for the purchase of batteries to power AT devices is limited to $20.00 per annual ISP year.

      3. Items used primarily for sensory stimulation shall not be approved.
4. Devices, materials or supplies used primarily during therapy services or directed primarily toward a therapeutic outcome such as increasing range of motion shall not be approved.

5. Educational software shall not be approved, with the exception of applications for IPad, smartphones, and other similar devices used to increase the individual’s level of independent functioning.

6. Items intended to prepare a person for a functional activity rather than perform the functional activity shall not be approved.

7. The purchase of items or services that are prohibited by federal, state or local statutes and standards shall not be authorized or reimbursed.

8. Taxes charged for reimbursement of goods is not allowed.

3. AGENCY REQUIREMENTS

A. Reporting: The AT Purchasing Agent must provide the individual or his/her legal representative and the case manager with an annual report of the AT device(s) and/or materials purchased with DDW funds. The annual report shall contain all information contained in the individual’s primary financial file.

B. The Assistive Technology Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

4. REIMBURSEMENT

A. Financial Accounting: The AT Purchasing Agent is required to maintain a complete accounting of all finances used for each individual served. Complete accounting shall include a primary financial file for each individual, which contains receipts for all device(s) and/or materials purchased.

B. Record Retention: Assistive Technology Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Assistive Technology Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

C. Billable Unit: The billable unit for AT Services is a set dollar amount specified in the current Medicaid Supplement Rate Tables for the DDW and shall not exceed $250.00 plus any allowable administrative fee per year.
D. Billable Activities:

1. Purchases consistent with the scope of services subject to service limitations; and

2. The AT Purchasing Agent may include a service fee up to ten percent (10%) of the cost of the device(s) or materials purchased to cover administrative costs.
CHAPTER 3

BEHAVIORAL SUPPORT CONSULTATION

I. Behavioral Support Consultation

Behavioral Support Consultation (BSC) services are intended to enhance the DDW participant’s quality of life by providing positive behavioral supports as the individual works on functional and relational skills. BSC services identify distracting, disruptive, and/or destructive behavior that impact quality of life; and provides specific prevention and intervention strategies to manage and lessen the risks these behaviors present. BSC services do not include individual or group therapy, or any other mental health or behavioral health services that would typically be provided through the Medicaid state plan benefits.

1. SCOPE OF SERVICE

A. General: BSC identifies and addresses issues related to the opportunity, skills, and support needed:

1. To form and sustain a full range of relationships;

2. To pursue meaningful community integration and inclusion;

3. To acquire and/or maintain appropriate social skills and engage in routines of daily life; and

4. To manage and reduce behaviors which interfere with engagement in routines of daily life or that pose a health and safety risk to the individual or others.

B. BSC Services: To be authorized by the Department of Health (DOH), BSC must include, but not be limited to, the following scope of services:

1. Guide the individual and their IDT’s understanding of contributing factors that currently influence the individual’s behavior such as: genetic and/or syndromal predispositions, developmental and physiological compromises, traumatic events, co-occurring intellectual and/or developmental disabilities and mental illness, communicative intentions, coping strategies, and environmental issues;

2. Develop behavior support strategies to lessen the negative impact of contributing factors to enhance the individual’s autonomy and self-determination;

3. Enhance IDT competency to predict, prevent, intervene with, and potentially reduce behaviors that interfere with quality of life and pursuit of ISP outcomes, including recommendations regarding needed adaptations to environments in which the individual participates;
4. Be available to the individual and the IDT for timely discussion and revision of assessments, plans, and semi-annual reports per DOH/DDSD Service Plans for Individuals with Developmental Disabilities Living in the Community [7.26.5 NMAC], attending and consulting, either in person or by conference call, the annual ISP and any other IDT meeting convened for service planning that have behavioral implications for the individual and the provision of BSC services;

5. Support effective implementation of an individual’s desired ISP outcomes through comprehensive Positive Behavioral Support Assessment, (PBSA), subsequent Positive Behavior Support Plan, (PBSP), and semi-annual reports. The Behavior Crisis Intervention Plan (BCIP), Risk Management Plan (RMP), and PRN Psychotropic Medication Plan (PPMP) are developed as adjuncts to the PBSP when necessary to comply with DDSD Bureau of Behavioral Support (BBS) policies and procedures and ensure individual health and safety;

6. Provide IDT members, including Direct Support Personnel (DSP), with training, materials and/or other relevant information needed to successfully implement the PBSP and perform any ongoing data collection or provider reporting required by the PBSP and all other related plans (BCIP, PPMP, or RMP). This includes training staff and/or an agency designated trainer. Collaborate with medical personnel, ancillary therapies, and providers of Living Supports: Family Living, Supported Living, Intensive Medical Living Services, Customized In-Home Supports, Community Integrated Employment, and Customized Community Supports to promote coherent and coordinated support efforts, including mutual scheduling of timely training sessions. When possible training should be scheduled in appropriate groupings to maximize time efficiency for all participants;

   a. Training by BSC may be recorded and given by a trainer designated jointly by the agency and the BSC.

   b. Training will include discussions with the designated trainer and exercises designed by the BSC to demonstrate understanding by direct support personnel.

   c. After the designated training of DSP, the BSC will follow up with observation of DSP and, if indicated, individual or group re-training within thirty (30) calendar days.

7. Guide Family Living, Supported Living, Intensive Medical Living Services, Customized In-Home Supports, Community Integrated Employment, and/or Customized Community Supports agencies to reference relevant portions of the PBSP in the Teaching and Support Strategies (TSS);

8. Monitor the individual’s progress at a frequency determined by the BSC in conjunction with the IDT, in various settings through direct observation, staff
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interviews and/or data collection. The BSC must document his or her on-site visit in the agency program log where the visit occurred;

9. Attend a Human Rights Committee (HRC) meeting, either in person or by conference call, to answer questions that the HRC may have:

   a. at the initial presentation of any plan (PBSP, BCIP, PPMP or RMP) containing interventions requiring review;

   b. at the annual review of any plan(s), if the restriction(s) is (are) still applicable; and

   c. when any substantial changes are made to the restriction(s) that a plan contains.

10. Advocate for supports that assure the individual is free from aversive, intrusive measures; chemical, mechanical, and non-emergency physical restraint; isolation; incarceration; and abuse, neglect, or exploitation:

11. Attendance at psychiatric appointments when the individual:

   a. has a significant change in their psychiatric condition or has a mental health diagnosis not currently well managed, putting the individual at risk for reduced access to community or family affiliation or resources, or increased risk of psychiatric hospitalization or criminal justice involvement; or

   b. requires ongoing psychiatric evaluation where specialized data collection and analysis is needed; or

   c. is currently in Crisis Supports due to a psychiatric or behavioral issue; or

   d. has been recommended to have a Risk Management Plan as a result of a Preliminary Risk Screening in which psychiatric issues are considered a contributing factor.

2. SERVICE REQUIREMENTS

   A. Qualifications: Behavior Support Consultants are mental health professionals who meet the qualifications described in the licensure section below or qualify for one of the exemptions described in section D.

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

   1. An independent practice license as a:
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a. Psychologist;
b. Licensed Independent Social Worker (LISW);
c. Licensed Professional Clinical Mental Health Counselor (LPCC);
d. Licensed Professional Art Therapist (LPAT); or
e. Licensed Marriage and Family Therapist (LMFT).

2. A supervisory-level practice license: Professionals licensed at this level are approved in one year increments and require direct clinical supervision by an independently licensed mental health professional.
   a. Mental Health Counselor (LMHC);
   b. Professional Mental Health Counselor (LPC);
   c. Master Social Worker (LMSW); or
   d. Psychologist Associate (PA).

C. Clinical Experience with Individuals with Intellectual/Developmental Disabilities:

1. Behavior Support Consultants must have a minimum of one (1) year of clinical experience or history of working with individuals with intellectual/developmental disabilities.

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

D. Exceptions to Qualifications:

1. An academic intern from an accredited university may participate in the provision of BSC services under the clinical supervision of an independently licensed Behavior Support Consultant. The academic intern’s time is not billable. A copy of the signed academic internship agreement between the university, the clinical supervisor, and the academic intern and a supervision plan must be submitted to the DDSD and must not exceed two (2) years.
2. Professionals with a Master of Arts or Master of Science degree and certified as a Board Certified Behavior Analyst (BCBA) may provide BSC. Professionals in this category require clinical supervision by an independently licensed mental health professional and are approved in one (1) year increments. Professionals with a Master’s level teaching license working in the DDW Program as a Behavior Support Consultant as of November 1, 2012, in good standing, may continue to provide BSC. Professionals in this category require clinical supervision by an independently licensed mental health professional and are approved in one (1) year increments.

E. Supervision Requirements: Behavior Support Consultants who have a supervisory-level licensure or are in one of the exception categories require a written Supervision Plan. The supervisor is clinically responsible for all services provided by the supervisees and must follow all supervision requirements of his/her licensure board. Supervisors must assure compliance with the following requirements, and will consult their licensure board regularly to keep current on supervision requirements for their respective disciplines:

1. LMHC and LPC: A minimum of one (1) hour of face to face supervision per ten (10) individual contact hours [16.27.9 NMAC];

2. LMSW: A minimum of one (1) hour of supervision per (40) forty hours worked; no more than sixty percent (60%) of the supervision may occur in groups of four (4) members or less; seventy-five percent (75%) of the supervision must be face-to-face; live video teleconferencing is acceptable as face to face supervision. [16.63.1 NMAC];

3. PA: A minimum of two (2) hours of supervision per month [16.22.12 NMAC];

4. Documentation to address clinical issues, service issues, and review of case progress notes, assessments, and plans;

5. Supervisor’s countersignature on all assessments, plans and semi-annual reports;

6. Submission of documentation of supervision to the DDSD semi-annually: and

7. Code of Conduct: All BSCs are required to understand and adhere to the BSC Code of Conduct.

F. Professional Development: All Behavior Support Consultants will complete the following trainings/meetings and associated reporting requirements:

1. Within First Six (6) Months of Authorization to Practice as a BSC: The following trainings/BBS Quarterly meetings are required within the first six (6) months of authorization to practice as a Behavior Support Consultant:

   a. The One Day Person-Centered Planning in New Mexico course;
b. The *Beyond the ABC’s: An Introduction to Positive Behavioral Supports* course offered by DDSD/BBS; new BSCs are required to take ABCs Days 1, 2, and 3; and

c. At least one (1) BSC Quarterly Meeting offered by BBS.

2. **Within First Twelve (12) Months of Authorization to Practice as a BSC:** In addition, the following trainings/BBS Quarterly meetings are required within the first twelve (12) months of authorization to practice as a Behavior Support Consultant:

   a. The *Introduction to Sexuality for Persons with Developmental Disabilities* course offered by DDSD/BBS;

   b. The *Risk Management Strategies for the Preliminary Risk Screening* course offered by DDSD/BBS;

   c. The *Aspiration Risk Management* course offered by the DDSD; and

   d. At least one (1) BSC Quarterly Meeting offered by BBS.

3. In addition, the following trainings/BBS Quarterly meetings are required during the period between the second (2nd) and sixth (6th) year of practice as a Behavior Support Consultant and must include the content areas listed below. With BBS prior authorization to ensure relevancy to the DD population, topics d; e; and g; below can be fulfilled through professional courses, workshops or conferences not delivered by DOH/DDSD or its contractors per the procedure detailed in the Behavioral Support Consultation Practice Guidelines.

   a. *Friends and Relationships Educators Training (F.R.E.D.)* course or participation in the Friends and Relationships series;

   b. The *Participatory Communication and Choice Making* course;

   c. The *Effective Individual Specific Training* course offered by DDSD;

   d. Psychotropic Medication;

   e. Neurobehavioral Issues;

   f. *Risk Management Treatment Strategies*;

   g. Ethics; and

   h. *Co-occurring Disorders (DD/MI).*
4. **Additional Ongoing Requirements:** After the first twelve (12) months and ongoing, the BSC must:

   a. Attend annually a minimum of two (2) BSC Quarterly Meetings offered by BBS; and

   b. Participate in any additional mandated trainings identified by DDSD/BBS.

**G. Eligibility for DDW Behavioral Support Consultation Services:**

1. All DDW eligible children and adults may request an evaluation to determine the need for BSC services. It is the responsibility of IDT members to recognize the potential need for these services according to the specific needs of the individual and the potential benefit of the service. It is also the responsibility of the IDT to recognize when individual, family or group behavioral health services through Medicaid state plan benefits or Medicare would be beneficial. When behavioral health services are sought and delivered, the IDT must consider integration of therapeutic strategies, as appropriate, into daily life, the person’s ISP, other related service plans like the PBSP, as well as direct support personnel training. DDW BSC services may be provided concurrently with Medicaid or Medicare behavioral health services.

2. Children and young adults who receive counseling or behavioral health services through their local school may also receive BSC services through the DDW; however, the focus of their PBSP will be limited to home and community, rather than the school setting. Up to five hours of cross-over training and coordination between school behavioral health services and the DDW Behavior Support Consultant is allowed.

3. **Referral for DDW BSC:** The IDT members may refer the individual to Behavior Support Consultants for assessment, evaluation and recommendation(s) for the service. Subsequent BSC service delivery requires a prior authorization.

   a. The IDT must identify areas of concern to be included in the assessment;

   b. The Behavior Support Consultant will complete a written initial PBSA; and

   c. All referrals to this service for assessment or treatment must be documented in the individual’s ISP.

**H. Service Limitations:**

1. BSC services do not include individual or group therapy, or any other mental health or behavioral health services that would typically be provided through the behavioral health system.
2. Individual must have an Initial or Annual PBSA that indicates they meet the clinical necessity criteria for their respective NM DDW Group, and receive prior authorization for BSC.

3. No more than five (5) hours of service per year may occur in the school setting for school age children and young adults, for attending IEP meetings and cross-over training only.

3. AGENCY REQUIREMENTS

A. Agency Coordination of Training Requirements: All BSC Provider Agencies are required to report personnel training information to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy.

B. Professional with Independent Practice License: As of July 1, 2013 each BSC Provider Agency must employ or subcontract with at least one (1) professional with an independent practice license.

C. Requirements for Document Submission:

1. The BSC is responsible for the timely submission to core members of the individual’s IDT of the following documentation:
   a. The current PBSA, PBSP, and Semi-Annual Progress Report; and
   b. The BCIP, PPMP, and RMP when applicable.

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

   a. At the time of provider application or renewal, the initial or revised Provider Agency policies related to provision of BSC services; and

   b. The following lists and documentation:

      i. Annual list of all DDW participants served;

      ii. Updated personnel reports to reflect new hires/subcontractors, terminations, agency position changes, and name changes;

      iii. Annual documentation of all trainings attended and completed by any employee, subcontractor or intern of the agency, and any required trainings which were not completed specific to BSC; and

      iv. Semi-annual documentation of the name of the supervisor and supervision given by Provider Agency to interns, individuals with temporary licenses or special category subcontractors/employees.

D. Documentation: The BSC Provider Agency must ensure documentation meets the Behavioral Support Consultation Practice Guidelines and the following requirements. All documents referenced below (except an individual’s BSC’s progress notes) must be submitted according to the individual’s ISP budget year.

1. Positive Behavior Supports Assessment (PBSA): Individual written assessments are to be conducted at minimum on an annual basis, when there has been a change in the status of either the individual, or the BSC provider agency, or when the new BSC deems it necessary to ensure the assessment accurately reflects current situation and fulfills all requirements;

2. Positive Behavior Supports Plan (PBSP): When BSC services have been authorized based upon PBSA results, the PBSP must be developed and/or revised as needed; when there has been a change in the status of the individual or BSC Provider; and is updated at least annually at least two weeks prior to the ISP expiration date. PBSPs must contain written strategies for DSP to implement regarding positive behavioral supports;

3. Revisions required by DDSD: If the DDSD determines that there is a need to revise the PBSA and/or PBSP, the BSC must make the revisions within thirty (30) calendar days. If health and safety issues have been identified by DDSD, an assessment or revised assessment is to be completed, the plan revised and staff training on the revisions must occur within ten (10) calendar days of notification by DDSD;
4. **Behavioral Crisis Intervention Plan (BCIP):** When the individual’s needs episodically exceed the techniques and interventions contained in the PBSP, a BCIP must be developed. All direct support personnel must be trained on the BCIP within ten (10) calendar days of plan development. The BCIP must be reviewed and modified at least annually and in response to changes in the individual’s status or at the request of the DDSD. If health and safety issues have been identified by DDSD, the plan must be revised and direct support personnel training on the revisions must occur within ten (10) calendar days of notification by DDSD;

5. **PRN Psychotropic Medication Plan (PPMP), Comprehensive Aspiration Risk Management Plan (CARMP), and/or Risk Management Plan (RMP):** Develop, train, and monitor these plans when applicable;

6. **Semi-Annual Progress Report:** The semi-annual progress report documents progress toward PBSP goals. The first semi-annual report will cover the time period from the start of the individual’s ISP year until the end of the six month period (180 calendar days) and is due ten (10) calendar days after the period ends (190 calendar days). The second semi-annual progress report information covers the second time period and must be integrated into the annual PBSA. The annual the PBSA is due fourteen (14) calendar days prior to the annual ISP meeting as per [7.26.5 NMAC]; and

7. **Progress Notes:** Document all meetings, trainings, client visits, monitoring and all other interactions for which billing is generated; time spent compiling notes is not billable.

E. **Quality Assurance/Quality Improvement (QA/QI) Plan:**

Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provision of quality services.

1. **Development of a QA/QI plan:** The QA/QI Plan is used by an agency continually to determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI Plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI Plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider levels of service delivery. These monitoring activities
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provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; and

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. For Behavioral Support Consultation services, QA/QI plan benchmarks and review activities should include at least the following:

a. Adherence to Behavioral Support Consultation Practice Guidelines regarding delivery of BSC services, in the:
   i. timeliness and quality of the documentation;
   ii. extent that BSC services are delivered in accordance with the individual’s ISP (do the services support the individual’s vision, meaningful day and desired outcomes?); and
   iii. effectiveness of the implementation, in part, indicated by trends in achievement of the individual’s desired outcomes;

b. Compliance with DDSD training requirements;

c. Analysis of trends in data (individual and/or systemic); and

d. Descriptions of actions taken:
   i. regarding individual grievances; and
   ii. to make significant systemic improvements.

3. Preparation of the Report: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. REIMBURSEMENT

A. All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Behavioral Support Consultation Provider Agency
records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. **Billable Unit:** The billable unit for BSC is a fifteen (15) minute unit/rate specified in the current Medicaid Supplement Rate Tables for the DDW. There are two applicable BSC rates:

1. **Standard Rate;** and

2. **Incentive Rate:** The Incentive rate may be applied to BSC services that are provided in a county or area designated by the DDSD as underserved for DDW BSC services. An official list of such counties/areas will be published by the DDSD according to established criteria and revised/distributed at least annually.

C. **Billable Activities:**

1. All BSC activities that are:
   - d. Included in the individual’s approved ISP;
   - e. Provided in accordance with the scope of services; including assessment report, development of PBSP and semi-annual report;
   - f. Provided in accordance with the behavior support consultant’s license and supervision requirements;
   - g. Provided collaboratively with occupational, speech or physical therapist; and
   - h. Consistent with service limitations and not included in non-billable services, activities or situations.

D. **Non-Billable Services, Activities or Situations:**

1. Services furnished to an individual who is:
   - d. Not residing in New Mexico;
   - e. Not eligible for DDW services; or
   - f. Hospitalized or in an institutional care setting.

2. Services not included in the:
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d. Scope of services; or

e. Individual’s approved ISP.

3. Time associated with:

d. Participating in client assessments that are not conducted by the BSC, except as described in the BSC Services section of this chapter;

e. Friendly visits where consultation activities are not conducted;

f. Travel to and from site of any billable service;

g. Services provided by an academic intern without the presence of the supervising BSC;

h. Missed appointments;

i. Writing progress notes or logs;

j. Employer activities including administrative duties, preparing or maintaining routine paperwork and billing documentation, employer staff meetings or meetings with supervisors;

k. Professional development/continuing education for the BSC; and

l. Mental health treatment otherwise billable as a State Plan benefit through the behavioral health system.
CHAPTER 4
CASE MANAGEMENT SERVICES

I. Case Management Services

Case Management Services assist participants in gaining access to needed Developmental Disabilities Waiver (DDW) and State Plan services. Case Managers link the individual to needed medical, social, educational and other services, regardless of funding source. Waiver services are intended to enhance, not replace existing natural supports and other available community resources. Case Management Services emphasize and promote the use of natural and generic supports to address the individuals assessed needs in addition to paid supports. Case Managers facilitate and assist in assessment activities.

Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while gaining independence and access to needed services and supports. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual, their designated representative/guardian, and the entire Interdisciplinary Team (IDT). The Case Manager serves as an advocate for the individual, and is responsible for the development of the Individual Service Plan (ISP) and the ongoing monitoring of the provision of services included in the ISP.

1. SCOPE OF SERVICES

   A. Facilitate the allocation process;

   B. Provide information to individuals/guardian regarding eligibility determination for the DDW, regular SIS assessments, and other services, and ensure timely completion;

   C. Complete and submit Level of Care (LOC) packets to the Medicaid Third Party Assessor (TPA) outlined in this standard;

   D. Review Supports Intensity Scale® (SIS): My Support Profile results with the individual/guardian;

   E. Organize and facilitate the service planning process in accordance with the following regulation: Service Plans for Individuals with Developmental Disabilities Living in the Community [7.26.5 NMAC], and based on NM DDW Group Assignment and correlating service package;

   F. Assist IDT members in exploring publicly funded programs, community resources available to all citizens and natural supports within the individuals’ community;

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G. Ensure the development of targeted, realistic desired outcomes and action plans with measurable action steps and relevant useful Teaching and Support Strategies (TSS) by the IDT;

H. Arrange for information about Community Integrated Employment services to be shared with adult DDW recipients in a manner consistent with the Developmental Disabilities Supports Division (DDSD) Employment First Principle to ensure informed choice;

I. Coordinate and advocate for the revision of the ISP when desired outcomes are completed or not achieved within expected timeframes;

J. Ensure timely submission of revisions to budgeted services and ISP content, if needed;

K. Submit for approval the Individual Service Plans (ISPs) and the Waiver Budget Worksheet or MAD 046 and any other required prior authorizations to the TPA Contractor, as outlined in this standard;

L. Monitor service delivery, to determine whether services are delivered as described in the ISP and are provided in a safe and healthy environment;

M. Monitor and evaluate, through a formal, ongoing process, effectiveness and appropriateness of services and supports as well as the quality of related documentation including the ISP, progress reports, and ancillary support plans;

N. Report in writing, unresolved concerns identified through the monitoring process, to the respective DDSD Regional Office and/or Division of Health Improvement (DHI) as appropriate, in a timely manner;

O. Monitor the health and safety of the individual;

P. Develop and monitor utilization of budgets for DDW services;

Q. Promote Self-Advocacy;

R. Advocate on behalf of the individual, as needed;

S. Maintain a complete record for the individual’s DDW services, as specified in DDSD Consumer Records Requirements Policy; and

T. Ensure individuals obtain all services through the Freedom of Choice (FOC) process.
2. SERVICE REQUIREMENTS

A. Eligibility:

1. At the time of allocation, DDSD will notify the individual of allocation status and initiate the Case Management FOC process to select a case management agency;

2. The Case Management Provider Agency will assign a Case Manager within five (5) business days of notification of selection through the Case Management FOC. Within those five (5) business days, the Case Manager will call the individual and set a time for their first meeting;

3. The Case Manager will keep the DOH Intake and Eligibility Bureau (IEB) informed of progress with allocation activities, in accordance with Central Registry Unit requirements by completing the Allocation Reporting form cumulatively and submitting the form and appropriate approved documents to the DDSD regional eligibility worker on the 1st and 15th of each month until the allocation process is completed and the individual is receiving services;

4. Within ninety (90) calendar days of the date the Case Management Provider Agency was selected by the individual, the Case Manager shall:

   a. Complete the initial Long Term Care Assessment Abstract packet and submit it to the Third Party Assessor (TPA);

   b. Obtain approval from the TPA;

   c. Support the individual to submit relevant financial information to their local Income Support Division (ISD) office to verify financial eligibility; and

   d. If the process of determining financial and medical eligibility takes longer than 90 days, contact the individual/guardian to request an extension from the Income Support Division (ISD) on their DDW eligibility determination. In addition, indicate the reason for the delay on the next Allocation Reporting form.

5. Ensure within ninety (90) calendar days of financial eligibility verification and LOC approval the Case Manager shall, in collaboration with the IDT:

   a. Inform the individual/guardian about the purpose and process for completing the Supports Intensity Scale ® (SIS) assessment and indicate the date on which this explanation occurred on the first Allocation Reporting form, so that the regional
eligibility worker can initiate a referral for SIS scheduling for individuals who are eighteen (18) or turning 18; and

b. Determine if the applicant is a Mi Via Waiver or Personal Care Option (PCO) Transition case and coordinate with the Human Service Division (HSD) as appropriate to determine an appropriate ISP and Category of Eligibility (COE), start date for the first of the following month.

6. Failure to meet initial eligibility timeframe requirements will result in corrective action by DDSD.

B. Assessment: The Case Manager is responsible to ensure that an initial evaluation for LOC is complete for all participants, and that all participants are reevaluated for LOC at least annually. The assessment tasks of the case manager includes, but are not limited to:

1. Completing, compiling and/or obtaining the elements of the Long Term Care Assessment Abstract packet to include:
   a. Long Term Care Assessment Abstract form (MAD 378);
   b. Comprehensive Individual Assessment (CIA);
   c. Current physical exam and medical/clinical history;
   d. For children: a norm-referenced assessment will be completed; and
   e. A copy of the Allocation Letter (initial submission only).

2. Review and Approval of the Long Term Care Assessment Abstract by the TPA Contractor:
   a. The Case Manager will submit the Long Term Care Assessment Abstract packet to the TPA Contractor for review and approval. All initial Long Term Care Assessment Abstracts must be approved by the TPA Contractor prior to service delivery;
   b. The Case Manager shall respond to TPA Contractor within specified timelines when the Long Term Care Assessment Abstract packet is returned for corrections or additional information;
   c. The Case Manager will submit the Long Term Care Assessment Abstract packet to the TPA Contractor, for review and approval. For all annual redeterminations, submission shall occur between forty five (45) calendar days and thirty (30) calendar days prior to the LOC expiration date; and
d. For children and Jackson Class members the Case Manager will facilitate re-admission to the DDW for individuals hospitalized more than three (3) calendar days (upon the third midnight). This includes ensuring that hospital discharge planners submit a re-admit LOC to the TPA Contractor and obtain and distribute a copy of the approved document for the client’s file. Discharge planning is required for all hospitalizations.

C. Individual Service Planning: The Case Manager is responsible for ensuring the ISP addresses all the participant’s assessed needs and personal goals, either through DDW waiver services or other means. The Case Manager ensures the ISP is updated/revised at least annually; or when warranted by changes in the participant’s needs.

1. The ISP is developed through a person-centered planning process in accordance with the rules governing ISP development [7.26.5 NMAC] and includes:

   a. Ongoing assessment of the individual’s strengths, needs and preferences shared with IDT members and used to guide development of the plan;

   b. To inform the planning process, assessments shall be shared with all IDT members. Such assessments shall include at least: the most current SIS assessment, most current e-CHAT if receiving Living Supports, annual reassessments completed by any therapists or BSCs, semi-annual reports from all providers, including therapists and BSCs, and for participants of Intensive Medical Living quarterly nursing reports. Current assessments shall be distributed by the authors to all IDT members at least fourteen (14) calendar days prior to the annual ISP meeting, in accordance with the DDSD Consumer File Matrix Requirements.

   c. The Case Manager shall notify all IDT members of the annual ISP meeting at least twenty one (21) calendar days in advance:

      i. The Case Manager meets with the DDW recipient prior to the ISP meeting to review current assessment information, prepare for the meeting, create a plan to facilitate or co-facilitate the meeting if the individual wishes, and facilitate greater informed participation;

      ii. The Case Manager convenes a meeting of all IDT members, including those individuals who have the best information regarding progress during the past year, and who know the individual best. There must be evidence that all IDT Members participated in the development of the ISP. The Case Manager documents how this participation occurred if IDT members were not present at the annual ISP meeting;
iii. The ISP shall include: the individual’s long-term vision, summary of strengths, preferences and needs, realistic and measurable desired outcomes for the individual, an action plan and strategies to support each action plan; and

iv. The ISP shall include information from the SIS assessment to guide what would determine what is important to the individual and what is important for the individual, to focus on the whole person and the individual’s quality of life, the responsibilities of team members, identify what supports can be used to enhance the individual’s well-being, how information obtained from the SIS relates to professional recommendations and how we know if supports provided have an effect on the individual.

d. The ISP is an ongoing process, based on the individual’s long-term vision and not a one-time-a-year event; and is completed and implemented in response to what the IDT members learn from and about the person. The process shall involve those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends and providers).

e. The Case Manager will clarify the individual’s long-term vision through direct communication with the individual where possible, or through communication with family, guardians, friends, support providers and others who know the individual well. Information gathered prior to the annual meeting shall include, but is not limited to the following:

i. Strengths;

ii. Capabilities;

iii. Preferences;

iv. Desires;

v. Cultural values;

vi. Relationships;

vii. Resources;

viii. Functional skills in the community;

ix. Work/learning interests and experiences;

x. Hobbies;
xi. Community membership activities or interests;

xii. Spiritual beliefs or interests; and

xiii. Communication and learning styles or preferences to be used in development of the individual’s service plan.

f. The Case Manager will review with the individual/guardian results of the SIS, the NM DDW Group Assignment and corresponding service options and living care arrangements. This includes developing a sample budget, with a Waiver Budget Worksheet with the individual/guardian with the services the individual may receive, understanding that certain services require clinical criteria to be met, regardless of the NM DDW Group assignment.

g. Case Managers shall operate under the assumption all working age adults with developmental disabilities are capable of working given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options, per the Employment First Principle. It is the responsibility of the Case Manager and IDT members to ensure employment decisions are based on informed choices:

i. The Case Manager shall verify that individuals who express an interest in work or who have employment-related desired outcome(s) in their ISP have a current community-based situational assessment, vocational assessment, or other person-centered assessment, and an updated Work/Education/Volunteer section of the ISP and relevant Desired Outcomes and Action Steps;

ii. In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related outcomes and tasks within the ISP to be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.). This discussion related to employment issues shall be documented within the ISP; and

iii. Informed choice in the context of employment as outlined in Chapter 5 Community Integrated Employment Services of these standards.

h. The Case Manager will ensure a discussion on individualized Meaningful Day activities occurs in the ISP meeting, and is reflected in the ISP.

i. Secondary Freedom of Choice Process:
A. The Case Manager will obtain a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region;

B. The Case Manager will present the Secondary FOC form for each service to the individual or authorized representative for selection of direct service providers;

C. At least annually, rights and responsibilities are reviewed with the recipients and guardians and they are reminded they may change providers and/or the types of services they receive. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians. If they are interested in changing providers or service types, a new Secondary FOC shall be completed; and

D. When the individual or guardian signs a Secondary Freedom of Choice the Case Manager must contact the provider within 5 business days and schedule a transition meeting within 30 days of receipt of the signed Secondary Freedom of Choice.

j. The case manager will convene the Interdisciplinary Team (IDT), develop the Individual Service Plan (ISP) and Waiver Budget Worksheet, and submit the ISP packet and budget within the assigned NM DDW Group to the Medicaid Third Party Assessor for review.

k. The Case Manager ensures completion of the post IDT activities, including:

   i. The Case Manager will submit the ISP packet to TPA Contractor only after documented verification of financial and medical eligibility has been received.

   ii. Annually, the case manager will submit the ISP packet to the TPA Contractor for review and approval prior to the ISP expiration date. The required ISP packet documents include:

      a. ISP Face sheet;

      b. ISP Outcome Statements for Live, Work/Education/Volunteer, Develop Relationships/Have Fun, and Other (including Health and Safety related) Action Plans;

      c. ISP page(s) containing Vision Statements;

      d. Developmental Disabilities Waiver Budget Worksheet or MAD 046; and

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e. Relevant prior authorizations and supporting documentation, as applicable.

iii. Prior to the delivery of any service, the case manager ensures approval from the TPA contractor for:

a. Budget Worksheet Waiver Review Form (clinical necessity) or MAD 046;

b. Initial or Annual ISP; and

c. Revisions to the ISP, involving changes to the budget.

iv. Case Manager distributes approved Prior Authorizations to all Providers.

v. The Case Manager, with input from each Provider Agency, shall complete the Individual Specific Training Requirements section of the ISP form listing all training needs specific to the individual; and

vi. The Case Manager will obtain the completed TSS section of the ISP from providers at least fourteen (14) calendar days prior to the start of the annual ISP.

l. Case Managers shall facilitate and maintain communication with the individual and their representative, other IDT members, providers and relevant parties to ensure the individual receives maximum benefit of their services and revisions to the service plan are made as needed.

D. Monitoring And Evaluation of Service Delivery:

1. The Case Manager shall use a formal ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the individual specified in the ISP.

2. Monitoring and evaluation activities shall include, but not be limited to:

a. The case manager is required to meet face-to-face with adult DDW participants at least twelve (12) times annually (1 per month) as described in the ISP;

b. Parents of children served by the DDW may receive a minimum of four (4) visits per year, as established in the ISP. When a parent chooses fewer than twelve (12) annual units of case management, the parent is responsible for monitoring
and evaluating services provided in the months case management services are not received;

c. No more than one (1) IDT Meeting per quarter may count as a face-to-face contact for adults (including Jackson Class members) living in the community;

d. Jackson Class members require two (2) face-to-face contacts per month, one (1) of which must occur at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program); and one must occur at the individual’s residence; and

e. For non-Jackson Class members, who receive a Living Supports service, at least one face-to-face visit shall occur at the individual’s home quarterly; and at least one face-to-face visit shall occur at the day program quarterly if the individual receives Customized Community Supports or Community Integrated Employment services. The third quarterly visit is at the discretion of the Case Manager.

3. It is appropriate to conduct face-to-face visits with the individual either during times when the individual is receiving services, or times when the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit;

4. Visits may be scheduled in advance or be unannounced, depending on the purpose of the monitoring of services;

5. The Case Manager must ensure at least quarterly that:

a. Applicable Medical Emergency Response Plans and/or Behavior Crisis Intervention Plans (BCIPs) are in place in the residence and at the day services location(s) for all individuals who have chronic medical condition(s) with potential for life threatening complications, or individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and

b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans.

6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes;
7. If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. In situations where the concern is not urgent the provider agency will be allowed up to fifteen (15) business days to remediate or develop an acceptable plan of remediation;

8. If the Case Manager’s reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office:

   a. Submit the DDSD Regional Office Request for Intervention form (RORI); including documentation of requests and attempts (at least two) to resolve the issue(s); and

   b. The Case Management Provider Agency will keep a copy of the RORI in the individual’s record.

9. Conduct an online review in the Therap system to ensure that the electronic Comprehensive Health Assessment Tool (e-CHAT) and Health Passport are current for those individuals selected for the Quarterly ISP QA Review;

10. The Case Manager will ensure Living Supports are delivered in accordance with standards, including the minimum of thirty (30) hours per week of planned activities outside the residence. If the planned activities are not possible due to the needs of the individual, the ISP will contain an outcome that addresses an appropriate level of community integration for the individual. These activities do not need to be limited to paid supports but may include independent or leisure activities with natural supports appropriate to the needs of individual; and

11. For individuals with Intensive Medical Living Services, the IDT is not required to plan for at least thirty (30) hours per week of planned activities outside of the residence.

3. AGENCY REQUIREMENTS

   A. Case Management Provider Agency Qualifications:

      The Case Management Provider Agency shall comply with all applicable federal and state rules as well as DOH / DDSD policies and procedures.

   B. Case Management Administrative Requirements:

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

2. Communication Requirements:

It is the responsibility of the case management agency to convey all information received from DDSD that is relevant to service delivery to their employees/subcontractors, in a timely manner.

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

C. Programmatic Requirements:

1. Case Management Provider Agencies shall have an established system for tracking key steps and timelines in establishing eligibility, service planning, budget approval and distribution of records to IDT Members;

2. Case Management Agencies shall maintain at least one (1) office in each region served by the agency that meets the Americans with Disabilities Act (ADA) accessibility requirements and that includes:

   a. A 24-hour local telephone answering system. The Case Management Provider Agency must return all calls not later than 5:00 p.m. the following business day; the answering system must indicate regular office hours and expected response time by the end of the following business day;

   b. If case managers use their home office or cell number as primary contact for the individuals on their caseload, their voicemail must indicate that they return calls by 5 p.m. the next business day, as well as the main number for the case management agency;

   c. An operational fax machine;

   d. Internet and e-mail access, including use of a secure email systems (Scomm) for client identifying information, for every Case Manager employed or subcontracted;
e. Client records for each individual served by the Provider Agency consistent with DDSD Consumer Record Requirements and that are stored on site, in compliance with HIPAA requirements;

f. A meeting room that can accommodate IDT members’ meetings comfortably;

g. An area where a Case Manager may meet privately with an individual;

h. A separate physical space and entrance, if the office is connected to a residence; and

i. Exceptions to the above may be granted in writing by DDSD based on circumstances and needs of the service system. Requests for such exceptions shall be submitted to the Statewide Coordinator of the Case Management Unit of DDSD in writing with appropriate justification.

D. Adherence to Requirements: Case Management Provider Agencies and their staff/sub-contractors are required to adhere to all requirements communicated to them by DDSD, including participation in the Therap system for health assessment and health tracking functions for individuals they serve, attendance at mandatory meetings, mandated trainings and technical assistance sessions.

E. Sub-contractors: Case Management Agencies may use sub-contractors as case managers with permission from DDSD. Failure to address poor performance by a sub-contractor will be addressed by DDSD with the agency.

F. Minimum Staffing: Case Management Provider Agencies shall have and maintain a minimum of three full time equivalent Case Management positions, including a supervisor, in order to ensure proper oversight and coverage. Exceptions to this staffing requirement may be granted in writing by DDSD based on circumstances and needs of the service system. Requests for such exceptions shall be submitted to the Statewide Coordinator of the Case Management Unit of DDSD in writing with appropriate justification that addresses how the agency will ensure adequate back up coverage and quality assurance functions.

G. Case Manager Qualifications: Case Managers, whether subcontracting or employed by a Provider Agency, shall meet these requirements and possess these qualifications:

1. Licensed social worker, as defined by the NM Board of Social Work Examiners; or

2. Licensed registered nurse as defined by the NM Board of Nursing; or
3. Bachelor’s or Master’s degree in social work, psychology, counseling, nursing, special education, or closely related field; and

4. Have one-year clinical experience, related to the target population, working in any of the following settings:
   a. Home health or community health program;
   b. Hospital;
   c. Private practice;
   d. Publicly funded institution or long-term care program;
   e. Mental health program;
   f. Community based social service program; or
   g. Other programs addressing the needs of special populations, e.g., school.

5. Have a working knowledge of the health and social resources available within a region.

6. If a Case Management Provider Agency has made reasonable efforts to recruit Case Management personnel with the required qualifications without success, that Case Management Provider Agency may request an exception from the Case Manager Qualifications from the DDSD Central Office per the following procedure:
   a. The requesting Case Management Provider Agency will describe and document all efforts made to recruit Case Managers with the required qualifications and the results of those efforts.
   b. The requesting Case Management Provider Agency will describe and document in detail the relevant educational, employment, volunteer, familial, and other experience that will qualify the prospective candidate for successful employment as a Case Manager. Consideration may be given for unique skills needed by the Provider Agency such as fluency in a language other than English.
   c. If the exception is granted, DDSD reserves the right to add conditions (e.g., specific training, supervisory oversight) that shall be adhered to and may rescind the exception at any time for any reason.

H. Training:
1. Within specified timelines, Case Managers shall meet the requirements for training as specified in the DDSD Policy T-002: Training Requirements for Case Management Staff Policy. All Case Management Provider Agencies are required to report personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy and as follows:

   a. Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; and

   b. Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.

2. All Case Managers are required to review and adhere to the Case Manager Code of Ethics.

I. Criminal Background Screening: The Case Management Services Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

J. Employee Abuse Registry: The Case Management Services Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

K. Case Management Staffing Ratio:

   1. The Case Management Provider Agency shall ensure that caseloads are assigned in such a way as not to exceed thirty (30) cases per Case Manager on average:

      a. Case Management services for children may be weighted to the caseload proportionally, based upon the number of months of service provided per year (e.g., 4 months of Case Management service = ⅓ case; 6 months of Case Management service = ½ case); and

      b. Temporary exceptions to the maximum caseload average are allowed if a Case Manager is on approved leave, and the Case Management Provider Agency ensures a colleague or supervisor will perform essential duties during the Case Manager’s absence, including mandated face-to-face visits.

   2. The Case Management Provider Agency must maintain a current caseload list for each Case Manager in the Therap system, and provide Caseload Reports by the 15th of the month following the end of the quarter to the DDSD Statewide Case Management Coordinator and Regional Case Management Coordinators;
3. Working for or subcontracting with more than one DDW Case Management Provider Agency simultaneously is prohibited. If a Case Manager caseload includes individuals on more than one Medicaid Waiver, or other funding sources, the Case Manager/Provider Agency will clearly report that information to the DDSD Regional Office, and in the quarterly Case Manager Caseload Reports;

4. The Case Management Provider Agency shall hire and retain sufficient Case Managers to adequately serve the client population;

5. The Case Management Provider Agency shall ensure that supervisors or persons with subcontractor oversight responsibilities, who also have a caseload, shall have a reduced caseload in order to provide adequate supervision and oversight of case management staff and/or subcontractors; and

6. Failure of a Case Management Provider Agency to adhere to this policy will result in an immediate moratorium until caseloads are adjusted to an average of 30 or fewer cases per Case Manager.

L. Conflict of Interest:

1. The only circumstance in which a Case Manager may provide any other DDW service is if he or she is providing Family Living or Respite services either to a member of his or her own family, or to an individual who is receiving Case Management services from another Case Management Provider Agency, with applicable prior authorization from DDSD.

2. A Case Management Provider Agency may not be a Provider Agency for any other DDW service. In addition, Case Management Provider Agencies must disclose to DDSD and affected individuals served any familial relationships between employees/subcontract case managers and providers of other DDW services.

3. A Case Manager or Director of a Case Management Provider Agency may not serve on the Board of Directors of any DDW Provider Agency.

4. Case Management Provider Agency staff and subcontractors must maintain independence, and avoid all activity which could be perceived as a potential conflict of interest.

5. A Case Management Provider Agency may not provide guardianship services to an individual receiving case management services from that same agency.
6. A Case Manager may not provide training to staff of DDW Provider Agencies except when:

   a. They are certified to deliver the course by the DDSD Training Unit; and

   b. They offer training as an open session to staff from multiple agencies through the trainnewmexico.com website, paid on a fee per participant basis; and

   c. They are not paid via exclusive arrangements with specific provider agencies; or

   d. They are providing Individual Specific Training related to an individual on their caseload, on a topic which they are qualified to train, the training is part of their case management duties, and the case manager receives no separate payment from the Provider Agency (e.g. review of individual preferences or other aspects of the ISP).

M. Primary Record Documentation: The Case Manager is responsible for maintaining required documentation for each individual served:

1. The Case Manager will provide reports and data as specified/requested by DDSD within the required time frames;

2. Case Managers will provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of the new ISP effective date;

3. Case Managers will provide copies of the ISP to the respective DDSD Regional Offices within 14 days of the new ISP effective date;

4. Copies of the ISP are distributed by the case manager to providers, the individual and guardian(s) and shall include any related ISP minutes, teaching and support strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable; and

5. Recommendations for further evaluations, screenings, diagnostics and/or treatments may be made to the IDT members by healthcare practitioners, or other experts [e.g. Supports and Assessments for Feeding and Eating (SAFE) Clinic, Trans-disciplinary Evaluation and Support Clinic (TEASC)], or Jackson Community Monitor via the Community Practice Review findings and recommendations. The IDT Members shall discuss these recommendations and determine appropriate action;

   a. If the IDT Members concur with the recommendations, the ISP will be revised, follow-up completed and documented in progress reports. If applicable,
revisions are made to relevant therapy plans or DDSD Assessment Tracking Sheet;

b. If the IDT needs more information in order to make a decision, they may complete a Decision Consultation Form, indicating that further information and assessment/consultation is needed. Such additional information must then be collected in a timely fashion, and the IDT reconvened to make a final decision;

c. If the IDT Members, in their professional judgment, do not agree with the recommendation, the reasons for this shall be clearly documented in the Decision Consultation Form and filed by the Case Manager with the healthcare practitioner or consultant report which contained the recommendation; and

d. A copy of the Decision Consultation Form is also given to the residential provider (if any) and the guardian;

6. The individual’s name and the date the document was prepared are required to be included on all pages of all documents.

N. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance;

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and
d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:
   
   i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
   
   ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

O. **REIMBURSEMENT:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.
P. **Billable Services:** The following activities are deemed to be billable services;

1. All services and supports within the Case Management Scope of Services; and

2. Case Management may be provided at the same time on the same day as any other service.

Q. **Billable Unit:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD).

3. Reimbursement to the Case Management Provider Agency is based upon a monthly rate for a maximum of twelve (12) months per ISP year.

4. The Case Management Provider Agency shall provide and document at least one hour of case management services per individual served, and a monthly average of at least four (4) hours of DDW service per individual, including face to face contacts, across the caseload of each Case Manager. A Case Management Provider Agency cannot bill for an individual for whom a face to face contact did not take place during the month.

5. Partial units are paid when the individual transitions from one Case Management Provider Agency to another during the month, and a Case Manager provides at least one hour of billable service including face to face contact during that calendar month. The monthly rate is pro-rated based on the number of days the individual was with the Case Management Provider Agency.

6. Reimbursement to the Case Management Provider Agency for pre-assessment up to 20 hours per individual (one time only) for new allocations.

R. **Non-Billable Services:**

1. Services furnished to an individual who does not reside in New Mexico;

2. Services furnished to an individual who is not eligible for DDW Case Management services;

3. Time spent on the following activities:
   a. Traveling;
   b. Missed appointments; and
c. Employer activities including any time spent in employer staff meetings, meetings with supervisors that are not client specific, or attending to employer/contractor administrative duties.

4. Participation by the Case Manager in any educational courses or training unless such training is listed in the ISP as Individual Specific Training that the Case Manager needs to receive or deliver;

5. Outreach activities, including contacts with persons potentially eligible for the DDW; or

6. Case Management services furnished to an individual who is in an institution (e.g., ICF/IDD, nursing facility, hospital), except for discharge planning services in accordance with MAD Supplement No. 01-22.
CHAPTER 5
COMMUNITY INTEGRATED EMPLOYMENT SERVICES

I. Community Integrated Employment

The objective of Community Integrated Employment is to provide supports to DDW recipients that result in jobs in the community which increase economic independence, self-reliance, social connections and the ability to grow within a career.

Community Integrated Employment services are geared to place individuals with disabilities in employment situations with non-disabled co-workers within the general workforce; or assist the individual in business ownership. This service may include small group employment such as mobile work crews or enclaves. Individuals are supported to explore and seek opportunity for career advancement through growth in wages, hours, experience, promotions and/or movement from group to individual employment. Individuals are provided the opportunity to participate in negotiating his/her work schedule, break/lunch times, and leave and medical benefits with his/her employer. Each of these activities is reflected in individual career plans.

Implementation of the Employment First Principle: Interdisciplinary team (IDT) members are required to offer Community Integrated Employment Services as a priority service over other day service options for all working age adults. In cases when employment is not the immediate outcome, the Case Manager must document the reasons for this decision. The Case Manager and the IDT then need to develop Desired Outcomes, Actions Plans and Teaching and Support Strategies within the ISP, to explore alternative options that may lead to employment (e.g., trial work opportunities, career exploration, situational assessments, etc.). It is the responsibility of the IDT and Case Manager to ensure that these decisions are based on an informed choice made by the individual and/or guardian.

Informed Choice on Employment: In the context of employment, informed choice must include the following activities:

A. Assessing the individual’s vocational interests, abilities and needs;

B. Discussing with the individual/guardian what was learned through the assessment;

C. Providing information about employment options available to the individual; including information regarding self-employment, and customized employment options, and resources;

D. Providing opportunities for career exploration activities including trial work opportunities;

E. Considering potential impact on the individual’s benefits and services; including information and plans to address any benefit related issues that may arise; and
F. Assuring wages or compensation for work are in compliance with the Fair Labor Standards Act and Code of Federal Regulations. Medicaid funds (e.g., the Provider Agency’s reimbursement may not be used to pay the individual for work).

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

1. **SCOPE OF SERVICES**

   **A. Job Development**: Job Development may include, but is not limited to, activities to assist an individual to plan for, explore and secure Community Integrated Employment including:

   1. Conducting community-based situational assessments, Vocational Assessment Profiles (VAP) or other person-centered assessments;

   2. Developing and/or identifying community based job opportunities that are in line with the individual’s skills and interests;

   3. Developing a résumé (written or visual) that identifies an individual’s relevant vocational experience;

   4. Assisting the individual to find jobs that are well-matched to his/her vocational outcome including negotiating with employers for job customization;

   5. Supporting the individual in gaining the skills or knowledge to advocate for themselves in the workplace;

   6. Educating the individual and IDT on rights and responsibilities around employment;

   7. Promoting career exploration based on interests within various careers through job sampling, job trials or other assessments as needed;

   8. Arranging for or providing benefits counseling;
9. Ensuring consistent implementation of Written Direct Support Instructions (WDSI) by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans related to the work place;

10. Facilitating job accommodations and use of assistive technology such as communication devices;

11. Assisting the individual with the development of natural supports;

12. Assisting the individual to communicate and express their needs with co-workers;

13. Providing job site analysis (matching workplace needs with those of the individual);

14. Arranging for, providing or training on transportation supports during Job Development activities, including the use of public transportation options;

15. Assisting the individual in gaining and/or increasing job seeking skills training (JSST), which include, but are not limited to: (interviewing skills, résumé writing, work ethics training, etc.);

16. Assist employers with the Americans with Disabilities Act (ADA) issues, Work Opportunity Tax Credit (WOTC) eligibility, requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies; and

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

B. Job Maintenance: The scope of work for Community Integrated Employment may include, but is not limited to the following:

1. Providing effective job coaching and on-the-job training as needed to assist the individual to maintain the job placement and enhance skill development, including providing systematic instruction and completing a task analysis as appropriate;

2. Maintain ongoing communication with various levels of the company to assure satisfaction for both the individual and the company;

3. Arranging for, providing or training on transportation supports during Job Maintenance activities, including the use of public transportation options;

4. Providing assistance with medication delivery as outlined in the ISP;
5. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans related to the work place;

6. Assessing the need for additional hours of Intensive Community Integrated Employment based on individual need;

7. Assessing the usefulness of continuing Community Integrated Employment Service when the individual needs less than one hour of face-to-face service per month. In those cases, the IDT members must consider whether Community Integrated Employment Service remains suitable for the individual. If a decision is made to discontinue the service the IDT will determine alternate supports, if any, needed to maintain the job;

8. Advocate for the individual to be integrated into the work culture, including attending job–related social functions and interacting with their non-disabled co-workers during lunch or break times. In addition individuals should have full access to employer designated dining/break areas;

9. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

10. All Providers are required to store information and have policy in accordance with HIPAA requirements;

11. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

12. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable; and

13. Provide a secure place for the individual to store personal belongings.

C. Self-Employment: When an individual elects to start their own business, the Community Integrated Employment Provider supports the individual by assisting with the development of a business plan, conducting a market analysis for the product or service and establishing the infrastructure to support a successful business. Self-employment does not preclude employment in the other models. The scope for Self-employment may include but is not limited to the following:

1. Completing a market analysis of product/business viability;
2. Assisting with and/or utilizing community resources to develop a business plan, developing a business infrastructure to sustain the business over time and marketing plans;

3. Referring and coordinating with the Division of Vocational Rehabilitation (DVR) to determine possible funding for business start-up;

4. Providing assistance in obtaining tax ID, incorporation documents and completing any other business paperwork required by local and state codes;

5. Supporting the individual in developing and implementing a system for bookkeeping and records management;

6. Providing effective job coaching and on-the-job training and skill development;

7. Arranging for, providing or training on transportation supports during self-employment activities, including the use of public transportation options;

8. Providing assistance with medication delivery as outlined in the ISP;

9. Ensuring consistent implementation of WDSI's for therapy by providing assistance or instruction on the use of assistive technology, medical equipment, and/or any relevant behavioral plans related to the workplace (e.g. the PBSP or other applicable plans); and

10. Coordinating personal care activities as identified in the ISP.

D. Intensive Community Integrated Employment (ICIE): Is to designed provide services for individuals who are working in a community integrated employment setting and require more than 40 hours of staff supports per month in order to maintain their employment.

1. The scope of services for ICIE is the same as those outlined under Job Maintenance in this chapter.

2. A request must be approved by DDSD prior to their implementation. Such requests will be considered after all reasonable adjustments to the base budget for day services have been made. The request must include the reason (e.g. new job) and the number of hours that the IDT is requesting. The DDSD prior approval is for up to three hundred and sixty five (365) days.

Community Inclusion Aide: The Community Inclusion Aide provides one-to-one (1:1) personal care services in an individual integrated employment setting for individuals who requires assistance with Activities of Daily Living (ADLs) during work hours in order to maintain successful employment as job coaching is reduced. The scope of work includes but is not limited to the following:
1. Assisting with activities of daily living such as eating, meal preparation on the job, and individual personal hygiene;

2. Assisting with mobility, access and communication within the workplace;

3. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans related to the work place;

4. Assisting with implementation of health maintenance supports;

5. Providing assistance with medication delivery as outlined in the ISP;

6. Arranging for, providing or training on transportation supports during community inclusion aid activities including the use of public transportation options;

7. Advocate for the individual to be integrated into the work culture, including attending job-related social functions and interacting with their non-disabled co-workers during lunch or break times. In addition individuals should have full access to employer designated dining/break areas;

8. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

9. All Providers are required to store information and have policy in accordance with HIPAA requirements;

10. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

11. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable; and

12. Provide a secure place for the individual to store personal belongings.

E. Group Community Integrated Employment: In Group Community Integrated Employment more than one individual works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers and/or the public occurs. The scope of work for Group Community Integrated Employment may include but is not limited to the following:
1. Participating in the IDT to develop a plan to assist an individual who desires to move from group employment to individual employment;

2. Providing effective job coaching and on-the-job training as needed to assist the individual in maintaining the job placement and enhancing skill development;

3. Arranging for, providing or training on transportation supports during Group Community Integrated Employment including the use of public transportation options;

4. Providing assistance with medication delivery as outlined in the ISP;

5. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans related to the work place;

6. Advocate for the individual to be integrated into the work culture, including attending job–related social functions and interacting with their non-disabled co-workers during lunch or break times. In addition individuals should have full access to employer designated dining/break areas;

7. Advocate for the individual to be integrated into the work culture, including attending job–related social functions and interacting with their non-disabled co-workers during lunch or break times. In addition individuals should have full access to employer designated dining/break areas;

8. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

9. All Providers are required to store information and have policy in accordance with HIPAA requirements;

10. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

11. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

12. Provide a secure place for the individual to store personal belongings;
13. In agency-occupied setting, the agency must encourage visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. Evidence of this must be present; and

14. Allow individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs):

   a. Provide for an alternative meal and/or private dining if requested by the individual.

2. SERVICE REQUIREMENTS

A. Community Integrated Employment is intended for individuals who are 18 years of age or older. Any exception to the age requirement must have the prior written approval of DDSD on at least an annual basis.

B. Community Integrated Employment Services are provided in community integrated settings. For purposes of this standard a community integrated setting is a work environment in which 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. Self-Employment and Group Employment may be exempt from this requirement in certain settings with prior approval from the Regional Community Inclusion Coordinator.

C. The individual has specific rights including, but not limited to:

   1. The opportunity to develop self-advocacy skills and to advocate on their own behalf in regards to planning and using waiver services;

   2. The right to make informed choices throughout the course of the day about his or her everyday life, including daily routines and schedules;

   3. The individual retains the right to assume risk; this dignity of risk must be balanced with the individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety; and

   4. The right to work with necessary supports regardless of disability including behavioral or medical needs.
D. The Community Integrated Employment Agency will meet with the employer prior to and during employment to identify expectations and specific supports needed for success at the work site.

E. Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual’s desired outcome and the job.

F. **Staffing Ratio:** The agency will ensure staffing ratios that support the health and safety of each individual served.

   1. Community Integrated Employment, Intensive Community Integrated Employment (ICIE), Self-Employment and Community Inclusion Aide require a one-to-one (1:1) participant to staff ratio;

   2. Group Community Integrated Employment, staff ratios, depending on the individuals’ NM DDW Group are not to exceed:
      a. One-to-six (1:6) for NM DDW Groups A-D; or
      b. One-to-four (1:4) for NM DDW Groups E-G.

   3. The provider must provide adequate staffing to assure health and safety and promote positive work behavior and growth.

G. **Service Limitations:**

   1. Individuals are eligible for DDW Community Integrated Employment Services only when services otherwise available to individuals under a program funded under the Rehabilitation Act of 1973, available through the DVR or through the New Mexico Department of Education are not currently available or are no longer available;

   2. Medicaid funds (i.e., Provider Agency reimbursement) may not be used to pay the individual; and

   3. Job Development services are limited to 4 months of service per ISP year.

3. **AGENCY REQUIREMENTS**

   A. **Community Integrated Employment Agencies must:**

      1. Must comply with all applicable federal and state rules as well as DOH/DDSD policies and procedures;

      2. Maintain and comply with all provisions of the annual Performance Contract that covers all individuals receiving services from the agency; and
3. Appropriate staff from the Community Integrated Employment Agency will participate on each individual’s IDT, as specified in the ISP regulations [NMAC 7.26.5].

4. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers:

5. All agency-occupied buildings shall meet ADA standards and be physically accessible;

6. Providers are required to store information and have policy in accordance with HIPAA requirements;

7. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

8. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

9. Provide a secure place for the individual to store personal belongings; and

10. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be common practice.

B. Community Integrated Employment Agency Staff Requirements:

1. **Direct Support Personnel Qualifications and Competencies:** Individuals working as DSP and supervisors for Community Integrated Employment Provider Agencies must meet the following requirements and have the ability to instruct and assist individual to carry out the scope of services:

   a. Be eighteen (18) years or older;

   b. Have a high school diploma or GED; and

   c. Maintain current First Aid and CPR certification.
2. **Qualifications and Competencies for Community Inclusion Aides:** Staff providing Community Inclusion Aide Services must at a minimum:

   a. Be eighteen (18) years or older;

   b. Have a high school diploma or GED; and

   c. Maintain current First Aid and CPR certification.

3. **Qualifications and Competencies for Job Development:** In addition to the competencies listed above, staff providing job development and related services must, at a minimum:

   a. Be twenty-one (21) years of age or older; and

   b. Maintain current First Aid and CPR certification.

C. Additional pre-service and on-the-job training will be provided as needed by the agency to ensure that agency staff have the related competencies listed above.

D. Agencies may not employ or sub-contract direct support personnel who are an immediate family member or who are a spouse of the individual served to work in the setting in which the individual is served.

E. In a group employment setting, the provider determines the job site and is responsible for the day-to-day supervision of the individuals and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with his or her role as employer. When necessary and appropriate, the Community Integrated Employment Agency may supplement these services.

F. **General Events Reporting:** Community Integrated Employment Services provider agencies must enter General Events Reporting into Therap as specified in the New Mexico DDSD General Events Report (GER) Guide.

G. **Training Requirements:**

   1. All Community Integrated Employment Services must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

   2. All Community Integrated Employment Services Providers are required to report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD policy T-001: Reporting and Documentation of DDSD Training Requirements Policy.
3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.

H. Criminal Background Screening: Community Integrated Employment Services Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

I. Employee Abuse Registry: Community Integrated Employment Services Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

J. Consumer Records Policy: Community Integrated Employment Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

K. Reporting Requirements: The Community Integrated Employment agency must submit the following:

1. Progress Reports: Community Integrated Employment Services providers must submit written status reports to the individual’s Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:
   a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcome to the case manager. These updates do not require an IDT meeting unless changes requiring team input need to be made (e.g., adding more hours to the Community Integrated Employment budget); and
   b. Written annual updates to the ISP work/learn action plan to DDSD.

2. VAP or other assessment profile to the case manager if completed externally to the ISP;

3. Initial ISP reflecting the Vocational Assessment or other assessment profile or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD; and

4. Reports as requested by DDSD to track employment outcomes.
L. **Quality Assurance Quality Improvement (QA/QI) Plan**: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI Plan**: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.
   
   b. The entities or individuals responsible for conducting the discovery/monitoring process;
   
   c. The types of information used to measure performance; and
   
   d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee**: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:
      
      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
      
      ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.
   
   b. Compliance with Caregivers Criminal History Screening requirements;
   
   c. Compliance with Employee Abuse Registry requirements;
   
   d. Compliance with DDSD training requirements;
e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. **REIMBURSEMENT:**

A. Community Integrated Employment Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Community Integrated Employment Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. **Billable Units:**

1. The billable unit for Community Integrated Employment, which includes Job Development and Job Maintenance, is a monthly unit.

2. The billable unit for Group Community Integrated Employment is a fifteen (15) minute unit.

3. The billable unit for Intensive Community Integrated Employment is an hourly unit.

C. **Billable Activities:**

1. Self and Individual Community Integrated Employment, Community Inclusion Aide: All one-to-one (1:1) DSP activities that are included in the individual’s approved ISP and delivered in accordance with the Scope of Services, and not included in non-billable services, activities or situations.
2. Self-Employment may include non-face-to-face activity in support of the participant’s business up to 50% of the billable time. The activities include development of a business plan and market analysis, marketing, advertising, DVR referral, document submission and processing regarding taxes or licenses, processing or filling orders.

3. Group Community Integrated Employment: All DSP face to face activities with the consumer as specified in the Scope of Services, the individual’s approved ISP and the performance based contract, and which are not included in non-billable services, activities or situations.

4. Job Development: both face to face and non-face to face activities as described in the Scope of Services, the individual’s approved ISP and the performance based contract. 50% of billable activities must be face to face.

5. Conducting the Vocational Assessment Profile (VAP) or other vocational assessment.

6. A minimum of four (4) hours of service must be provided monthly with a maximum of forty (40) hours per month for Community Integrated Employment Job Maintenance. The rate structure assumes a caseload of five (5) individuals per job developer which allows for an average support of approximately 22 hours of support per individual per month.

D. Non-Billable Services, Activities or Situations:

1. Services delivered to an individual who:
   
   a. Does not reside in New Mexico;
   
   b. Is not eligible for the DDW; or
   
   c. Is hospitalized or in an institutional care setting.

2. Services furnished in a non-integrated setting, unless a prior authorized exemption was granted by DDSD.

3. Services not included in the Scope of Services and the Individual’s approved ISP.

4. Participating in client assessments conducted by other parties.

5. Time spent on the following activities:
   
   a. Program preparation set up and clean up;
b. Traveling to or from any service site, except when transporting the individual in accordance with the Scope of Services;

c. Missed appointments;

d. Preparing or updating reports, progress notes and logs;

e. Agency activities including time spent in agency staff meetings, meetings with supervisors that are not client specific, attending to agency or contractor administrative duties, or routine paperwork including billing documentation;

f. Participation in personnel development activities; and

g. Participation in client specific training unless such training occurs during delivery of Community Integrated Employment Services with the individual present.
CHAPTER 6
CUSTOMIZED COMMUNITY SUPPORTS

I. Customized Community Supports

Customized Community Supports for adults are designed to assist an individual to: increase their independence and potentially reduce the amount of paid supports, establish or strengthen interpersonal relationships, join social networks and participate in typical community life.

Customized Community Supports are based upon the preferences and choices of each individual and designed to measure progress toward outcomes specified in the Individual Service Plan (ISP). Activities include: adaptive skill development, adult educational supports, citizenship skills, communication, social skills, self-advocacy, informed choice, community integration and relationship building.

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

Customized Community Supports may be provided in a variety of settings including community, classroom and agency-operated sites. Services provided in any location are required to either lead to participation and integration in the community or support the individual to reach his or her personal goals for growth and development.

When planning Customized Community Supports, the Interdisciplinary Team (IDT) members shall recognize the individual’s right to make life choices that may include risk. The IDT members shall assess risk on an individual basis and develop or enhance risk mitigation strategies, as needed. The assumption of risk shall be balanced with the individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety while maintaining compliance with DDSD Standards and the NM Nurse Practice Act for those with health related supports.

Implementation of the Employment First Principle:

Interdisciplinary team (IDT) members are required to offer Community Integrated Employment Services as a priority service over other day service options for all working age adults. In cases when employment is not the immediate outcome, the Case Manager must document the reasons for this decision. The Case Manager and the IDT then need to develop Desired Outcomes, Actions Plans and Teaching and Support Strategies within the ISP, to explore alternative options that may lead to employment (e.g., trial work opportunities, career exploration, situational assessments, etc.) It is the responsibility of the IDT and Case Manager to ensure that these decisions are based on an informed choice made by the individual and/or guardian.
Implementation of a Meaningful Day:

The objective of Meaningful Day services is to provide supports to implement the individual’s definition of a meaningful day, contained in their Individual Service Plan (ISP).

A. Included are purposeful and meaningful work; substantial and sustained opportunity for optimal health; self-empowerment; personalized relationships skill development and/or maintenance; social, educational and community inclusion activities; that are directly linked to the vision, desired outcomes and action plans stated in the individual’s ISP. Implementation activities of the individual’s meaningful day are documented in daily schedules and progress notes.

B. The term “day” does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. Provision of community inclusion services is not limited to specific hours or days of the week. However, these services may not be used to supplant the responsibility of the Living Supports Provider for persons who receive both services.

1. SCOPE OF SERVICES

A. Individual Customized Community Supports: Customized Community Supports are age appropriate and provided on a one-to-one (1:1) basis. Such activities are delivered in a manner consistent with the individual’s ISP and are provided exclusively in the community:

1. Assessments (which may include certain personal planning processes such as MAPS, PATH, or Personal Profiles) to identify individual interests, connections, and strategies for providing services and supports to achieve desired outcomes. Assessments will be conducted in a location designated by the individual. Assessment activities also include participation in or input to evaluations conducted by other team members such as therapists, behavior support consultants, and nurses;

2. Skill building activities to support the individual’s desired ISP outcomes;

3. Skills application activities in typical community settings (banking or shopping etc.);

4. Providing information regarding a range and variety of employment options;

5. Providing supports for volunteer activities, offering information and coaching to community members to support the individual’s success;

6. Identifying and connecting the individual to community resources and options present in the ISP Action Plan;
7. Arranging or providing opportunities (time, information, materials and other resources) to pursue age appropriate hobbies, recreation/leisure activities and interests with non-disabled peers;

8. Providing opportunities for active individual choice-making during the course of the day, including daily schedules, activities, skill building and community participation;

9. Providing information pertaining to individual rights and responsibilities in the community;

10. Assisting in the development of self-advocacy skills;

11. Providing support to the individual to assume social roles that are valued by both the individual and the community;

12. Providing support for active engagement in community sponsored activities specifically related to the individual’s (as compared to group and/or agency) interests;

13. Assisting with budgeting to pay for adult education activities designed to promote personal growth, development, and community integration as presented in the ISP Action Plan and Outcomes;

14. Providing supports to participate in age-appropriate generic community retirement activities with non-disabled peers;

15. Arranging and assisting the individual to participate in adult education classes available to the general public, including staff time to support the individual while in class, in cases where the support needs have been deemed clinically or medically necessary;

16. Arranging for, providing or training on transportation supports during Job Development activities, including the use of public transportation options;

17. Providing personal care and support for activities of daily living (such as eating, toileting and personal hygiene);

18. Coordinating with required Adult Nursing Services for training and oversight for persons with health related supports such as providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; assisting with Nursing and Medical Oversight Services as needed and with associated Healthcare Plans and to implement practitioners’ orders that must occur during Customized Community Supports Services;
19. Assisting with the development of natural support networks that compliment or replace paid supports through personal relationships/friendships with people who are not disabled who have similar interests and preferences;

20. Ensuring consistent implementation of Written Direct Support Instructions (WDSI) by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans;

21. In agency-occupied setting, the agency must encourage visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. Evidence of this must be present.

22. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

23. All agency-occupied buildings shall meet ADA standards and be physically accessible;

24. Providers are required to store information and have policy in accordance with HIPAA requirements;

25. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

26. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

27. Provide a secure place for the individual to store personal belongings;

28. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be common practice;

29. Allow individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs):

   a. Provide for an alternative meal and/or private dining if requested by the individual.

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30. Monitoring, implementation and effectiveness of therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans, if applicable; and

31. Providing other individual specific activities and training needed to successfully implement the individual’s ISP.

B. **Community Inclusion Aides:**

The Community Inclusion Aide provides one-to-one (1:1) personal care services in an individual integrated community setting for individuals who require assistance with Activities of Daily Living (ADLs). The scope of work includes but is not limited to the following:

1. Assisting with activities of daily living such as eating, meal preparation on the job, and individual personal hygiene;

2. Assisting with mobility, access and communication within the community;

3. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans;

4. In agency-occupied setting, the agency must encourage visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. Evidence of this must be present;

5. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

6. All agency-occupied buildings shall meet ADA standards and be physically accessible;

7. Providers are required to store information and have policy in accordance with HIPAA requirements;

8. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

9. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;
10. Provide a secure place for the individual to store personal belongings;

11. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be common practice;

12. Allow individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs):

   a. Provide for an alternative meal and/or private dining if requested by the individual.

13. Coordinating with required Adult Nursing Services for training and oversight for persons with health related supports such as assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; providing assistance with Nursing and Medical Oversight Services as needed and with associated Healthcare Plans and to implement practitioners’ orders that must occur during Customized Community Supports; and

14. Arranging for, providing or training on transportation supports during community inclusion aid activities including the use of public transportation options.

C. Small Group Customized Community Support: Small Group Customized Community Support is provided in groups of three (3) or less. The following types of age appropriate activities are delivered in a manner consistent with the individual’s ISP and are provided exclusively in the community:

1. Participating in assessment activities designed to identify specific strategies to achieve desired outcomes; including participation in assessments conducted by therapists, nurses, BSC, or other team members;

2. Providing skill building activities to support the individual’s desired ISP outcomes;

3. Assisting with skills application activities in typical community settings (e.g., banking or shopping);

4. Providing information regarding employment options available to the individual;

5. Providing support for volunteer activities including offering information and coaching to generic community supports to ensure the individual’s success;
6. Arranging access to age appropriate adult education opportunities available to the general public (e.g., coursework or conferences with non-disabled peers);

7. Identification and connection to community resources and options related to the ISP Action Plan;

8. Arranging or providing opportunities (time, information, materials, and other resources) to pursue age appropriate hobbies, recreation/leisure, and other interests with non-disabled peers;

9. Providing opportunities for active individual choice-making during the course of the day, including daily schedules, activities, skill building, and community participation;

10. Providing information pertaining to individual rights and responsibilities in the community;

11. Assisting the individual with developing their self-advocacy skills;

12. Providing support to the individual to assume social roles that are valued by both the individual and the community;

13. Providing support to the individual in becoming actively engaged in community sponsored activities specifically related to individual’s (as compared to agency) interests;

14. Assisting with budgeting to pay for adult education activities designed to promote personal growth, development, and community integration as presented in the ISP Action Plan and Outcomes;

15. Providing supports to participate in age-appropriate generic community retirement activities with non-disabled peers;

16. Arranging and assisting the individual to participate in community classes, including staff time to support the individual while in class, in cases where the support needs has been deemed clinically or medically necessary;

17. Arranging for, providing or training on transportation supports during Customized Community Support activities, including the use of public transportation options;

18. Providing personal care and support for activities of daily living (such as eating, toileting and personal hygiene);

19. Coordinating with required Adult Nursing Services for training and oversight for persons with health related supports such as assistance or supports with medications
in accordance with DDSD Medication Assessment and Delivery policy; providing assistance with Nursing and Medical Oversight Services as needed and with associated Healthcare Plans and to implement practitioners’ orders that must occur during Customized Community Supports;

20. Assisting with the development of natural support networks that complement or replace paid supports through development of personal relationships/friendships with people who are not disabled who have similar interests and preferences;

21. Assisting with the development and use of functional age-appropriate assistive devices, specific communication dictionary, and medical equipment;

22. In agency-occupied setting, the agency must encourage visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. Evidence of this must be present;

23. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

24. All agency-occupied buildings shall meet ADA standards and be physically accessible;

25. Providers are required to store information and have policy in accordance with HIPAA requirements;

26. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

27. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

28. Provide a secure place for the individual to store personal belongings;

29. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be common practice;

30. Allow individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, and afford dignity to
the diners (i.e., individuals are treated age-appropriately and not required to wear bibs):

a. Provide for an alternative meal and/or private dining if requested by the individual.

31. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans; and

32. Other individual specific activities needed to successfully implement the individuals ISP.

D. **Group Customized Community Supports:** The following types of age appropriate activities are delivered in a manner consistent with the individual’s ISP and are provided in the community (at least fifty (50)% of the planned, billable time) or group, classroom, or other similar settings:

1. Participation in assessment activities designed to identify specific strategies to achieve desired outcomes; including participation in assessments conducted by therapists, nurses, BSC, or other team members;

2. Providing skill building activities to support the individual’s desired ISP outcomes;

3. Assisting with skills application activities in typical community settings (e.g., banking or shopping);

4. Providing information regarding employment options available to the individual;

5. Providing of support for volunteer activities including offering information and coaching to generic supports to support the individual’s success;

6. Arranging access to age appropriate adult education opportunities available to the general public (e.g., coursework or conferences with non-disabled peers);

7. Identification and connection to community resources and options related to the ISP Action Plan;

8. Arranging or providing opportunities (time, information, materials, and other resources) to pursue age appropriate hobbies, recreation/leisure, and other interests with non-disabled peers;

9. Providing opportunities for active individual choice-making during the course of the day, including daily schedules, activities, skill building, and community participation;
10. Providing information pertaining to individual rights and responsibilities in the community;

11. Assisting the individual with the development of self-advocacy skills;

12. Providing support to the individual to assume social roles that are valued by both the individual and the community;

13. Providing support to the individual in becoming actively engaged in community sponsored activities specifically related to individual’s (as compared to agency) interests;

14. Assisting with budgeting to pay for adult education activities designed to promote personal growth, development, and community integration as presented in the ISP Action Plan and Outcomes;

15. Providing supports to participate in age-appropriate generic community retirement activities with non-disabled peers;

16. Arranging and assisting the individual to participate in community classes, including staff time to support the individual while in class, in cases where the support needs has been deemed clinically or medically necessary;

17. Arranging for, providing or training on transportation supports during Customized Community Supports activities, including the use of public transportation options;

18. Providing personal care and support for activities of daily living (such as eating, toileting and personal hygiene);

19. Providing health related supports with oversight and training from the Customized Community Supports- Group nurse for individuals during this service. These supports may include assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; providing assistance with Nursing and Medical Oversight Services as needed and with associated Healthcare Plans and to implement practitioners’ orders that must occur during Customized Community Supports;

20. Assisting with the development of natural support networks that complement or replace paid supports through development of personal relationships/friendships with people who are not disabled who have similar interests and preferences;

21. Assisting with the development and use of functional age-appropriate assistive devices, specific communication dictionary, and medical equipment;
22. In agency-occupied setting, the agency must encourage visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. Evidence of this must be present;

23. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be used as barriers;

24. All agency-occupied buildings shall meet ADA standards and be physically accessible;

25. Providers are required to store information and have policy in accordance with HIPAA requirements;

26. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable;

27. Ensure DSP don’t talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present;

28. Provide a secure place for the individual to store personal belongings;

29. When services are being provided within an agency-occupied building, the agency must allow individuals to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals’ entrance to or exit from certain should not be common practice;

30. Allow individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, and afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs):

   a. Provide for an alternative meal and/or private dining if requested by the individual.

31. Ensuring consistent implementation of WDSI by providing assistance or instruction on the use of assistive devices or adaptive equipment and/or any relevant BSC plans; and

32. Other individual specific activities needed to successfully implement the individuals ISP.
E. Individual Intensive Behavioral Customized Community Supports: Individual Intensive Behavioral Customized Community Supports are designed to meet the needs of individuals with high and extraordinary behavioral needs. This support provides age appropriate activities (listed in this Chapter for Customized Community Direct Supports) that should be delivered primarily on an individual basis in the community through group, classroom, or other similar settings. This level of support must meet specific clinical criteria and receive prior authorization through the respective Regional Office. Individual Intensive Behavioral Customized Community Supports includes:

1. Provision of the necessary level of staffing for the individual in NM DDW Group G to reduce the risk of harm to self or others in the community or in a group setting in accordance with a Positive Behavioral Support Plan;

2. Providing supports through Direct Support Personnel who has received specialized individual specific behavioral training and accessing ongoing behavioral support from the Behavior Support Consultant as presented in the PBSP; and

3. Included in the PBSP is a plan to implement the extra supports needed each day, as well as when to return to a typical staffing pattern once the circumstance associated with the increased risk has ended. The PBSP will also address additional training and other supports needed (e.g. regular meetings for communication among DSP, agency supervisors, and the Behavior Support Consultant) for the agency delivering this service. The Behavior Support Consultant will present the PBSP to the team and the team, in conjunction with the Behavior Support Consultant, will determine when and under what circumstances this will occur.

F. Fiscal Management for Adult Education Opportunities: The provider shall pay for tuition, fees and/or related materials associated with classes, lessons or conferences designed to promote personal growth, development and community integration as determined necessary for the individual by the IDT. This support includes the:

1. Processing request for payments, review of financial documents, and issuing checks to vendors on behalf of the individual;

2. Establishment of an account for each individual receiving this service; and

3. Tracking and accounting for approved expenditures on behalf of the individual (classes purchased shall not exceed 550 dollars per ISP year including 10% administrative processing fee).

2. SERVICE REQUIREMENTS

Customized Community Supports for adults is intended for individuals who are eighteen (18) years of age or older. Any age exception shall be pre-approved by DDSD on at least an annual basis by the DDSD Regional Office.
A. Providers must comply with the DDSD Employment First Principle. When Customized Community Supports is selected as a service for an individual rather than Community Integrated Employment, the ISP shall include a documentation summary of the employment options discussed and the basis for the determination of informed choice regarding the selection of Customized Community Supports over Community Integrated Employment.

B. Providers must comply with the Meaningful Day requirements as specified in these Standards and in ISP Regulations.

C. Group Customized Community Supports are not segregated vocational or prevocational activities (e.g. center-based or sheltered work). Individuals participating in this type of activity as a continuation of previous service models must have a transition plan, developed by the IDT, which will lead to more integrated, age appropriate options such as employment. The plan must be implemented within one hundred ninety (190) days following the annual ISP.

D. Group Customized Community Supports providers must have nurse staffing available to meet the needs of the individuals and staff during that service as part of the bundled nursing rate.

1. If Group CCS providers also offer Individual and/or Small Group CCS, and wish to provide nursing supports during those service, may opt to add Adult Nursing Services to their provider contract in order to be able to deliver and bill Adult Nursing Services to individuals who require health related supports during Individual or Small Group CCS. If the agency does not offer Adult Nursing Services the individual will need to select an Adult Nursing Services provider from the SFOC to receive health related support when they are not participating in Group CCS.

E. Providers who offer only Individual and or Small Group Customized Community Supports may opt to add Adult Nursing Services to their provider contract. If the agency does not offer Adult Nursing Services the individual will need to select an Adult Nursing Services provider from the SFOC. Refer to Adult Nursing Services chapter for more information.

F. Staffing Ratios:

1. Individual Customized Community Supports: The ratio is one-to-one (1:1) and is to be delivered in the community exclusively;

2. Intensive Behavioral Customized Community Supports: The ratio is one-to-one (1:1) or as necessary to adequately support the individual with challenges in both an individual and group setting;
3. Community Inclusion Aide: The ratio is one-to-one (1:1) and is to be delivered in the community exclusively;

4. Small Group Customized Community Supports: The group ratio is one-to-two (1:2) or one-to-three (1:3) and is to be delivered exclusively in the community; and

5. Group Customized Community Supports:Staff ratios, depending upon the individual’s NM DDW group assignment are not to exceed:

   a. NM DDW Groups A-D: one-to-six (1:6) at a day facility or in the community; or
   
   b. NM DDW Groups E-G: one-to-four (1:4) at a day facility or in the community; and

   c. At least 50% of Group Customized Community Supports is expected to occur in the community with the exception of those individuals who also receive Intensive Medical Living Services. (Individuals in Intensive Medical Living Services who access Customized Community Supports should be in the community as often as they are able according to their ISP.)

G. The agency nurse(s) for Group Customized Community Supports providers must provide the following services:

1. The Group Customized Community Supports nurse has the primary responsibility for completing the e-CHAT assessment for individuals who do not receive Supported Living, Intensive Medical Living or Adult Nursing Services for Family Living or Customized In Home Supports:

   a. An e-CHAT shall be completed by the Group Customized Community Supports agency nurse for any individual with conditions that require ongoing medically related supports when receiving this service;

   b. If the e-CHAT summary report lists Health Care plans or MERPs as required (indicated by an “R” for required in report) that are not applicable to the individuals needs during Customized Community Supports, the nurse is not required to proceed with care planning and shall document the reason in the comment section of the e-CHAT summary sheet; and

   c. If the individual also receives Individual and/or Small Group Customized Community Supports from the Group-CCS agency, based upon the results of the e-CHAT, the Group-CCS nurse may also request prior authorization for Adult Nursing Services for ongoing nursing supports in those service settings.
2. For individuals who receive Supported Living, Intensive Medical Living Services, or Adult Nursing Services for Family Living or Customized In Home Supports the Community Supports- Group Nurse will:

   a. Communicate and collaborate with nurses from these agencies in order to review their assessment findings and existing Health Care Plans and MERPs in order to develop and implement their own Healthcare Plans and MERPs that are pertinent during Group Customized Community Supports; and

   b. Train, monitor, and provide oversight for DSP to meet the individuals’ health care needs during Group Customized Community Supports services and to support the implementation of pertinent Health Care Plans and MERPs.

3. Implementation of pertinent Primary Care Practitioner (PCP) orders; ongoing oversight and monitoring of the individual’s health status and medically related supports when receiving this service;

4. Provision of oversight, training, and guidance to DSP as necessary, based on the individual’s health needs and diagnosis; PCP orders; Healthcare Plans and MERPs for those issues or needs that are relevant during Group Customized Community Supports including any delegated nursing tasks;

5. Documentation by the nurses of these efforts in designated electronic or paper documents according to DDSD policy. Customized Community Support Providers are required to provide Adult Nursing Services and complete the scope of services for nursing assessments and consultation as outlined in the Adult Nursing Standard. The agency nurse will provide the individual’s team with a semi-annual nursing report that discusses the services provided during CCS-Group and additional Community Services if provided by the Group-CCS agency, and the status of the individual over the last (6) months. This may be provided electronically or in a paper format to the team no later than (2) weeks prior to the ISP meeting and semi-annually;

6. Provision of nursing services based on prudent nursing practice and compliance with all DDSD policies, procedures and standards, and the New Mexico Nurse Practice Act; and

7. For requirements regarding Adult Nursing Services (ANS) provided in the Community, refer to the ANS chapter.

3. AGENCY REQUIREMENTS

Customized Community Support Agencies must comply with all of the following requirements:

A. Maintain and comply with all provisions of the annual Performance Contract that covers all individuals receiving services by the provider agency, including:

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1. Ensure that appropriate staff from the Customized Community Supports Agency will participate on each individual’s IDT, as specified in the ISP regulations [NMAC 7.26.5];

2. Enter General Events Reporting into Therap; and

3. The Customized Community Supports Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures

B. Provide fiscal management to individuals served for the purchase of tuition, fees and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes.

C. Employ or subcontract with at least one RN to comply with services under “Nursing and Medical Oversight Services as needed” that is detailed in the Scope of Services above for Group Customized Community Supports Services.

1. Ensure compliance with the New Mexico Nurse Practice Act and DDSD Policies and Procedures regarding Delegation of Specific Nursing Functions, including:

a. Provider agencies (Small group and Group services) must develop and implement policies and procedures regarding delegation which must comply with relevant DDSD Policies and Procedures, and the New Mexico Nurse Practice Act. Agencies must ensure that all nurses they employ or contract with are knowledgeable of all these requirements;

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

   a) Train each DSP to skill level competency;

   b) Monitor ongoing staff performance, skill level and the individual’s health status; and

   c) Rescind delegation at any time the nurse determines that the DSP is unwilling or unable to safely perform the delegated task.

c. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office; and

d. Delegation is a unique relationship between a nurse and a DSP that cannot be mandated and cannot be transferred between nurses or between DSP. If a staff nurse or DSP is no longer employed or contracted by the agency, the delegation relationship is nullified.
D. Ensure that when an individual changes providers that safe and appropriate planning takes place. This is the responsibility of both the existing and new provider. An IDT meeting to develop a transition plan shall be held to address the following:

1. Exchange of health-related information;
2. Individual preferences;
3. Required documentation; and
4. Training of staff.

E. Meet all Customized Community Supports Agency Staff Requirements:

1. Qualifications and Competencies: Agencies will maintain qualified and competent staff. Staff providing direct services must, at a minimum:
   a. Be eighteen (18) years of age or older;
   b. Have a high school diploma or GED;
   c. Complete any additional training required as part of Regional Office Technical Assistance or Performance Improvement plan;
   d. Know the individuals they support well (e.g., likes, dislikes, preferences, choices, interests, gifts, needs, etc.);
   e. Communicate effectively and respectfully with the individual;
   f. Contribute ideas to support the individual in achieving desired ISP outcomes;
   g. Assist the individual to identify desired activities throughout the day and actively help the individual accomplish them;
   h. Provide instruction to facilitate the development of new skills and generally support individual learning and development;
   i. In collaboration with the IDT, identify and become familiar with any community resources and options needed to fulfill ISP outcomes, Action Plans, and personal Meaningful Day definitions;
   j. Contribute to developing and implementing purposeful activities that meet the individual’s definition of a meaningful day;
k. Document and effectively communicate daily progress toward achievement of desired outcomes, as well as barriers/concerns encountered;

l. Communicate effectively with community members, other staff and IDT members to accomplish the individual’s desired outcomes;

m. Model appropriate behaviors;

n. Instruct and assist with the implementation of therapy, healthcare, PBSP, BCIP, MERP, CARMP and other risk management plans, if applicable;

o. Implement individual specific strategies to help the individual achieve desired outcomes and maintain health as stated in the ISP action plans, strategies, Therapy WDSI, and applicable behavioral or healthcare related support plans such as PBSP, BCIP, or MERP;

p. Maintain safety standards and required related documentation at all times to ensure health and wellness;

q. Understand and implement crisis or emergency responses needed for individuals served;

r. Report incidents;

s. Implement DDSD standards, regulations and performance contract requirements;

t. Effectively implement relevant activities from the provider Quality Management System;

u. Agencies may not employ or sub-contract direct care personnel who are an immediate family member or who are a spouse of the individual served to work in the setting in which the individual is served; and

v. Maintain current First Aid and CPR certification.

2. **Criminal Background Screening:** The Customized Community Supports Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

3. **Employee Abuse Registry:** The Customized Community Supports Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

F. **Meet all training requirements as follows:**
1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

2. All Customized Community Supports Providers are required to report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;

3. Agency nurses shall complete the following training:
   a. DDW Nurse Orientation and Health Care Planning modules within ninety (90) calendar days of hire;
   b. Observation of the full two-day “Assisting with Medication Delivery” course to gain awareness of expectations for DSP who assist with medication delivery within one hundred and eighty (180) calendar days of hire;
   c. Within twelve (12) months of hire complete training for ARM; Effective Individual Specific Training, and Person Centered Planning; and
   d. Effective Individual Specific Training Clinic within twelve (12) months of hire.

4. Because much of the training by therapists and BSC is most effective in the context of daily routines, DSP must be available to participate in therapy/BSC appointments on a regular basis as requested.

G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:

   1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

H. General Events Reporting: Customized Community Supports provider agencies must enter General Events Reporting into Therap as specified in the New Mexico DDSD General Events Report (GER) Guide.

I. Reporting Requirements: Progress Reports: Customized Community Supports providers must submit written status reports to the individual’s Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress
since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:

1. Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting:
   
a. Identification of and implementation of a Meaningful Day definition for each person served;

b. Documentation for each date of service delivery summarizing the following:
   
i. Choice based options offered throughout the day; and

ii. Progress toward outcomes using age appropriate strategies specified in each individual’s action steps in the ISP, and associated support plans/WDSI.

c. Record of personally meaningful community inclusion activities;

d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcomes. These updates do not require an IDT meeting unless changes requiring team input need to be made; and

e. Data related to the requirements of the Performance Contract to DDSD quarterly.

J. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;
c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at
least a quarterly basis and as needed to review monthly service reports, to identify
and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for
quality improvement. The QA/QI meeting must be documented. The QA/QI review
should address at least the following:

a. Implementation of the ISP, including:
   i. Implementation of outcomes and action steps at the required frequency
      outlined in the ISP; and
   ii. Outcome statements for each life area are measurable and can be readily
determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report
annually from the QA/QI Plan by February 15th of each calendar year. The report must be
sent to DDSD, kept on file at the agency, and made available upon request. The report
will summarize the listed items above.

4. **REIMBURSEMENT**

A. **Required Records:** Customized Community Supports Services Provider Agencies must
maintain all records necessary to fully disclose the type, quality, quantity and clinical
necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. Billable Unit:

1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.

2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.

3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.

4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.

5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.

6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.

7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.

C. Billable Activities:

1. All DSP activities that are:
   a. Provided face to face with the individual;
   b. Described in the individual’s approved ISP;
   c. Provided in accordance with the Scope of Services; and
   d. Activities included in billable services, activities or situations.

2. Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee.
3. Therapy Services, Behavioral Support Consultation (BSC), and Case Management may be provided and billed for the same hours, on the same dates of service as Customized Community Supports.

D. **Non-Billable Services, Activities or Situations include:**

   a. Services to an individual who:

      i. Does not reside in New Mexico;

      ii. Is not eligible for the DDW; or

      iii. Is hospitalized or in an institutional care setting.

   b. Services that are not:

      i. Included in the Scope of Services;

      ii. Included in the Individual’s approved ISP; or

      iii. Provided face to face with the consumer.

   c. Time spent on the following activities:

      i. Traveling to or from any service site, except when transporting the individual in accordance with the Scope of Service;

      ii. Program preparation, set up or clean up;

      iii. Missed appointments;

      iv. Medical appointments;

      v. Conducting, observing or participating in client assessments;

      vi. Preparing or updating reports, progress notes or logs;

      vii. Employer activities including time spent in employer staff meetings, meetings with supervisors that are not client specific, attending to employer or contractor administrative duties, routine paperwork included billing documentation;

      viii. Participation in personnel development; and

      ix. Training, except for Individual Specific Training delivered during Customized Community Supports with the individual present.
CHAPTER 7

CUSTOMIZED IN-HOME SUPPORTS

I. Customized In-Home Supports

Customized In-Home Supports are intermittent services and/or supports that are individually designed to instruct or enhance home living skills, community skills and to address health and safety as needed. Customized In-Home Supports provides individuals the opportunity to design and manage the services and/or supports needed to live in their own home or their family home.

Customized In-Home Supports include a combination of instruction and personal support activities provided intermittently as they would normally occur to assist the individual with activities of daily living, health related supports, meal preparation, household services and money management. Supports also include providing support to acquire, maintain or improve interaction skills in the community or at the individual’s place of employment.

Customized In-Home Supports is not a residential service and is intended for individuals that do not require the amount/intensity of support provided under Living Supports services.

Customized In-Home Supports consists of two types of living arrangements:

A. Living independently; and

B. Living with paid or unpaid families or natural supports.

1. SCOPE OF SERVICES

A. The Scope of Customized In-Home Supports: Provide assistance with the acquisition, improvement, and/or retention of skills to achieve personal outcomes that enhance the individual’s ability to live independently in the community as specified in the Individual Service Plan (ISP) and associated support plans (e.g., Positive Behavior Support Plan), and Written Direct Support Instructions (WDSI). The scope of Customized In-Home Supports includes, but is not limited to:

1. Assist/instruct the participant with activities of daily living including grooming, bathing, dressing, oral care, eating, transferring, exercise, mobility, and toileting;

2. Assist the individual with the acquisition, restoration, and/or retention of independent living skills such as shopping, banking, money management, and use of public transportation;

3. Provide assistance in the acquisition or maintenance of social interaction skills, community involvement and transportation;

4. Address health and safety as needed to include the following as applicable;
a. Support to access medical services or behavioral health services through the Medicaid State Plan;

b. Assist with medication delivery such as setting up medications or reminders to take medication;

c. Implement, track progress and document outcomes of healthcare orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans, if applicable; and

5. Assistance with use of the individuals’ adaptive equipment, augmentative communication and assistive technology devices, including supports related to maintenance of such equipment and devices to ensure they are in working order.

2. SERVICE REQUIREMENTS

A. Individual Age Requirements: To receive Customized In-Home Supports the individual must be eighteen (18) years of age or older.

1. DDW participants assigned to NM DDW Groups A-G are eligible to receive Customized-In Home Supports living independently, living with family (paid or unpaid), or living with natural supports.

B. Interdisciplinary Team (IDT) Assessment for Customized In-Home Supports: The IDT determines whether the individual’s assessed needs for support are best met through this service model. This service is designed to provide the individual with intermittent support and teaching of skills to live successfully in the community and to maintain a safe and healthy living environment.

C. Provision of Services:

1. Services shall be available up to 365 days per ISP year.

2. Services are delivered by direct support personnel in the individual’s own home, family home, or in the community;

3. This service is intended to provide individual support, but may be provided to more than one individual at a time under the following circumstances:

   a. Roommates (up to three individuals with developmental disabilities) who all receive this service and who have compatible outcomes for the service in their ISPs;

   b. In small groups (no more than three individuals with developmental disabilities) during activities outside the home, such as social events or grocery shopping;
c. Roommates (up to four individuals) who have compatible interests and who receive another service such as Supported Living services. Example: three (3) individuals receive Supported Living and one (1) individual receives Customized In-Home Supports;

4. Respite services may be accessed for individuals receiving Customized In-Home Supports who are living with family members or with natural supports (paid or unpaid). Any such Respite may not be provided by a primary caregiver or any other person who resides in the same dwelling as the individual served.

D. Service Limitations:

1. Respite may not be accessed for individuals that are living independently; and

2. Customized In-Home Supports cannot be provided in conjunction with Living Supports. An individual cannot receive Customized In-Home Supports and Living Supports simultaneously.

E. Supervision: The Customized In-Home Support Provider Agency must provide and document:

1. Monthly face-to-face consultation by agency supervisors or internal service coordinators, with the individual and direct support personnel in order to:

   a. Review, advise, and implement the individual’s ISP Action Plans and associated support plans, WDSI’s, schedule of activities and appointments; and

   b. Assist with service or support issues raised by the direct support personnel or observed by the supervisor, service coordinator or other IDT members.

2. Entry of General Events Reporting into Therap if the event occurs while the individual is receiving Customized In-Home Supports.

F. Individual Rights: The individual retains the right to assume risk. The assumption of risk must be considered by the team in light of the individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety.

G. Financial Responsibilities of the Individual:

1. An individual receiving Customized In-Home Supports will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.

2. Costs for room and board are the responsibility of the individual receiving the service.
H. Health Care Requirements for Customized In-Home Supports: The rate for Customized In-Home Supports does not provide funding for nursing services and therefore is not a service component for Customized In-Home Supports. Individuals in Customized In-Home Supports that need nursing services can purchase Adult Nursing as a separate service through their other services budget.

To ensure compliance with the NM Nurse Practice Act, unless nursing supports are obtained through a source other than the DD waiver, Adult Nursing services must be budgeted if the individual cannot self-administer their own medication or requires or receives health related supports from DSP who are not related by affinity or consanguinity.

I. Transportation: The Customized In-Home Supports Provider Agency is responsible for assisting the individual to coordinate transportation.

3. AGENCY REQUIREMENTS

A. Customized In-Home Supports Provider Agency Qualifications:

1. The Customized In-Home Supports Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

B. IDT Coordination:

1. Appropriate staff from the Customized In-Home Supports Provider Agency will participate on each individual’s IDT, as specified in the ISP regulations [NMAC 7.26.5].

2. When an individual changes providers or waiver programs, it is the responsibility of both the existing and new provider to participate to ensure that safe and appropriate planning takes place. An IDT meeting to develop a transition plan must be held to address exchange of health-related information, individual preferences, required documentation, training of staff and any moving logistics.

3. Appropriate staff will be available to the individual and the IDT as a qualified primary respondent or an ancillary respondent for scheduled Supports Intensity Scale® assessments and provide information to accurately reflect the person’s needs for supports.

4. Ensure the individuals have access to augmentative communication and assistive technology which aid the individual to participate in meaningful activities.

5. Monitor that DSP’s implement and document progress of the assistive technology inventory, physician and nurse practitioner orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans.
C. Customized In-Home Supports Provider Agency Staff Requirements:

1. Customized In-Home Supports Staff Qualifications and Competencies: Individuals working as direct support personnel and supervisors for Customized In-Home Supports Provider Agencies must:
   
a. Be eighteen (18) years old or older;
   
b. Have a high school diploma or GED; DSP hired prior to January 1, 2013 are exempt from this requirement;
   
c. Maintain current First Aid and CPR certification;
   
d. Be able to:
      
i. Understand and implement the individual’s ISP within the scope of this service; and
   
   ii. Assist and support the individual to make informed choices.

2. Qualifications for Agency Supervisors: Personnel who are directly responsible for the supervision of Customized In-Home Supports staff are required to meet the following requirements:
   
a. The individual must be twenty-one (21) years of age or older;
   
b. Have a high school diploma or G.E.D; and
   
c. Have a minimum of one year experience working with individuals with developmental disabilities or related field; or a degree in a related field may substitute for experience.

D. Training Requirements:

The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy, including the following:

1. Current First Aid and CPR certification;
2. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and

3. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

E. Criminal Background Screening: Customized In-Home Supports Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

F. Employee Abuse Registry: Customized In-Home Supports Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

G. Residence Case File: The Agency must maintain in the individual’s home a copy of the ISP and progress notes.

H. Consumer Records Policy: Customized In-Home Supports Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

I. Customized In-Home Supports Provider Agency Reporting Requirements:

1. Progress Reports: Customized In-Home Supports providers must submit written status reports to the individual’s Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:

   a. Name of individual and date on each page;
   b. Timely completion of relevant activities from ISP Action Plans;
   c. Progress towards desired outcomes in the ISP;
   d. Significant changes in routine or staffing;
   e. Unusual or significant life events, including significant change of health condition;
   f. Data reports as determined by IDT members; and
   g. Signature of the agency staff responsible for preparing the reports.
J. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

   b. The entities or individuals responsible for conducting the discovery/monitoring process;

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:

      a. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

      b. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

   b. Compliance with Caregivers Criminal History Screening requirements;

   c. Compliance with Employee Abuse Registry requirements;
d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. Preparation of the Report: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. REIMBURSEMENT

A. All Provider Agencies must maintain all records necessary to fully disclose the service, quality, and quantity provided to individuals. The Provider Agency records shall be sufficiently detailed to substantiate the individual’s name, date, time, Provider Agency name, nature of services and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.

1. The maximum allowable billable hours cannot exceed the budget allocation in the associated base budget.

II. Billable Units: The billable unit for Customized In-Home Support is based on a fifteen (15) minute unit.

1. Customized In-Home Supports has two separate procedures codes with the equivalent reimbursed amount.

   a. Living independently; and

   b. Living with family and/or natural supports:

      i. The living with family and/or natural supports rate category must be used when the individual is living with paid or unpaid family members.

III. Billable Activities:

1. Direct care provided to an individual in the individual’s residence, consistent with the Scope of Services, any portion of the day.
2. Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual’s residence.

IV. **Non-Billable Activities:**

1. When an individual is hospitalized or in an institutional care setting;

2. Services which are not covered in the Scope of Services; or

3. To individuals receiving any type of Living Supports or Intensive Medical Living Services.
CHAPTER 8
CRISIS SUPPORTS

I. Crisis Supports

Crisis Supports are designed to provide an intensive level of supports by trained staff to an individual experiencing a behavioral or medical crisis either within the individual’s present residence or in an alternate residential setting.

1. SCOPE OF SERVICE

The scope of service for Crisis Supports shall include:

A. Providing trained Crisis Response Staff (CRS) to assist in supporting and stabilizing the individual’s medical or behavioral condition;

B. Providing training and mentoring for staff, family members and other natural supports that normally support the individual, in order to remediate the crisis and minimize or prevent recurrence;

C. Arranging, if necessary, for an alternative residential setting and provision of CRS to support the individual in that residential setting;

D. Delivering crisis support in a way that maintains the individual’s normal routine to the maximum extent possible;

E. Stabilizing and preparing the individual to return to their original residence or to move into a new permanent residence;

F. Consulting with Interdisciplinary Team (IDT) members, Direct Support Personnel (DSP) and other relevant personnel needed to ensure the implementation of the individual’s Positive Behavioral Support Plan (PBSP); and

G. Attendance by Crisis Response Staff at IDT meetings.

2. SERVICE REQUIREMENTS

A. General requirements: Crisis Supports are provided when an individual requires crisis intervention as determined through the Developmental Disabilities Support Division (DDSD) Bureau of Behavioral Support (BBS), in accordance with the DDSD Establishment of Administrative Procedures for Crisis Services.

1. These services require referral and prior written authorization from the BBS;
2. The timeline may exceed ninety (90) calendar days under extraordinary circumstances, with approval from BBS, in which case duration and intensity of the crisis intervention will be assessed weekly by BBS staff.

B. Service Criteria Location:

All Crisis Services will conform to the supports needed by the individual as per their ISP, with accommodations consistent with the IDT members’ consideration of the crisis event and the individual’s status.

1. Crisis Supports in the Individual’s Residence: The Crisis Provider Agency will provide CRS to support the individual in the individual’s residence when feasible and recommended by the BBS. The Crisis Provider Agency will provide or coordinate support services with the individual’s approved Living Supports, Customized In-Home Supports, Community Integrated Employment, and Customized Community Supports Provider Agencies.

2. Crisis Supports in an Alternate Residential Setting: The Crisis Provider Agency will provide or coordinate an alternate residential setting, if necessary. In the event an individual needs to receive crisis supports in a setting away from his or her original residence, the Crisis Provider Agency will arrange to have such a setting available. This may be an apartment, a motel or a bedroom at a different residence.

   a. The Crisis Provider Agency’s plan for an alternate residential setting will be submitted to DDSD within thirty (30) calendar days of the approval of the Provider Agency’s Agreement to provide this service. The plan will include primary and secondary arrangements for providing an alternate residential setting. Additionally, if a change in residence is required beyond a primary and secondary arrangement to assure the health and safety of the individual or others, the Crisis Provider Agency shall assist the individual, his or her team, and the BBS to secure an alternate residential placement for the individual.

C. General Events Reporting: The Crisis Supports Provider Agency must enter General Events Reporting into Therap as specified in the New Mexico DDSD General Events Report (GER) Guide.

D. Consumer Records Policy: Crisis Supports Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

3. AGENCY REQUIREMENTS

The Crisis Supports Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

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A. **On-Call Coverage:** The Crisis Provider Agency will establish an “on call” system and ensure that sufficient staff is available to respond to relevant crisis events on a twenty-four hour/seven days a week basis. Initial on-call response to BBS should occur within 30 minutes. The Crisis Provider Agency is required to designate sufficient staff to be available in the event of a crisis.

B. **IDT Coordination:** The Crisis Provider Agency shall work with the individual’s IDT members, respective DDSD Regional Office and Regional BBS staff to affect a timely transition of services to the contracted Crisis Provider Agency. In accordance with DOH policies and regulations, any permanent change in residence due to a crisis will occur as a consequence of an ISP modification reviewed and approved by the members of the IDT and the guardian, and will be based upon the long term interests of the individual. As outlined in 7.26.5 NMAC regulating the individualized services planning process, any member of the IDT (including the Crisis Supports provider) may request an IDT meeting.

C. **Required Orientation:** The Crisis Provider Agency’s upper and middle management, including the Chief Executive Officer(s), agency directors, service coordinators and DSP supervisors, will attend orientation to the crisis response system and the DDW Crisis Supports service. Orientation will be conducted by DDSD/ BBS staff and will address the following:

1. Elements of crisis response;
2. DDSD policy regarding Behavior Support Service Provisions; and
3. Review and monitoring process for this crisis service.

D. **Staffing Requirements:**

1. Staff-to-client ratio for this service is, at a minimum, one-to-one (1:1).

2. The Crisis Provider Agency is responsible for the management and staffing of the crisis, unless an alternative agreement has been reached between the Crisis Provider Agency and the BBS Chief or designee. The BBS Clinical Director, BBS Consultant and/or designated BBS staff will be available for consultation and technical assistance on a case-by-case basis.

3. All DSP designated by the provider agency to be CRS shall have already completed the required DDSD training in accordance with the DDSD Policy T-003: Training requirements for Direct Service Agency Staff Policy.

   a. The Crisis Services Provider agency shall report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy.
b. In addition, designated CRS shall receive the following training no later than ninety (90) calendar days after approval of the provider agreement, or if designated after the initial ninety (90) days of the initial provider agreement to provide Crisis Supports, any newly designated staff will receive the training within ninety (90) calendar days of designation to the Crisis Response position:

   i. Crisis Response Training (eight (8) hours);

   ii. Clinical Training (four (4) hours);

   iii. Settings/Consideration Grid (four (4) hours);

   iv. Positive Behavioral Supports for Crisis (four (4) hours); and


4. Designated DSP that have not completed this training may not work alone as the designated CRS for any individual, but may support the individual during the same time period with a designated CRS if the support is deemed necessary by the BBS, in conjunction with the IDT.

5. Crisis Supports Provider agencies will assure required staff has a current and clear caregivers criminal history screening.

E. Criminal Background Screening: Crisis Supports Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

F. Employee Abuse Registry: Crisis Supports Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

G. Provision of Nursing Services:

1. Crisis Supports are usually delivered in conjunction with either Supported Living or Family Living. They may also be provided for individuals receiving Customized In-Home Supports or Intensive Medical Living Services.

   a. For individuals in a service with nursing bundled in, nursing supports during the crisis shall be delivered by the Crisis Alternative Placement, Supported Living or Intensive Medical Living Provider; and

   b. Individuals other than those who are receiving Supported Living or Intensive Medical Living may access Adult Nursing Services separately as needed with relevant prior authorization.
H. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI Plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI Plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI Plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or process related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP and the individual’s vision, meaningful day and desired outcomes, with specific notation regarding delays or deletions of current ISP outcomes due to crisis considerations;

b. Effectiveness of implementation of crisis supports, including achievement of desired outcomes and the disruption of achieving desired outcomes;

c. Analysis of General Events Reports data;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;
f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. **REIMBURSEMENT**

   A. All Crisis Services Provider agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Crisis Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

   B. **Billable Unit:**

   1. The billable unit for Crisis Supports in an Alternative Residential Setting is a daily unit.

   2. The billable unit for Crisis Supports in an Individual’s Residence is a fifteen (15) minute unit. Regardless of the number of CRS involved simultaneously for a particular fifteen (15) minute period of time, only one unit may be billed.

   3. It may include crisis support during attendance at Community Integrated Employment and Customized Community Supports services, which may be billed on the same dates and times of service as Crisis Supports.

   C. **Billable Activities:**

   1. All CRS activities that are:

      a. Provided face to face with the individual;

      b. Included in the individual’s approved ISP;
c. Provided in accordance with the Scope of Services; and

d. Not included in non-billable services, activities or situations.

D. Non-Billable Services, Activities or Situations:

1. Services furnished to an individual who:
   
a. Does not reside in New Mexico;
   
b. Is not eligible for the DDW; or
   
c. Is hospitalized or in an institutional care setting.

2. Services not included in the:
   
a. Scope of Services; or
   
b. Individual’s approved ISP.

3. Time spent on the following activities:
   
a. Traveling to or from any service site, except when transporting the individual in accordance with the Scope of Services;
   
b. Employer activities including time spent in employer staff meetings, meetings with supervisors that are not client specific, attending to employer/contractor administrative duties including billing;
   
c. Writing or updating reports, progress notes or logs;
   
d. DSP supports on behalf of the individual that are not delivered face to face with the individual;
   
e. Participation in personnel development; and
   
f. Individual specific training unless delivered during provision of Crisis Supports with the individual present.

4. For Crisis Supports in an Alternative Residential Setting:
   
a. Room and Board; including building maintenance, upkeep and improvement.
   
b. Respite or Nutritional Counseling as separate services; and
   
c. Transporting the individual.
CHAPTER 9
ENVIRONMENTAL MODIFICATION SERVICE

I. Environmental Modification Service

Environmental Modifications are physical adaptations identified in the individuals ISP, which provide direct medical or remedial benefits to the individual’s physical environment. All environmental modifications must address the individual’s disability and enable the individual to function with greater health, safety or independence in their residence. All services shall be provided in accordance with applicable federal, state, and local building codes.

1. SCOPE OF SERVICE

A. Environmental Modifications address targeted medical, safety or functional concerns that incorporate the individual’s specific clinical and functional strengths and needs. Examples include the following modifications of the individual’s physical environment and the accompanying purchases as well as the necessary installation services:

1. Ramps;
2. Lifts/elevators;
3. Porch or stair lifts;
4. Hydraulic, manual or other electronic lifts/elevators, that are incorporated into the building structure;
5. Roll-in showers;
6. Sink modification;
7. Bathtub modifications;
8. Toilet modifications;
9. Water faucet controls;
10. Floor urinal and bidet adaptations;
11. Turnaround space adaptations;
12. Widening of doorways/hallways;
13. Specialized accessibility/safety adaptations/additions;
14. Installation of specialized electronic and plumbing systems to accommodate medical equipment and supplies;

15. Handrails, grab-bars, door handle adaptations, trapeze and mobility track systems for home ceilings;

16. Automatic door opener/doorbells;

17. Environmental controls incorporated into the house infrastructure:
   a. voice, light, and /or motion-activated and electronic devices;
   b. modified switches, outlets or other structural controls for home devices; and
   c. Alarm, alert or signaling systems which do not duplicate such systems included with personal support technology obtained under that separate service.

18. Fire safety adaptations;

19. Medically necessary air filtering devices;

20. Medically necessary heating/cooling adaptations; or

21. Glass substitutes for windows and doors or other structural safety modifications.

2. SERVICE REQUIREMENTS

A. Referral and Assessment: Environmental Modifications services are available to any individual of any age and shall be coordinated with the individual, guardian, case managers, service providers, licensed contractors, members of the Interdisciplinary Team (IDT) and Developmental Disabilities Support Division (DDSD). All environmental modification projects may include repairs or modification to existing equipment. All services shall be provided in accordance with applicable state and local building codes.

B. Procedure for Obtaining Environmental Modification services: The following procedure must be undertaken by the IDT, Case Manager, and Occupational Therapist (OT) or Physical Therapist (PT) in order to obtain environmental modifications for an individual on the Developmental Disabilities Waiver (DDW):

1. The individual or any member of the individual’s IDT may request an assessment for environmental modifications through the Case Manager if it is determined that environmental modifications may be needed to enhance the individual’s health, safety or functionality.

2. Upon notification by the Case Manager, an OT shall complete the assessment. For children the OT must be obtained through their state plan benefits; adults may
include OT units in their DDW budget for this purpose. The assessment should outline the targeted medical, safety, or functional concerns and include detailed recommendations for environmental modifications that incorporate the individual’s specific clinical and functional needs. For example, when grab bars are recommended the evaluator shall mark the specific location of installation that will meet the individual’s needs. If an OT is not available, the services of a PT or other qualified individual approved by the DDSD Regional Office may be substituted.

3. The OT or PT or other qualified individual shall submit the assessment report to the Case Manager. The Case Manager and therapist or other qualified individual are required to consider less costly alternative methods, including Assistive Technology and other funding sources that may be available to address the individual’s needs. For example: Various adaptive bathing equipment may mitigate the need for some environmental modifications for safe bathing or bathing transfer options.

4. The Case Manager shall submit the individual’s contact information, the assessment report and the Freedom of Choice form to the Environmental Modification Service Provider (EMSP).

5. The EMSP must coordinate with the Therapist and/or qualified individual who provided the assessment to acknowledge, document and assure planned modifications will meet the individual’s clinical and functional needs. Coordination should occur at an in-person on-site evaluation. Only if in-person on-site coordination cannot occur or if this is not needed because the planned modification is very minor, then coordination may occur via e-mail or phone given RO approval. Both the evaluator and the EMSP should document what was agreed upon regarding the Environmental Modification Plan during this meeting or through alternate communication.

C. The EMSP procedures:

1. Develop an Environmental Modification Plan;

2. Ensure that proper design criteria is addressed in planning and design of the adaptation;

3. Provide or secure licensed contractor(s) or vendor(s) to provide construction and/or remodeling services. Ensure that proper design criteria is addressed in planning and design of the adaptation;

4. Provide administrative and technical oversight of construction projects;

5. Provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the individual’s residence; and

6. Inspect the final environmental modification project to ensure that the adaptation(s) meet the approved plan submitted for environmental adaptation.
D. Service Limitations:

1. Environmental modification improvements or repairs to the existing home, which do not provide direct medical, safety, or functional benefit to the individual or that should be included as part of routine home maintenance, shall not be approved. Such non-covered adaptations, modifications or improvements include:

   a. Carpeting is excluded with the exception of repairs to carpet needed due to permitted modification. For example, repair to carpet in the area of a door widening;

   b. Roof Repair;

   c. Furnace Replacement;

   d. Remodeling Bare Rooms;

   e. Other General Household Repairs;

   f. Vehicle modifications; and

   g. Outdoor Fences.

2. No duplicate environmental modifications shall be approved. For example, if the individual has a safe and usable ramp, a replacement ramp shall not be approved.

3. New Construction: Environmental modifications cannot be used to fund new residential construction, even if the new dwelling is designed to accommodate the needs of individuals with disabilities.

4. Equipment covered under the State of New Mexico’s Medicaid program shall not be purchased under the DDW.

3. AGENCY REQUIREMENTS

A. Environmental Modification Request: The Environmental Modification Service Provider must submit the itemized bid to the Case Manager. The Case Manager submits the request and itemized bid to the DDSD Regional Office for approval including the Secondary Freedom Of Choice (SFOC). The request must include:

1. The DDSD Regional Office Prior Approval Form completed with all required information regarding the individual receiving the service, including:

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1. The secondary freedom of choice;

2. Current Individual Service Plan (ISP) indicating modifications being requested; the modifications must be addressed in the Health and Safety Section of the ISP;

3. IDT Meeting Minutes with signature page indicating team agreement;

4. An itemized quote including detailed cost of material and labor of the total estimated and authorized amount that outlines detailed costs associated with the environmental modification;

5. A copy of the therapist’s assessment report; and

6. The home owner’s signed and dated written approval of the scope and project cost (including cost incurred by the home owner) obtained by the Case Manager (subsequent materially significant project changes must be approved in writing).

2. The Environmental Modification Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

B. Cost of Materials: Materials utilized in projects shall be of Medium Grade and meet industry construction standards while taking into account the personal preferences of the homeowner. DDW funds may not be used for upgrades in materials that do not offer functional benefits to the individual. Purchase receipts for all materials must be kept in ESMP’s file and must be furnished to Case Manager and/or Regional Office Lead upon request.

C. Use of Other Private Funding to Augment Environmental Modifications: Other non-DDW funding may be utilized to augment funding available under the DDW subject to the following restrictions:

1. Cost estimates, items and project plans are required to specifically identify the materials to be purchased and the labor costs associated with the expenditure of DDW versus non-DDW funds;

2. DDW funds may not be utilized to upgrade fixtures or other construction materials solely on the basis of aesthetic qualities or personal preferences when compared to lower cost fixtures or materials that provide the same or similar functional benefit to the individual. ESMP’s may not provide any materials/services to home owner that are not in the original bid which was approved by DDSD;

3. DDW funds cannot be used to repair environmental modification upgrades or other augmentations to environmental modifications when the original environmental modification was not covered by DDW funds;
4. Any augmentation or upgrade to the DDW funded portion of the environmental modification may void any warranties in place; and

5. When one or more individual(s) in DDW services who are roommates will benefit from an environmental modification, each impacted roommate shall equally divide the cost of the environmental modification from their respective ISP budget.

D. **General Requirements:** Providers of environmental modification services must perform the following:

1. Ensure proper design criteria is addressed in planning and design of the modification;

2. Coordinate environmental modification pre-plan reviews with the individual, guardian, or other family members, case managers, service providers as applicable and the therapist who conducted the assessment report;

3. Interpret codes and clarify building procedures to the individual, guardian, homeowner or other family members, Case Manager, service providers, and DDSD prior to construction activities;

4. When requested, provide consultation to individual, guardian, homeowner or other family members, Case Managers, service providers, subcontractors and DDSD concerning environmental modification projects to the individual’s residence prior to or during construction activities;

5. Review plans submitted by sub-contractors, if applicable, for environmental modifications to ensure that the plans are architecturally sound, address functional needs outlined in the Environmental Modification Evaluation, and are in compliance with state and local building codes and standards;

6. Environmental Modifications to provider owned or leased homes must be compliant with the DDW Standards and should meet Americans with Disabilities Act (ADA) applicable guidelines when ADA guidelines will also meet the individual’s functional needs; and are in compliance with state and local building codes and standards;

7. Review accuracy of construction costs submitted by sub-contractors, if applicable;

8. Ensure inspection of the final environmental modifications to ensure compliance with all local, state and federal codes and requirements;

9. Meet reasonable time-lines for completion of environmental modifications;

   a. EMSP must contact individual/guardian/homeowner within one business week of being notified of job award to schedule the initial site visit;
b. EMSP must provide itemized price quote to case manager within 10 business days after first visit with homeowner/individual/guardian; and

c. EMSP must complete all modifications within four weeks. A waiver of this time-line from the RO must be sought if extraordinary circumstances prevent the EMSP from meeting this requirement.

10. EMSP must meet in person at DDSD with Regional DDSD representative where the provider headquarters are located at signing of initial contract and at renewal of each new contract period, in order for training and updates to occur for EMSP by DDSD; and

11. Provide a minimum one-year written warranty of the work completed, including both materials and labor, to individual, guardian, homeowner or other family members, Case Manager and DDSD Regional Office.

E. Environmental Modification Service Providers Qualifications: Environmental Modification Service Providers (EMSP) must demonstrate qualifications in the following areas:

1. Documentation must verify that the provider and any subcontractors utilized are bonded and Licensed Building Contractor(s) authorized to complete the project by the State of New Mexico.

2. When a building permit is required for the environmental modification to meet local and state codes, the work must be performed by a licensed and bonded contractor.

3. EMSP shall obtain all necessary permits as required by local and state laws.

4. Demonstrable knowledge and work history showing the ability:

   a. To interpret the principles and practices of architecture, building codes and standards, building materials and construction methods, structural, mechanical, plumbing and electrical systems;

   b. To interpret and prepare architectural working drawings and specifications, mediate contractual problems and ensure compliance with all laws, rules and standards of the State of New Mexico, including the federal, state and local building codes;

   c. To understand and implement contracting practices and procedures, construction cost estimating and knowledge of comparable costs to accomplish the adaptations;

   d. To incorporate architectural design, standards and technical data relating to building design and construction; and
e. To interpret, implement and ensure that Federal ADA standards and applicable
guidelines are followed in all environmental adaptations when applicable to the
individual’s needs.

4. REIMBURSEMENT

A. All Environmental Modification Service Providers must maintain all records necessary to
fully disclose the service, quality, quantity and clinical necessity of modifications
furnished to individuals who are currently receiving DDW services. The EMSP records
must be sufficiently detailed to substantiate the date, time, and individual name, servicing
EMSP, nature of services and length of time of the service billed. Providers are required
to comply with the Human Services Department Billing Regulations.

1. The documentation of the billable time spent on the job shall be kept on a written or
electronic record that is prepared prior to a request for reimbursement from the
Human Services Department (HSD). For each unit billed, the record shall contain the
following:

a. Start and end date of each service or other billable service interval;

b. EMSP must provide written notice (email or fax) of completion of work to
DDSD in order for DDSD to approve, in writing, final payment for job. Billing
without final approval from DDSD may result in recoupment; and

c. The signature or authenticated name of individual providing the service.

2. Withholding or denial of payment may occur if the individual in service or their
guardian file a dispute to the respective DDSD Regional Office regarding the quality
of work and the DDSD Regional Office agrees with the complaint.

A. Billable Unit:

1. The billable unit for environmental modification is a set dollar amount specified in
the current Medicaid Supplement Rate Tables for the Developmental Disabilities
Home and Community Based Services Waiver and is available every five years not to
exceed $5,000.00.

B. Billable Activities:

1. Permitted uses detailed in the Scope of Service.

2. Administrative costs of the EMSP not to exceed fifteen percent (15%) of the total
cost of the environmental modification project managed by the Provider Agency.

3. Partial payment of up to fifty percent (50%) of the estimated project costs may be
requested of the DDSD Regional Office Lead prior to the completion of the project

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based on a request submitted by the EMSP; to the Regional Office Lead. This request must be approved in writing by the DDSD Regional Office Lead.
CHAPTER 10
INDEPENDENT LIVING TRANSITION SERVICE

I. Independent Living Transition Service

Independent Living Transition Service is a one-time expense for individuals who transition from a 24 hour living supports setting into a home or apartment of their own with intermittent support that allows the individual to live more independently in the community.

1. SCOPE OF SERVICE

   A. Independent Living Transition Service includes but is not limited to:

      1. Expenses associated with security and/or rental deposits that are required to obtain a lease on an apartment or home;
      2. Set up fees or deposits for utilities (telephone, electricity, heating etc.);
      3. Furnishings and household goods to establish safe and healthy living arrangements (bed, chair, dining table and chairs, bed linens and bath towels, eating utensils, food preparation items and a telephone); and
      4. Initial or one time fees associated with the cost of paying for pest control, allergen control or cleaning fee prior to occupancy.

2. SERVICE REQUIREMENTS

   A. Written justification must address the need for Independent Living Transition Service to fulfill supports in the Individual Service Plan (ISP) and identify the associated ISP outcomes. Developmental Disabilities Waiver (DDW) funds are the payer of last resort; the team is required to identify all other sources of funds prior to accessing this service.

   B. Exclusions and Restrictions:

      1. Funds may not be utilized to pay for food, clothing or rental/mortgage costs excluding deposits as specified above.

3. AGENCY REQUIREMENTS

   A. Provider Agency Records:

      1. Independent Living Transition Providers will maintain documentation in the form of a log to include:

         a. Individual’s name on all pages of all documents;

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b. Dates of expenditures including signature of author on all documents;

c. Expenditure amount based on the following funding categories:
   i. Security and/or Rental deposit;
   ii. Utility deposit;
   iii. Household goods (specify items);
   iv. Furniture (specify items);
   v. Pest control, allergen control; and
   vi. Cleaning fee prior to occupancy.

d. Receipts for the above must be maintained.

B. Reporting Requirements: Upon request, the Independent Living Transition Provider will submit a copy of the Independent Living Transition log to the case manager.

C. IDT Coordination: Independent Living Transition Providers are not required to attend Interdisciplinary Team (IDT) meetings. However, the Independent Living Transition Provider will provide documentation or information to the IDT to support the planning process. This information may be provided in person or through the case manager.

D. Independent Living Transition Service Provider’s must develop and implement policies and procedures that comply with these standards.

4. REIMBURSEMENT

A. All Provider Agencies must maintain all records necessary to fully disclose the service, quality and quantity of transition supports furnished to individuals who are currently receiving services. Providers are required to comply with the Human Services Department Billing Requirements.

B. Billable Unit: Independent Living Transition Service is billable at a one (1) dollar per unit amount with a maximum cost of $1,500.

C. Billable Activities:

1. The Administrative cost of the Independent Living Transition Provider will not exceed fifteen percent (15%) of the total cost of dollars expended. The Administrative cost must be included within the one-time maximum cost of $1,500.
CHAPTER 11

LIVING SUPPORTS—FAMILY LIVING

I. Living Supports – Family Living

Living Supports are residential habilitation services that are individually tailored to assist DDW recipients 18 years or older who are assessed to need daily support and/or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living Supports include residential instruction that is intended to increase and promote independence and to support individuals to live as independently as possible in the community in a setting of their own choice.

Living Support services assist and encourage individuals to grow and develop, to gain autonomy, become self-governing and pursue their own interests and goals. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each person who receives services.

Services promote inclusion in the community and individuals are provided the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living Supports will assist individuals to access generic and natural supports, and with opportunities to establish or maintain meaningful relationships throughout the community.

Living Support providers are responsible for providing an appropriate level of services and supports up to twenty four (24) hours per day, seven (7) days per week. Living Supports will be provided in accordance with all applicable regulations, policies and procedures.

Living Supports- Family Living: Family Living services are intended for individuals who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living services are intended to increase and promote independence and to provide the skills necessary to prepare individuals to live on their own in a non-residential setting, and is designed to address assessed needs and identified individual outcomes. Family Living services provide direct support and assistance to no more than two individuals in a home. Services and supports are furnished by a natural or host family member, or companion, who meets the requirements and is approved to provide Family Living Services in the individual’s home or the home of the Family Living direct support provider. The individual lives with the paid direct support provider. The provider agency is responsible for substitute coverage for the primary caregiver when the primary care giver is sick or taking time off as needed. Individuals receiving Family Living services are required to live in the same residence as the paid Direct Support Personnel (DSP).

Home Studies: Family Living Services Provider Agency must complete all Developmental Disabilities Support Division (DDSD) requirements for approval of each direct support provider.
including completion of an approved home study and training of the direct support provider prior to placement. After the initial home study, an updated home study must be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies must be approved by DDSD.

Living Supports-Family Living Services: Family Living can be provided to no more than two individuals receiving state funded services. An exception may be granted by DDSD for up to three (3) individuals.

1. SCOPE OF SERVICES

A. Living Supports-Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Individual Service Plan (ISP):

1. Residential training, teaching and assistance, with activities of daily and home living that assist the individual to live as independently as possible in the most integrated setting;

2. Skill development for shopping, social engagement, household maintenance, personal hygiene and money management;

3. Training, support and assistance for community integration, including implementation of preferential meaningful activities;

4. Training, support and assistance for community integration, including access and participation in preferred activities;

5. Training and assistance in developing and maintaining social, spiritual, cultural and individual relationships, to include the development of generic and natural supports of choosing;

6. Assistance to access training and educational opportunities on self-advocacy and sexuality;

7. Ensuring ready access to and assistance with use of each individual’s adaptive equipment, augmentative communication and assistive technology devices, including support related to maintenance of such equipment and devices to ensure they are in working order;

8. Providing or arranging transportation to and from Customized Community Supports, Community Integrated Employment, leisure and recreation activities, medical, dental, and therapy appointments etc.;
9. Implementing and monitoring the effectiveness of the ISP to achieve desired outcomes;

10. Coordination and collaboration with therapists and therapy assistants to receive training and implement Written Direct Support Instructions (WDSI) in accordance with the participatory approach;

11. Coordination and collaboration with behavior support consultants to receive training and implement positive behavior support plans in accordance with the Behavioral Support Consultation (BSC) Standards;

12. Assisting the individual as needed to obtain medical, dental, therapy, nutritional, nursing and Behavioral Support Consultation and behavioral health services;

13. Provision of nutritional counseling, if recommended by the IDT and clinically indicated;

14. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’S Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate;

15. Ensuring nurse response to unanticipated medical events requiring intervention or coordination for individuals in Family Living receiving Adult Nursing Services;

16. Monitoring, implementing and documenting progress of therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans, if applicable; and

17. Implement, track progress and document outcomes of healthcare orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans, if applicable.

2. SERVICE REQUIREMENTS

A. IDT assessment for Living Supports Services: Living Supports- Family Living is a residential habilitation service intended for individuals assigned to NM DDW Groups C through G and for whom Living Supports are the best service alternative at the time. Family Living is intended to increase and promote independence and to support the individual to live as independently as possible in the community in a setting of their own choice.
**B. Provision of Services:** Living Supports- Family Living Services must be available up to twenty-four (24) hours per day, three hundred sixty five (365) days a year, but does not include the time when an individual is employed, at school, visiting their family or participating in Customized Community Supports or Community Integrated Employment. Examples of when twenty-four (24) hour care must be provided include:

1. During illness, accidents and recovery;
2. In the event of emergencies;
3. If an individual works non-traditional hours; and
4. On weekends and holidays.

**C. Individual Age Requirements:** To receive Living Supports- Family Living, the individual must be eighteen (18) years of age or older. In extraordinary circumstances, case by case exceptions to the age restriction for Living Supports may be approved annually by the DDSD Director. Under no circumstances will parents or other legally responsible relatives be approved to provide Family Living Services to a child under age 18.

**D. Supervision:** The Living Supports- Family Living Provider Agency must provide and document:

1. Monthly face to face consultation in the Family Living home, by agency supervisors or internal service coordinators, with the DSP and individual receiving service on at least a monthly basis to include:
   a. Review implementation of the individual’s ISP Action Plans and associated support plans, including, HCP, MERPs, Positive Behavior Support Plan (PBSP), Written Direct Support Instructions (WDSI) from therapist(s) serving the individual, schedule of activities and appointments; and advise direct support personnel regarding expectations and next steps including need for individual specific training or retraining from therapists and Behavior Support Consultants (BSC); and
   b. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator or other IDT members.

**F. Individual Rights:** When planning Living Supports- Family Living, the IDT members must recognize the individual’s rights including, but not limited to:

1. Informing individuals of their rights;
2. Support to learn and exercise their rights;
3. Home ownership;

4. Individuals right to have a lease or other legally enforceable agreement;

5. Having utilities and/or phone in their own names;

6. Individual needs and preferences regarding housemates;

7. Individual’s right to choose how to decorate their room and residence based on their own personal preferences;

8. Individual’s right to have his or her own bed and consent to share a bedroom;

9. Owning personal property;

10. Pursuing adult relationships;

11. Privacy;

12. Individual’s free use of all common space in the residence with regard for privacy, personal possessions and individual interests;

13. General control over when, if, and to where he or she moves, unless precluded by a situation which presents an immediate risk to the individual or others in the home;

14. The individual retains the right to assume risk; this dignity of risk must be balanced with the individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety;

15. Individuals have access to food at any time. There must be a Human Rights Committee review when food has a potential to be a danger to the individuals; and

16. Individuals can have visitors in their home at any time they choose.

G. Financial Responsibilities of the Individual:

1. An individual receiving Family Living will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.

2. Costs for room and board are the responsibility of the individual receiving the service.
H. Health Care Requirements for Family Living:

1. All Family Living Providers are required to be an Adult Nursing Provider for those that receive Family Living Services from their agency. Please refer to Adult Nursing chapter for requirements.

2. Individuals are supported to receive coordinated health care services based on each individual’s specific health needs, conditions and desires. Health care services are accessed through the individual’s Medicaid State Plan benefits through Fee for Service or Managed Care and through Medicare and/or private insurance for individuals who have these additional types of insurance coverage.

I. Transportation: Family Living provider agencies must have written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD Policy and Procedures.

J. Enter General Events Reporting: Family Living provider agencies must enter General Events Reporting into Therap as specified in the New Mexico DDSD General Events Report (GER) Guide.

K. Consumer Records Policy: Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

3. SERVICE LIMITATIONS: Family Living Services cannot be provided in conjunction with any other Living Supports Service, Customized In-Home Supports, or Nutritional Counseling.

4. AGENCY REQUIREMENTS

A. IDT Coordination:

1. Appropriate staff from the Living Supports Provider Agency will participate on each individual’s IDT, as specified in the ISP regulations [NMAC 7.26.5]. The Family Living Provider will ensure that at least one staff who works directly with the individual is available to attend IDT meetings, and that further staff input is collected for IDT consideration. This may be as part of the semi-annual reports, or as a separate document. For individuals receiving DDW Adult Nursing Services with high e-CHAT acuity, the nurse must also attend the annual IDT meeting and any other IDT meeting where health issues are on the agenda in person or by phone.

2. It is the responsibility of the IDT to ensure at least thirty (30) hours per week of participation in activities of their choice outside the residence, unless prior
authorization has been obtained from DDSD to occur in the home, as per the DDSD Customized Community Supports Individual In-Home Services Policy and Procedure. These activities are not limited to paid supports and may include activities appropriate to the individual that are not the responsibility of the Family Living Provider.

3. When an individual changes providers, or waiver programs, it is the responsibility of both the existing and new provider to work together to ensure that safe and appropriate planning takes place.

4. It is the responsibility of the IDT to ensure the individuals have access to augmentative communication and assistive technology which aid the individual to participate in meaningful activities.

5. Appropriate staff will be available to the individual and the IDT as a qualified primary respondent or an ancillary respondent for scheduled Supports Intensity Scale® assessments and provide information to accurately reflect the person’s needs for supports.

6. Monitor that DSP’s implement and document progress of the assistive technology inventory, physician and nurse practitioner orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans.

B. Living Supports- Family Living Services Provider Agency Staff Requirements:

1. Staff Qualifications and Competencies: Individuals working as DSP and supervisors for Family Living Provider Agencies meet the following requirements and have the ability to instruct and assist individuals to carry out the scope of services:

   a. Be eighteen (18) years or older;
   
   b. Have a high school diploma or GED. DSP hired prior to January 1, 2013 are exempt from this requirement as are immediate family members;
   
   c. Ability to maintain accurate records;
   
   d. Ability to maintain standards of confidentiality and ethical practice;
   
   e. Ability to effectively employ communication skills to build rapport and channels of communication by recognizing and adapting to the range of individual communication styles;
2. **Qualification for Agency Supervisors:** Personnel who are directly responsible for the supervision of Family Living DSP’s are required to meet the following requirements:

   a. Be twenty-one years of age or older;
   
   b. Have a high school diploma or G.E.D; and
   
   c. Have a minimum of one-year experience working with individuals with developmental disabilities or related field or a degree in a related field may substitute for experience.

3. **Training:** Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state.

   a. All Family Living Provider agencies must ensure staff and supervisor training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

   b. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies, and information about the individual’s preferences with regard to privacy, communication style, and routines.

   c. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation from existing DSP and when new DSP are assigned to work with an individual, or when an existing DSP requires a refresher they need to receive training. The individual should be present for and involved in individual specific training whenever possible.
d. DSP must be available to participate in therapy/BSC appointments with the individual on a regular basis as requested.

4. **Criminal Background Screening:** Family Living Provider agencies will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required employees/subcontractors.

5. **Employee Abuse Registry:** Living Supports-Family Living Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

6. **Staffing Restrictions:**

   a. Any individual who operates or is an employee of a boarding home, residential care home, nursing home, group home or other similar facility in which the individual resides must not serve as guardian for that individual, except when related by affinity or consanguinity [§ 45-5-31(1) A NMSA (1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

   b. The spouse of the individual may not provide Family Living Services to that individual.

C. **Residence Case File:** The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.

D. **Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

E. **Living Supports- Family Living Service Provider Agency Reporting Requirements:**

1. **Semi-Annual Reports:** Family Living Provider must submit written status reports to the individual’s Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:

   a. Name of individual and date on each page;

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b. Timely completion of relevant activities from ISP Action Plans;

c. Progress towards desired outcomes in the ISP; since the last report;

d. Significant changes in routine or staffing;

e. Unusual or significant life events, including significant change of health condition;

f. Data reports as determined by IDT members; and

g. Signature of the agency staff responsible for preparing the reports.

2. Document for each individual that:

   i. The individual has a Primary Care Provider (PCP);

   ii. The individual receives an annual physical examination and other examinations as specified by a PCP;

   iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

   iv. The individual receives a hearing test as specified by a licensed audiologist; and

   v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist.

F. Agency Accounting for Individual Funds: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies must maintain and enforce written policies and procedures regarding the use of the individual’s SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.

1. The Family Living Provider Agency must produce an individual accounting of any personal funds managed or used by Family Living Provider Agency on a monthly basis.

2. A copy of this documentation must be provided to the individual and/or his or her guardian upon request.
3. When room and board costs are paid from the individual’s SSI payment to the Family Living Provider, the amount charged for room and board, must allow the individuals to retain twenty percent (20%) of their SSI payment each month for personal use. A written agreement must be in place between the individual and the provider agency that addresses room and board and allows the individual an amount of discretionary spending money that is both required and reasonable.

G. Residence Requirements for Living Supports - Family Living Services:

1. Family Living Services providers must assure that each individual’s residence is maintained to be clean, safe and comfortable and accommodates the individuals’ daily living, social and leisure activities. In addition the residence must:

   a. Maintain basic utilities, i.e., gas, power, water and telephone;

   b. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;

   c. Have a general-purpose first aid kit;

   d. The individual has the right to select their roommate(s);

   e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;

   f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year;

   g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual’s ISP;

   h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; and

   i. Provide lockable doors with individuals and appropriate staff having keys as needed.
H. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance;

   b. The entities or individuals responsible for conducting the discovery/monitoring process;

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:

      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

      ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

   b. Compliance with Caregivers Criminal History Screening requirements;

   c. Compliance with Employee Abuse Registry requirements;

   d. Compliance with DDSD training requirements;
e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

4. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

5. **REIMBURSEMENT**

A. Family Living Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Family Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

1. From the payments received for Family Living services, the Family Living Agency must:

   a. Provide a minimum payment to the contracted primary caregiver of $2,051 per month; and

   b. Provide or arrange up to seven hundred fifty (750) hours of substitute care as sick leave or relief for the primary caregiver. Under no circumstances can the Family Living Provider agency limit how these hours will be used over the course of the ISP year. It is not allowed to limit the number of substitute care hours used in a given time period, other than an ISP year.

B. **Billable Units:**

1. The billable unit for Family Living is based on a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service, are provided then
one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period.

2. The maximum allowable billable units cannot exceed three hundred forty (340) days per ISP year or one hundred seventy (170) days per six (6) months.

C. **Billable Activities:** Any activities which DSP provides in accordance with the Scope of Services for Living Supports which are not listed in non-billable services, activities or situations below.

D. **Non-Billable Services, Activities or Situations:**

1. Services furnished to an individual who is:

   a. Not residing in New Mexico;

   b. Not eligible for DDW services; or

   c. Hospitalized or in an institutional care setting.

2. Payment for Family Living must not be made for the cost of room and board including the cost of building maintenance, upkeep and improvement.

3. Time spent on the following activities:

   a. Client assessments;

   b. Writing or updating reports, progress notes and logs;

   c. Employer activities including administrative duties, routine paperwork including billing documentation; employer staff meetings or meetings with supervisors that are not client specific;

   d. Personnel development; and

   e. Client specific training to DSP unless delivered during provision of Family Living and with the individual present.
CHAPTER 12

LIVING SUPPORTS—SUPPORTED LIVING

I. Living Supports – Supported Living

Living Supports are residential habilitation services that are individually tailored to assist participants eighteen (18) years or older who are assessed to need daily support and/or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living Supports include health related supports from non-related direct support personnel and residential instruction that is intended to increase and promote independence and to support individuals to live as independently as possible in the community in a setting of their own choice.

Living Support services assist and encourage individuals to grow and develop, to gain autonomy, become self-governing, and pursue their own interests and goals. Living Support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each person who receives services.

Services promote inclusion in the community and individuals are provided the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living Supports will assist individuals to access generic and natural supports, and the opportunities to establish or maintain meaningful relationships throughout the community.

Living Supports providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week.

Living Supports will be provided in accordance with all applicable regulations and policies and procedures.

Living Supports—Supported Living: Supported Living is intended for individuals who are assessed to need residential habilitation in order to ensure their health and safety. It is intended to increase and promote independence, and to provide the skills necessary to prepare individuals to live on their own in a non-residential setting. Supported Living services are designed to address assessed needs and identified individual outcomes. The service is provided to two (2) to four (4) individuals in a home that is leased or owned by the individual.

Supported Living Services cannot be provided in conjunction with any other Living Supports, Respite, Adult Nursing Services (unless provided during participation in Customized Community Supports and or Community Integrated Employment), or Nutritional Counseling.

1. SCOPE OF SERVICES
A. Living Supports- Supported Living: The scope of Supported Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):

1. Residential instruction, with activities of daily and home living that assist the individual to live in the most integrated setting appropriate to need.

2. Adaptive skill development, shopping, social skill development and money management;

3. Training and assistance for community integration, including implementation of preferential meaningful activities;

4. Training and assistance in developing and maintaining social, spiritual, cultural and individual relationships, to include the development of generic and natural supports of the individual’s choosing;

5. Assistance to access training and educational opportunities on self-advocacy and sexuality;

6. Ensuring ready access to and assistance with use of each individual’s adaptive equipment, augmentative communication, and assistive technology devices, including support related to maintenance of such equipment and devices to ensure they are in working order;

7. Providing or arranging transportation for, but not limited to, Customized Community Supports, Community Integrated Employment, leisure and recreation activities, medical, dental, and therapy appointments;

8. Implementation and monitoring the effectiveness of the Individual Service Plan (ISP) to achieve desired outcomes;

9. Coordination and collaboration with therapists and therapy assistants to receive training and implement Written Direct Supports Instruction (WDSI) in accordance with the participatory approach;

10. Coordination and collaboration with the behavior support consultants to receive training and implement Positive Behavior Support Plans (PBSPs) in accordance with the Behavioral Support Consultation (BSC) Standards;

11. Coordination and collaboration with agency nurses to receive training and implement Health Care Plans and Medical Emergency Response Plans;

12. Monitoring, implementation and documenting progress of therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans;
13. Provision of nutritional counseling, if recommended by the IDT and clinically indicated;

14. Assisting the individual as needed, with access to medical, dental, therapy, nutritional, nursing, behavioral support consultation services, behavioral health services, home health care and hospice services benefits;

15. Ensuring timely implementation of healthcare orders, tracking of individual health indicators (e.g. weight, seizure frequency, vital signs), and development, training, implementation and monitoring of required Healthcare Plans and MERPs;

16. Assistance in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate;

17. Ensuring nurse response to unanticipated medical events requiring intervention or coordination; and

18. Implement, track progress and document outcomes of healthcare orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans, if applicable.

2. SERVICE REQUIREMENTS

A. IDT Assessment for Living Supports- Supported Living Services: - Supported Living is a residential habilitation service intended for individuals who are assigned to NM DDW Group C through G and for whom living supports are the best service alternative at the time. It is also available to individuals authorized for Categorical Group H as outlined in the DDSD Group H Policy and Procedure. Living Supports are intended to increase and promote independence and to support the individual to live as independently as possible in the community in a setting of their own choice.

B. Clinical Necessity Criteria for Living Supports Services: Substantiated clinical necessity criteria must be met and prior authorization obtained for each individual to qualify for Supported Living, including the following:

1. Documentation from the IDT that substantiates that the severity of the individual’s needs warrants the level of support associated with the services requested to prevent institutionalization;

2. Documented determination by the IDT that the individual needs paid daily staff support based on the NM DDW Groups C through G; and
3. Documented analysis by the IDT members that Supported Living is being provided due to the unavailability of an alternative and appropriate residential service option because natural supports or less intensive support services (e.g. Respite, or Customized-In Home Supports) are insufficient or ineffective in meeting the individual’s residential habilitation service needs.

C. Provision of Services:

1. Supported Living must be available up to twenty-four (24) hours per day, three hundred sixty five (365) days a year, but does not include the time when an individual is employed, at school, visiting their family, utilizing other natural supports as identified in the ISP or participating in Customized Community Supports or Community Integrated Employment. Examples of when twenty-four (24) hour care must be provided include:

   a. During illness, accidents and recovery;
   
   b. In the event of emergencies;
   
   c. If an individual works non-traditional hours; and
   
   d. Weekends and holidays.

D. Staffing Ratios for Living Supports- Supported Living Provider Agencies:

1. The agency will ensure staffing ratios that support the health and safety of each individual served. Agency Direct Support Personnel (DSP) must not simultaneously provide coverage to more than one residence, except as emergency on-call staff.

2. Non-Ambulatory Stipend

   a. Adults who are non-ambulatory and receiving Supported Living services and are determined to need an increased level of staffing to assist with transfers and other activities of daily living may be approved for a non-ambulatory stipend; refer to the DDSD Non-Ambulatory Stipend Policy and Procedure, January 1, 2013.

   b. The non-ambulatory stipend rate is based on an assumption that a 2nd asleep staff person will be available through the night to assist with transfers if awakened to deal with evacuation or other emergency.

E. Individual Age Requirements: To receive Living Supports the individual must be eighteen (18) years of age or older. In extraordinary circumstances, case by case
exceptions to the age restriction for Living Supports may be approved annually by the DDSD Director.

F. Supervision: The Supported Living Provider Agency must provide and document:

1. Monthly face-to-face consultation in the Supported Living home, by agency supervisors or internal service coordinators, with DSP and individual receiving services on at least a monthly basis to include:

   a. Review implementation of the individual’s ISP Action Plans and associated support plans, including e.g. HCP, MERPs, Positive Behavioral Support Plans (PBSP), Written Direct Support Instructions (WDSI) from therapist(s) serving the individual, schedule of activities and appointments; and advise the DSP regarding expectations and next steps, including the need for individual specific training or retraining from the therapist and Behavioral Support Consultants (BSC’s); and

   b. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members.

G. Individual Rights: When planning Supported Living, the IDT members must recognize the individual’s rights including, but not limited to:

1. Informing individuals of their rights;

2. Support to learn and exercise their rights;

3. Home ownership;

4. The individual has a lease or other legally enforceable agreement;

5. Be provided information in advance, (to the Individual and/or guardian) about all costs including room and board, if paid to the provider;

6. Having utilities/phone in their own names;

7. Individual needs and preferences regarding housemates;

8. Individual’s right to choose how to decorate their room and residence based on their own personal preferences;

9. Individual’s right to have his or her own bed and consent to share a bedroom;

10. Owning personal property;
11. Pursuing adult relationships;

12. Privacy;

13. Individual’s free use of all common space in the residence with regard for privacy, personal possessions and individual interests;

14. General control over when, if, and to where the individual moves, unless precluded by a situation which presents an immediate risk to the individual or others in the home;

15. The individual retains the right to assume risk; this dignity of risk must be balanced with the individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety;

16. Individuals have access to food at any time. There must be a Human Rights Committee review when food has a potential to be a danger to the individuals; and

17. Individuals can have visitors in their home at any time they choose.

**H. Financial Responsibilities of the Individual:**

1. An individual receiving Supported Living will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.

2. Costs for room and board are the responsibility of the individual receiving the service.

**I. Health Care Requirements for Living Supports- Supported Living:**

1. Individuals are supported to receive coordinated health care services based on each individual’s specific health needs, conditions, and desires. Health care services are accessed through the individual’s Medicaid State Plan benefits through Fee for Service or Managed Care and through Medicare and/or private insurance for individuals who have these additional types of insurance coverage.

2. Nursing Services are bundled into the rates for Supported Living and all Nursing requirements in this section apply to the service.

3. All Supported Living providers must ensure that practitioner orders are carried out until discontinued. If orders cannot be implemented as directed, the ordering practitioner must be notified as soon as possible and no later than within three (3) business days. If an order cannot be implemented due to individual or guardian refusal, a Decision Consultation Form must be completed in consultation with the
practitioner. Based on the final decision the order must be reinstated, altered or discontinued.

a. RN’s may determine, based on prudent nursing practice, to hold a practitioner order but must document the circumstances and rationale and notify that practitioner by the next business day.

4. Practitioner recommendations must be considered by the individual and their guardian/health decision maker in consultation with the IDT and implemented unless a DDSD Decision Consultation Form is completed indicating an informed decision not to implement the recommendation.

5. Supported living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

6. A nurse employed or contracted by the Supported Living provider must complete the e-CHAT, the Aspiration Risk Screening Tool per DDSD policy and procedure, and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration. LPNs may contribute to the assessment but the assessment must be reviewed, may be edited and must be approved by an RN.

a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first;

b. For individuals already receiving services, the assessments are required to be completed no more than forty-five (45) and at least fourteen (14) days prior to the annual ISP meeting, within three (3) business days following any significant change of clinical condition, and within three (3) business days following return from hospitalization; and

c. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information, including the individual complaints, signs, and symptoms noted by staff, family members, or other team members; objective information, including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure
frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems; and follow up on any recommendations of medical consultants.

J. Health Care Plan: The agency nurse must create, with input from the IDT, a Healthcare Plan for each individual that addresses all areas identified as required in the most current e-CHAT summary report, as indicated by “R” in the Healthcare Plan column. At the nurse’s sole discretion, based on prudent nursing practice, this Healthcare Plan may also include any or all of the areas indicated for consideration for inclusion, as indicated by “C” on the e-CHAT summary report or any other areas the nurse decides are warranted. Each Healthcare Plan must:

1. Be clearly developed or revised within five (5) business days of admission, readmission or change of medical condition. At the nurse’s discretion, and based on prudent nursing practice, interim Healthcare Plans may be developed to address issues that must be implemented immediately after admission, readmission, or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim aspiration risk management plans in those newly-identified at moderate or high risk for aspiration.

2. Include a statement of the individual’s healthcare needs and list measurable goals to be achieved through implementation of the Healthcare Plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability, or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage existing health conditions.

3. Include goals that are measurable and are revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

4. Have interventions/strategies described in the plan that are individualized to reflect the individual’s unique needs, subtle signs and symptoms of illness if applicable; to provide guidance to the DSP, and designed to support successful interactions. Some interventions may be carried out by DSP, family or other team members; other interventions may be carried out exclusively by an agency nurse. Persons responsible for each intervention/strategy must be specified in the plan discipline/title; interventions/strategies must be written in language easily understood by the person responsible for implementation.

5. Include the individual's name and date of birth on each page. The Healthcare Plan must be signed by the author. Plans authored by an LPN must have RN review and approval as indicated by review date and signature.

6. The Healthcare Plan must be reviewed semi-annually and/or when the individual has a significant change in health condition to determine its effectiveness and must be
revised as needed (e.g. as goals are achieved, circumstances change, or new issues or strategies are identified). This review must be documented.

7. After the annual ISP meeting, Healthcare Plans may need to be developed or revised. Plans developed or revised by an LPN must have RN review and approval as indicated by review date and signature.

K. Training and Requirements: The agency nurse must deliver and document training for DSP regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee such as awareness, knowledge, or skill.

1. If such healthcare strategies are not delegated nursing tasks, at the nurse’s discretion, a designated trainer may be identified by the nurse who is then authorized to train DSP.

2. For delegated nursing tasks, the delegating nurse must provide training and monitoring for continued competence consistent with the New Mexico Nurse Practice Act, prudent nursing practice, the agency policies on delegation, and related DDSD policies and procedures.

3. Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Assistance with Medication Delivery Training, Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

   a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

   b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

      i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

      ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

      iii. Initials of the individual administering or assisting with the medication delivery;

      iv. Explanation of any medication error;
v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. When PRN medications are used, there must be clear documentation that the DSP contacted the agency nurse prior to assisting with the medication;

d. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and

e. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.

4. **Nurse Delegation:** Living Supports- Supported Living Provider agencies must develop and implement policies and procedures regarding delegation which must comply with relevant DDSD Policies and Procedures and the New Mexico Nurse Practice Act. Agencies must ensure that all nurses they employ or subcontract with are knowledgeable of all these requirements.

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

   i. Train each DSP to skill level competency;

   ii. Monitor ongoing staff performance, skill level, and the individual’s health status; and

   iii. Rescind delegation at any time that the nurse determines that the DSP is unwilling or unable to safely perform the delegated task.

b. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office; and

c. Delegation is a unique relationship between a nurse and a DSP that cannot be mandated and cannot be transferred between nurses or between DSP. If a staff nurse or DSP is no longer employed by the agency, the delegation relationship is nullified.
5. **Health Related Documentation:** For each individual receiving Living Supports-Supported Living, the provider agency must ensure and document the following:

   a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;
   
   b. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and
   
   c. Document for each individual that:
      
      i. The individual has a Primary Care Provider (PCP);
      
      ii. The individual receives an annual physical examination and other examinations as specified by a PCP;
      
      iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;
      
      iv. The individual receives a hearing test as specified by a licensed audiologist;
      
      v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist;
      
      vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine); and
      
      vii. The agency nurse will provide the individual’s team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP meeting and semi-annually.

6. **Nursing Requirements and Roles:**

   a. Supported Living Provider Agencies are required to have a RN licensed by the State of New Mexico on staff. The agency nurse may be an employee or a sub-contractor.
b. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.

c. The Supported Living Provider Agency must not use a LPN without a RN supervisor. The RN must provide face-to-face supervision required by the New Mexico Nurse Practice Act and these service standards for LPNs, CNAs and DSP who have been delegated nursing tasks.

d. On-call nursing services: An on-call nurse must be available to DSP during the periods when a nurse is not present. The on-call nurse must be able to make an on-site visit when information provided by DSP over the phone indicate, in the nurse’s professional judgment, the need for a face to face assessment to determine appropriate action. An LPN taking on-call shifts must have access to their RN supervisor by phone during their on-call shift in case consultation is required. It is expected that no single nurse carry the full burden of on-call duties for the agency and that nurses be appropriately compensated for taking their turn covering on-call shifts.

L. **Transportation:** Supported Living provider agencies must have written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD Policy and Procedures.

M. **General Events Reporting:** Supported Living provider agencies must enter General Events Reporting into Therap as specified in the New Mexico DDSD General Events Report (GER) Guide.

3. **AGENCY REQUIREMENTS**

A. **IDT Coordination:**

1. Appropriate staff from the Supported Living Provider Agency will participate on each individual’s IDT, as specified in the ISP regulations (NMAC 7.26.5). The Living Supports Provider will ensure that at least one staff who works directly with the individual is available to attend IDT meetings, and that further staff input is collected for IDT consideration. This may be as part of the semi-annual reports, or as a separate document. For individuals with high e-CHAT acuity, the nurse must also attend the annual IDT meeting and any other IDT meeting where health issues are on the agenda in person or by phone.

2. Ensure the e-CHAT is completed/updated between forty-five 45 and fourteen 14 calendar days prior to the ISP meeting.

3. It is the responsibility of the IDT to ensure at least thirty (30) hours per week of participation in activities of their choice outside the residence, unless prior
authorization has been obtained from DDSD to occur in the home, as per the DDSD Customized Community Supports Individual In Home Services Policy and Procedure. These activities are not limited to paid supports and may include activities appropriate to the individual that are not the responsibility of the Supported Living Provider.

4. When an individual changes providers, or waiver programs, it is the responsibility of both the existing and new provider to work together to ensure that safe and appropriate transition planning takes place.

5. It is the responsibility of the IDT to ensure the individuals have access to augmentative communication and assistive technology which aid the individual to participate in meaningful activities.

6. Appropriate staff will be available to the individual and the IDT as a qualified primary respondent or an ancillary respondent for scheduled Supports Intensity Scale assessments and provide information to accurately reflect the person’s needs for supports.

7. Monitor that DSP’s implement and document progress of the assistive technology inventory, physician and nurse practitioner orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans.

B. Living Supports- Supported Living Services Provider Agency Staffing Requirements:

1. Direct Support Personnel (DSP) Qualifications and Competencies: Individuals working as DSP and supervisors for Supported Living Provider Agencies must meet the following requirements and have the ability to instruct and assist individuals to carry out the scope of services:

   a. Be eighteen (18) years or older;

   b. Have a high school diploma or GED. DSP hired prior to January 1, 2013 are exempt from this requirement;

   c. Ability to maintain accurate records;

   d. Ability to maintain standards of confidentiality and ethical practice;

   e. Ability to effectively employ communication skills to build rapport and channels of communication by recognizing and adapting to the range of individual communication styles;

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f. Ability to identify the need for community supports and work with the individual’s informal support system and other IDT Members to initiate meaningful community connections; and

g. Maintain current First Aid and CPR certification.

2. **Qualifications for Agency Supervisors:** Personnel who are directly responsible for the supervision of Supported Living DSP are required to meet the additional following requirements:

   a. Be twenty-one (21) years of age or older;

   b. Have a high school diploma or G.E.D;

   c. Have a minimum of one (1) year experience working with individuals with developmental disabilities or related field; or a degree in a related field may substitute for experience.

3. **Training:** Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state.

   a. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

   b. Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, and information about the individual’s preferences with regard to privacy, communication style, and routines.

   c. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

   d. DSP must be available to participate in therapy/BSC appointments with the individual on a regular basis as requested.
e. Nurse Training: Nurses must meet the following requirements:
   
i. Current CPR certification;

   ii. Completion of the DDSD Nurse Orientation and Healthcare Planning modules within the first ninety (90) calendar days of hire or assignment to this service;

   iii. Within the first one hundred eight (180) calendar days of hire or assignment to the service, observation of a full (two (2) day) Assisting with Medication Delivery course in order to ensure awareness of expectations of DSP personnel assisting individuals with medication; and

   iv. Within twelve (12) months of hire complete training for ARM; Effective Individual Specific Training, and Person Centered Planning.

4. Criminal Background Screening: Supported Living Provider Agency will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required staff.

5. Employee Abuse Registry: Supported Living Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

6. Staffing Restrictions:
   
a. Any individual who operates or is an employee of a boarding home, residential care home, nursing home, group home or other similar facility in which the individual resides must not serve as guardian for that individual, except when related by affinity or consanguinity [§ 45-5-31(1) A NMSA (1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

C. Residence Case File: The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.

D. Consumer Records Policy: Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.
E. Living Supports—Supported Living Service Provider Agency Reporting Requirements:

2. Semi-Annual Reports: Supported Living providers must submit written status reports to the individual’s Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:

   a. Name of individual and date on each page;

   b. Timely completion of relevant activities from ISP Action Plans;

   c. Progress towards desired outcomes in the ISP;

   d. Significant changes in routine or staffing;

   e. Unusual or significant life events, including significant change of health condition;

   f. Data reports as determined by IDT members; and

   g. Signature of the agency staff responsible for preparing the reports.

F. Agency Accounting for Individual Funds: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justify limitations or supports for self-management and, where appropriate, reflects a plan to increase this skill. Supported Living Provider Agencies must maintain and enforce written policies and procedures regarding the use of the individual’s SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.

1. The Supported Living Provider Agencies must produce an individual accounting of any personal funds managed or used by the Living Supports Service Provider Agency on a monthly basis.

2. A copy of this documentation must be provided to the individual and or his or her guardian upon request.

3. When room and board costs are paid from the individual’s SSI payment to Supported Living Providers the amount charged for room and board must allow the individual to
retain twenty (20%) percent of their SSI payment each month for personal use. A written agreement must be in place between the individual and the provider agency that addresses this reasonable amount of discretionary spending money.

G. Residence Requirements for Living Supports - Supported Living Services:

1. The Supported Living Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

2. Supported Living Provider Agencies must assure that each individual’s residence is maintained to be clean, safe, and comfortable and accommodates the individual’s daily living, social, and leisure activities. In addition the Provider Agency must:
   a. Maintain basic utilities, i.e., gas, power, water, and telephone;
   b. Allow environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;
   c. Ensure water temperature in home does not exceed safe temperature (110°F);
   d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;
   e. Have a general-purpose First Aid kit;
   f. Allow the individual the right to select their roommate. A maximum of two (2) individuals can share a bedroom and each individual has the right to have his or her own bed;
   g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift;
   h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual’s ISP;
   i. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;
   j. Provide lockable doors with individuals and appropriate staff having keys as needed; and
k. An average of five (5) hours of documented nutritional counseling must be available annually, if recommended by the IDT and clinically indicated.

H. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   e. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

   f. The entities or individuals responsible for conducting the discovery/monitoring process;

   g. The types of information used to measure performance; and

   h. The frequency with which performance is measured.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:

      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

      ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

   b. Compliance with Caregivers Criminal History Screening requirements;
c. Compliance with Employee Abuse Registry requirements;
d. Compliance with DDSD training requirements;
e. Patterns in reportable incidents;
f. Sufficiency of staff coverage;
g. Patterns in medication errors;
h. Action taken regarding individual grievances;
i. Presence and completeness of required documentation; and
j. Significant program changes.

3. Preparation of the Report: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. REIMBURSEMENT

A. Supported Living Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Supported Living Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.

   a. The rate for Supported Living is based on categories associated with each individual’s NM DDW Group; and

   b. A non-ambulatory stipend is available for those who meet assessed need requirements.

B. Billable Units:

1. The billable unit for Supported Living is based on a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service are provided then one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period.
2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred seventy (170) calendar days per six (6) months.

C. Billable Activities:

1. Billable activities shall include any activities which DSP provides in accordance with the Scope of Services for Living Supports which are not listed in non-billable services, activities, or situations below.

D. Non-Billable Services, Activities or Situations:

1. Services furnished to an individual who is:
   a. Not residing in New Mexico;
   b. Not eligible for DDW services; or
   c. Hospitalized or in an institutional care setting.

2. Payment for Supported Living must not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement.

3. Time spent on the following activities:
   a. Client assessments;
   b. Writing or updating reports, progress notes and logs;
   c. Employer activities including administrative duties, routine paperwork including billing documentation, employer staff meetings, or meetings with supervisors that are not client specific;
   d. Personnel development; and
   e. Client specific training to DSP unless delivered during provision of Living Supports and with the individual present.
I. Living Supports - Intensive Medical Living Services

Intensive Medical Living Services is a Living Supports option for persons with complex medical needs who require intensive direct nursing care and oversight. This service promotes health and supports each individual to acquire, retain or improve skills necessary to live in the community and prevent institutionalization.

1. SCOPE OF SERVICE

A. Living Supports- Intensive Medical Living Service includes the following:

1. **Provide appropriate levels of supports:** Agency nurses and Direct Support Personnel (DSP) provide individualized support based upon assessed need. Assessment shall include use of required health-related assessments, eligibility parameters issued by the Developmental Disabilities Support Division (DDSD), other pertinent assessments completed by the nurse, and the nurse’s professional judgment.

2. **Provide daily nursing visits:**
   a. A daily, face to face nursing visit must be made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in order to deliver required direct nursing care, monitor each individual’s status, and oversee DSP delivery of health related care and interventions. Face to face nursing visits may not be delegated to non-licensed staff.
   b. Although a nurse may be present in the home for extended periods of time based on individual(s) needs, a nurse is not required to be present in the home during periods of time when direct nursing services are not needed.

3. **Provide weekly RN oversight visits:**
   a. A supervising RN must perform an RN oversight visit at least weekly. The RN oversight visit may not be delegated to an LPN or a non-licensed person. The supervising RN’s oversight visit is performed in order to monitor the clinical status and needs of the individual and the delivery of planned care and services, to provide consultation and serve as a resource, and to provide oversight of the licensed nurses and DSP;
   b. The frequency of the RN oversight visit may vary and must be based on the individual’s condition, the skill level of the DSP, and prudent nursing practice. It is up to the judgment of the supervising RN to determine if a weekly RN oversight visit is adequate or if there is a need to visit more frequently; and
c. RN oversight visit(s) may replace one or more of the daily nursing visits during each week if all ordered nursing tasks are completed during the RN visit.

4. **Provide on call nursing services:**

   a. An on call nurse must be available to DSP during periods when a nurse is not present. The on call nurse must be available within the hour to make an on-site visit when based on available information and the nurse’s professional judgment, there is a need for a face to face assessment to determine appropriate action;

   b. An LPN on duty in the home or taking on call duty must have access to their RN supervisor by phone in case consultation is required; and

   c. It is expected that no single nurse carry the full burden of on call duties for the agency covering on call shifts.

5. **Perform required screening and assessment tools:**

   a. Ensure accurate and timely completion of all DDSD required nursing screening and assessment tools, annually between forty-five (45) and fourteen (14) calendar days prior to the annual ISP meeting and as needed for significant change of medical condition;

   b. An agency nurse will complete the designated IMLS prior authorization packet prior to admission into IMLS services, no later than two (2) weeks before the sixth month of IMLS stay and then annually thereafter between forty-five (45) and fourteen (14) calendar days prior to the annual ISP meeting;

   c. The Agency RN supervisor will either complete or review and approve the completed designated IMLS prior authorization packet as indicated by date and signature; and

   d. The initial, six month, or annual IMLS prior authorization packet shall be submitted to the Regional Office Nurse upon completion for verification of eligibility and approval.

6. **Provide Nutritional Supports:** Provide an annual assessment of nutritional needs and all needed ongoing nutritional services including visits, attendance at meetings, plan development and training as indicated by an assessment performed by a licensed/registered dietician.

7. **Provide services delivered by DSP:**
a. Training and assistance with activities of daily living, as needed, such as bathing, dressing, grooming, oral care, eating, transferring, mobility, medication, toileting, and personal care;

b. Depending upon the results of e-CHAT and through the Therap Medication Administration Assessment Tool (MAAT) conducted by the nurse, such training may also include skills leading toward self-administration of medication (consistent with DDSD Medication Assessment and Delivery Policy and Procedures), and/or other tasks related to self-management of their health condition(s); and

c. DSP will train and assist individuals with instrumental activities of daily living, as needed, including housework, meal preparation, shopping, and money management.

8. **Provide access to Customized Community Supports:** Provide access to these services as outlined in the Individual Service Plan (ISP) and include any intermittent nursing or nursing consultation needed by the individual to participate in those services. Collaboration on care planning and regular communication between the Intensive Medical Living Services provider, Customized Community Supports nurse, and DSP is required.

9. **Ensure provision of transportation:** The individual must have transportation for all medical appointments, household functions and activities, to and from day services, leisure/recreational activities, and other meaningful community options. Provision may be either arranged or directly provided, but the Intensive Medical Living Services provider is responsible to make sure necessary transportation occurs.

10. **Provide assistance with social relationships:** The provider must assist individuals to develop and maintain social, cultural, and spiritual relationships of their choosing.

11. **Ensure access to medical services:** Ensure each individual has a licensed Primary Care Provider (PCP), receives an annual physical examination, and specialty medical care as needed, including an annual dental checkup by a licensed dentist.

   a. All practitioner orders shall be carried out until discontinued. If orders cannot be implemented as directed, the ordering practitioner must be notified within three (3) business days. (If an order cannot be implemented due to individual or guardian/health decision maker’s refusal, a Decision Consultation Form must be completed in consultation with the practitioner. Based on the individual and their guardian/health decision maker’s final decision the order shall be reinstated, altered, or discontinued);

   b. RN’s may determine, based on prudent nursing practice, to hold a practitioner order but must document the circumstances and rationale, and notify that practitioner by the next business day; and

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c. Practitioner recommendations shall be considered by the individual and their guardian/health decision maker in consultation with the Interdisciplinary Team (IDT) and implemented unless a DDSD Decision Consultation Form is completed indicating an informed decision not to implement the recommendation.

B. This service may be provided on a short term basis for thirty (30) calendar days to individuals, regardless of current DDW Group assignment, who require short-term Intensive Medical Living Services with IMLS approved prior authorization from the DDSD Regional Nurse. Short term Intensive Medical Living Services may be accessed due to recent hospitalization or a nursing home or rehabilitation facility stay, to allow time to update health care plans, train staff on new or exacerbated conditions, and to ensure the routine home environment is appropriate to meet the needs of the individual. Such short term placements may occur in their usual home if their provider is approved as an Intensive Medical Living Services provider. Otherwise, the individual may choose an approved Intensive Medical Living Services provider pending transition back to their usual home.

1. In addition to the completed IMLS prior authorization packet, all prior-authorization materials submitted for approval shall indicate the relevant individual specific training needed by DSP of the Intensive Medical Living provider to ensure health and safety during the short term stay.

2. Implementation of ISP outcomes and strategies unrelated to health and safety may be suspended during such short term stays.

C. Based on submission and approval of the IMLS prior authorization packet, and with prior authorization approval from DDSD, this service may be provided on a short term basis in a residence operated by an Intensive Medical Living Services provider to individuals with intensive medical needs who normally live in a Family Living setting, when the family needs a substantial break from providing care. Such short term placement may range from four (4) to thirty (30) consecutive days and shall not exceed thirty (30) days per ISP term. Paid Family Living services and Intensive Medical Living services may not be billed simultaneously.

D. Service Limitations:

1. No more than four (4) individuals may be served in a single residence at one time. Such residences may include a mixture of individuals receiving Intensive Medical Living Services and Supported Living Services.

2. Individuals receiving IMLS may not receive Adult Nursing Services, Nutritional Counseling, or Respite from the DDW during the days in which they participate in this service, including short term stays.
3. Individuals receiving long-term Intensive Medical Living Services must be at least eighteen (18) years of age. Individuals younger than eighteen (18) may be considered by DDSD for short-term placement on a case-by-case basis consistent with the scope of service in this chapter.

4. Any individual who operates or is an employee of a boarding home, residential care home, nursing home, group home, or other similar facility in which the individual resides shall not serve as guardian for that individual, except when related by affinity or consanguinity [§ 45-5-31(1) A NMSA (1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

2. SERVICE REQUIREMENTS

A. Eligible individuals must have assessed medical needs at a high acuity level, be assessed using the Supports Intensity Scale®, placed in NM DDW Group F, and require intensive clinical nursing oversight and health management that must be provided directly by a RN or LPN in accordance with the New Mexico Nursing Practice Act and consistent with eligibility parameters for IMLS prior authorization issued by DDSD for this service. The following requirements must be met:

1. Eligibility shall be confirmed by a Regional Office Nurse within the first ten (10) working days following initial admission and again during the sixth month of stay;

2. The IDT must use the e-CHAT; and

3. Current designated eligibility parameters tool posted on the DDSD website must be submitted to the Regional Office nurse and approved at least two (2) weeks prior to the annual ISP meeting, to confirm continued eligibility thereafter.

B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.

C. Intense Medical Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

D. Intensive Medical Living Services provider agencies must develop and implement policies and procedures that actively support nurses’ professional responsibilities regarding delegation of nursing tasks as defined in the New Mexico Nurse Practice Act, including but not limited to:

1. The initial and ongoing determination of the skill level of each DSP who will perform the delegated task, including:
a. Provision of initial and ongoing training of the delegated tasks;

b. Monitoring the implementation of delegated tasks by each DSP on an ongoing basis; and

c. Documenting all aspects of delegation and maintaining such documentation in a separate staff file at the agency office.

2. Delegation must be rescinded at any time the nurse determines that a particular DSP is unable to safely perform the delegated task.

3. Delegation is a unique relationship between a specific nurse and specific DSP that cannot be mandated by the provider agency or transferred between nurses or between DSP. If a nurse or DSP is no longer employed by the provider, the delegation relationship is nullified.

E. A nurse employed or subcontracted by the Intensive Medical Living Services provider must complete the e-CHAT, the Aspiration Risk Screening Tool per DDSD policy and procedure, and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations.

1. The MAAT must be updated:

   a. For any significant change of medication regime; or

   b. Change of route that requires a change in delivery or delivery by licensed or certified staff; or

   c. When an individual has completed training designed to improve their skills to support self-administration.

2. For newly-allocated or admitted individuals, the e-CHAT, Aspiration Risk Screening Tool, Medication History, MAAT, and any other screening tools or assessments identified as needed by the nurse’s professional judgment must be initiated immediately and completed within three (3) business days of admission into direct services or two (2) weeks following the initial ISP meeting, whichever comes first.

3. For individuals already in services, the e-CHAT, the Aspiration Risk Screening Tool, update of the Medication history, MAAT, and any other screening tools or assessments identified as needed by the nurse’s professional judgment must be completed between forty five (45) days and fourteen (14) days prior to the annual ISP meeting. These assessments must be revised within three (3) business days following any significant change of clinical condition or return from hospitalization.
4. Assessments may only be completed by a licensed nurse and may not be delegated. An LPN may contribute to an assessment but an RN must sign off on the assessment.

F. All nursing visits and activities must be documented in a signed progress note that includes:

1. Time and date;

2. Subjective information including the individual’s complaints, signs/symptoms reported by DSP, family, or other team members;

3. Objective information including:
   a. Vital signs, physical examination, weight, and other pertinent data for the given situation (e.g. seizure frequency, method by which temperature was taken);
   b. Assessment of the clinical status and plan of action addressing relevant aspects of all active health problems; and
   c. Follow up on any recommendations of medical consultants.

4. Any phone interactions with DSP in the home which occur between daily on-site visits must also be documented, by both the DSP and the nurse, in a signed progress note or phone log, indicating time, date, reason for the call including complaints/signs/symptoms reported by the individual and/or DSP, and any instructions given.

G. The agency nurse shall create, a Healthcare Plan for each individual that addresses all areas identified as required in the most current e-CHAT summary report, (as indicated by “R”: Required) in the Healthcare Plan column. At the nurse’s sole discretion, based on prudent nursing practice, this Healthcare Plan may also include any or all of the areas indicated for consideration for inclusion, as indicated by “C” on the e-CHAT summary report or any other areas the nurse decides are warranted. Nurses may combine related issues into Healthcare Plans as clinically appropriate. Each Healthcare Plan must:

1. Be clearly developed or revised within five (5) business days of admission, readmission or change of medical condition. At the nurses discretion based on prudent nursing practice, interim Healthcare Plans may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim aspiration risk management plans in those newly identified at moderate or high risk for aspiration;

2. Include a statement of the individual’s healthcare needs and list measurable goals to be achieved through implementation of the Healthcare Plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize, or manage existing health conditions;
3. Include goals that are measurable and are revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal;

4. Have interventions/strategies described in the plan that are individualized to reflect the individual’s unique needs, provide guidance to the DSP, and designed to support successful interactions. Some interventions may be carried out by DSP, family or other team members; other intervention may be carried out exclusively by an agency nurse. Persons responsible for each intervention/strategy shall be specified in the plan; discipline/title and interventions/strategies shall be written in language easily understood by the person responsible for implementation;

5. Include the individual’s name and date of birth on each page. The Healthcare Plan shall be signed by the author. Plans authored by an LPN must have RN review and approval as indicated by review date and manual or electronic signature;

6. The Healthcare Plan must be reviewed at least quarterly to determine its effectiveness and shall be revised as needed (e.g. as goals are achieved, circumstances change, or new issues or strategies are identified). This review will be documented on the Healthcare Plans or on a summary review sheet and will be reflected in the Quarterly Nursing Report; and

7. After the annual ISP meeting, Healthcare Plans must be clearly reviewed, revised and re-dated. Revisions authored by an LPN must have RN review and approval as indicated by date and manual or electronic signature.

H. The agency nurse shall deliver and document training for DSP regarding the healthcare interventions/strategies that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as awareness, knowledge, or skill:

1. If such healthcare strategies are general tasks (not delegated nursing functions), at the nurse’s discretion, a designated trainer may be identified by the nurse who is then authorized to train DSP; and

2. For delegated nursing tasks or nursing functions, the delegating nurse must provide training and monitoring for continued competence consistent with the New Mexico Nurse Practice Act, prudent nursing practice, the agency policies on delegation, and related DDSD policies and procedures. Delegation may not be mandated, may not be transferred and must be rescinded if the staff are not able or willing to safely perform the delegated function.

I. For residents of Intensive Medical Living Services who have a chronic condition with the potential to exacerbate into a life-threatening situation, and as indicated by ‘R’ for “required” in the MERP column on the e-CHAT summary report, a MERP must be
written, consistent with the DDSD Medical Emergency Response Plan Policy and Procedures, by the nurse or other appropriately designated health professional.

1. DSP must be trained prior to working alone with an individual and receive annual refresher training regarding when and how to implement the MERP. All training shall be documented, clearly indicating resulting competency level for each trainee;

2. The MERP shall include the individual’s name and date of birth on each page and the MERP shall be signed by the author;

3. DSP must document each time they implement the emergency response steps contained in the MERP; and

4. On a semi-annual basis, the nurse shall review the MERP, and DSP documentation regarding implementation of the emergency response steps, to determine how many times it was implemented during the six (6) month period and whether or not the MERP needs to be revised:
   a. Such review shall be documented; and
   b. If the MERP is revised, the nurse shall assure that the staff are trained and the revised copy is placed in the home with the new date indicated, and the old version removed from the home.

J. An agency nurse must coordinate with the hospital for discharge planning. Hospital discharge orders must be noted and initiated within twenty-four (24) hours and reflected via revision of the Healthcare Plan(s) within five (5) business days following a hospitalization. If the post-hospitalization e-CHAT summary report identifies additional required areas for the Healthcare Plan, those must also be incorporated.

K. In addition to ongoing, episodic charting, the nurse will complete a Quarterly Nursing Report that reflects the individual’s current health status and a summary of significant health related findings, events or activities that have occurred in the quarter; the individual’s progress toward Healthcare Plan goals and reference to review or revision of Healthcare Plans or MERPs. This Quarterly Nursing Report may be electronic or paper document but must be made available to the IDT on a quarterly basis.

L. If the individual or their guardian selects another provider, or an individual is departing from a short term stay:

1. The agency nurse shall prepare a discharge summary report and provide it to the case manager and receiving provider on the day of discharge, regardless of length of stay;

2. Likewise, if an individual no longer meets eligibility criteria for IMLS and is thus being transitioned to other living arrangements, a discharge summary report must be completed by the nurse;

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3. The summary must contain a synopsis of the individual’s stay and reflect current health status and needs at time of discharge;

4. The Intensive Medical Living Services nurse must collaborate with other agency nurses as needed to facilitate a smooth transition of care;

5. Any impact to the individual’s Level of Care due to health or functional status changes must be discussed with the case manager prior to the discharge; and

6. When an individual changes providers, it is the responsibility of both the existing and new provider to ensure that safe and appropriate planning takes place. An IDT meeting to develop a transition plan shall be held to address exchange of health-related information, individual preferences and required documentation, training of staff, and moving logistics.

M. Supported Living provider agencies must have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD Policy and Procedures.

N. An agency nurse and at least one DSP shall attend the annual ISP meeting, in person or by phone, for each individual receiving Intensive Medical Living Services and shall attend all other IDT meetings where health status or health-related interventions are to be discussed. If a nurse is unable to attend an annual or health related ISP meeting due to unavoidable circumstances, the nurse shall provide a written health status update to the IDT, which addresses the health related topics on the agenda, prior to the meeting and confer with the case manager as soon as possible after the meeting to arrange necessary follow up action.

O. Nurses and DSP shall collaborate and consult with speech-language pathologists, occupational therapists, physical therapists, and/or BSC regarding the development of, status of and relevant issues related to: Teaching and Support Strategies, Written Direct Support Instructions, PBSPs, BCIPs, PRN Psychotropic Medication Plans, and RMPs, if applicable.

P. Provider agencies shall assure proper sanitation and infection control measures consistent with current national standards that are published by the Centers for Disease Control and Prevention. This includes:

1. Development and implementation of policies related to use of standard precautions;

2. Specific isolation or cleaning measures for specific illnesses; and/or

3. Communicable diseases policies which ensure that employees, subcontractors and agency volunteers are not permitted to work with signs/symptoms of communicable
disease or infected skin lesions until such time as authorized to do so in writing by a qualified health professional.

Q. Staff Qualifications:

1. **Nurse Qualifications:**
   a. Current licensure in compliance with the New Mexico Nurse Practice Act;
   b. Current CPR certification;
   c. Completion of the DDSD Nurse Orientation and Healthcare Planning modules within the first ninety (90) calendar days of hire or assignment to this service;
   d. Within the first one hundred eighty (180) calendar days of hire or assignment to the service, observation of a full two (2) day Assisting with Medication Delivery course in order to ensure awareness of expectations of direct support personnel assisting individuals with medication; and
   e. Within twelve (12) months of hire complete training for ARM; Effective Individual Specific Training, and Person Centered Planning.

2. **DSP Qualifications:**
   a. Age eighteen (18) or older and have a high school diploma or GED;
   b. Have a minimum of one (1) year of experience working with individuals with developmental disabilities or experience in a related field such as home health aide, certified medication aide, or nursing home care provision;
   c. Able to correctly implement the ISP, designated strategies within Healthcare Plans, designated strategies in Written Direct Support Instructions, and any other individual-specific activities required to support the individuals to which they are assigned;
   d. Able to communicate in the language functionally required by the individual, including the use of any specific augmentative communication system utilized by the individual;
   e. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
f. Monitor that DSP’s implement and document progress of the assistive technology inventory, physician and nurse practitioner orders, therapy, healthcare, positive behavior support, behavior crisis intervention, PRN psychotropic medication, risk management, medical emergency response, and comprehensive aspiration risk management plans;

g. Maintain current First Aid and CPR certification; and

3. Supervisor Qualifications And Requirements:

a. Age twenty-one (21) or older and have a high school diploma or GED;

b. Have a minimum of one (1) year of experience working with individuals with developmental disabilities or related field, or a degree in a related field may substitute for experience;

c. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;

d. Maintain current First Aid and CPR certification;

e. Ensure that every thirty (30) days at least one supervisory residence visit will be conducted on each shift. Once per month the visit shall include a face to face interview with each individual served. Results of these visits shall document in each individual’s case record the safety of the service, quality of services provided, and extent to which the individual’s ISP is being implemented;

The visit shall also ensure and document that assistive technology and/or equipment used by the individuals served are in good working order and being used as outlined in the ISP, Healthcare Plan and/or WDSI. At least one-third of residence visits for each shift shall be unannounced; and

f. Arrange regular staff meetings and training sessions as needed to ensure competent implementation of the ISP, Healthcare Plan, Written Therapy Support Plans, and any behavioral plans as applicable.

R. Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household
appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.

S. Each residence shall have a blood borne pathogens kit as applicable to the residents’ health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home.

T. If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions.

U. For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.

3. AGENCY REQUIREMENTS

A. Intensive Medical Living Services require supervision of medically related supports by a RN. The RN must reside in the New Mexico and must be able to be available within one (1) hour.

B. Each provider agency approved to deliver this service must have capacity for at least one (1) short-term placement within their organization.

C. Criminal Background Screening: Family Living Provider agencies will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required employees/subcontractors.

D. Employee Abuse Registry: Living Supports-Family Living Provider Agency will ensure compliance with the Employee Abuse Registry requirements.

E. Financial Accounting: Intensive Medical Living Service providers shall produce on a monthly basis an individual accounting of any personal funds managed or used. A copy of this documentation shall be provided to the individual and his or her guardian upon request.

F. Staffing Ratios:

1. At least one (1) DSP or nurse must remain awake throughout all night shifts. The RN supervisor may identify that additional staff must be awake based on the needs of the individuals and skill level of the staff.
2. Twenty Four (24) hour staffing must be adequate to meet the ongoing medical needs of the individuals receiving (Intensive Medical Living) IML services. This staffing may be covered by any combination of DSP, nurse and supervisory employees.

   a. When IMLS recipients share a residence with persons receiving other types of living services, at least two (2) employees must be available in the home during all mealtimes as well as when individuals are being assisted with bathing, and preparing for the day and for bed.

   b. At least two (2) staff members must be present at all times when two (2) or more individuals receiving IML services reside in the same home.

G. Quality Assurance/Quality Improvement (QA/QI) Program: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

   b. The entities or individuals responsible for conducting the discovery/monitoring process;

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:
i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. Preparation of the Report: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. REIMBURSEMENT

A. All Living Supports Intensive Medical Living Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Intense Medical Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

1. The maximum allowable billable units cannot exceed three hundred forty (340) days per year and also cannot exceed one hundred seventy (170) days in a six (6) month period.

B. Billable Unit:

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1. The billable unit for Intense Medical Living Services is a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service are provided then one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period.

C. Billable Activities:

1. Services included in the individual’s approved ISP;

2. Supports delivered consistent with the scope of services subject to service limitations; and

3. Activities included in billable services, activities or situations.

D. Non-Billable Services, Activities and Situations:

1. Services furnished to an individual who is:
   a. Not residing in New Mexico;
   b. Not eligible for DDW services;
   c. Hospitalized or in an institutional care setting; or
   d. Not eligible for services based on DDSD Regional Office review of the IMLS eligibility parameters.

2. Services not included in the:
   a. Scope of Services; or
   b. Individual’s approved ISP.

3. Time spent on the following activities:
   a. Client assessments;
   b. Writing or updating reports, progress notes and logs;
   c. Employer activities including administrative duties, employer staff meetings and meetings with supervisors that are not client specific, and routine paperwork including billing documentation; and
   d. Personnel development.
4. Room and board including the cost of building maintenance, upkeep, and improvement;

5. Respite, Nutritional Counseling, and Adult Nursing Services shall not be billed to the DDW as separate services for an individual receiving Intensive Medical Living Services; and

6. Cannot be billed if the individual is receiving Customized In-Home Supports, Family Living (unless on pre-approved short term respite), or Supported Living.
CHAPTER 14

NON-MEDICAL TRANSPORTATION SERVICE

I. Non-Medical Transportation Service

Non-Medical Transportation Service enables individuals to gain access to waiver and non-medical community services, events, activities and resources as specified in the Individual Service Plan (ISP).

1. SCOPE OF SERVICE

   A. Non-Medical Transportation services shall include transportation services between the individual’s home and non-medical services, resources or activities related to work, volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic, cultural, and spiritual activities or events.

2. SERVICE REQUIREMENTS

   A. Service Criteria: Written justification shall address the need for Non-Medical Transportation services to fulfill identified activities and supports in the ISP and identify the associated ISP outcomes.

      1. The Non-Medical Transportation Provider may use funding under this service to purchase a pass for public transportation for the individual, when determined appropriate by the IDT to support or fulfill identified activities associated with ISP outcomes.

      2. For individuals who receive Family Living, Supported Living or Intensive Medical Living Services, Non-Medical Transportation services may ONLY be provided under situations where:

         a. Extensive travel (more than one hundred (100) miles round trip) is required to meet outcomes in the ISP; or

         b. For the purchase of a public transportation pass.

      3. The Non-Medical Transportation provider shall be required to provide both funding for purchase of public transportation on behalf of the individuals served and direct Non-Medical Transportation services.

      4. The Non-Medical Transportation provider is required to deliver this service to all DDW participants selecting their agency through a Secondary Freedom of Choice regardless of whether they also receive other services from the agency.
B. Driver Responsibilities:

a. No individual will remain unattended in the vehicle;

b. Keys will be removed from the vehicle at all times when the driver is not in the driver's seat;

c. Doors will be locked at all times while the vehicle is moving; and

d. All persons will use appropriate safety restraints as required for the individual (seat belts; car seats, or other age appropriate restraint systems).

C. Service Limitations:

1. This service cannot be used to supplant the transportation responsibility of:

   a. Living Supports- Family Living;

   b. Living Supports- Supported Living;

   c. Living Supports- Intensive Medical Living Services Provider; or

   d. Customized Community Supports.

3. AGENCY REQUIREMENTS

A. Provider Agency Records:

1. A signed consent form shall be obtained prior to transporting a child (age birth through seventeen. The appropriate parent, guardian, or legal representative shall complete the consent form. The signed form shall be maintained at the Non-Medical Transportation Provider Agency.

2. The Non-Medical Transportation Provider will maintain documentation in the form of a transportation log to include:

   a. Proper individual identification shall be included on all pages of documents;

   b. Date(s) of service, including dates and signatures of authors on all documents;

   c. Time in and time out;

   d. Location(s) where the individual begins travel and the destination point (point to point, not round trip); and
e. Total miles traveled.

3. For those using public transportation passes, documentation supporting the implementation of activities in the ISP including desired outcomes may be substituted in lieu of the time in/time out and beginning destination/location for audit and billing purposes. The Non-Medical Transportation Provider is responsible for compiling and maintaining this documentation.

B. Reporting Requirements: Upon request, the Non-Medical Transportation Provider will submit a copy of the transportation log to the Case Manager on a quarterly basis throughout the individual’s ISP year.

C. IDT Coordination: The Non-Medical Transportation Provider is not required to attend Interdisciplinary Team (IDT) meetings. However, the Non-Medical Transportation Provider, if requested, will provide documentation or information to the IDT in order to support the planning process. This information/documentation may be provided in person or through the Case Manager.

D. Policy Requirements: The Non-Medical Transportation Provider shall develop and implement policies and procedures that comply with these standards.

E. Driver Qualifications/Vehicle Requirements:

1. Driver Qualifications: All drivers shall meet the following requirements:
   a. Possess a valid New Mexico driver’s license, and be free of physical or mental impairment that would adversely affect driving performance. Eligible drivers will not have any Driving Under the Influence convictions, or chargeable (at fault) accidents within the previous two (2) years;
   b. Have current CPR/First Aid certification;
   c. Be trained to implement individual-specific techniques to ensure the safe transportation of individuals who have unique medical, physical, or behavioral considerations;
   d. Non-Medical Transportation Service Provider Agency will ensure compliance with the Employee Abuse Registry requirements; and
   e. Non-Medical Transportation Service Provider agencies will comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required employees/subcontractors.

2. Vehicle Requirements:
a. All vehicles used to provide Non-Medical Transportation are required to be in compliance with state automobile insurance requirements;

b. Vehicles used to transport individuals with physical disabilities shall be accessible. Special lifts and other equipment shall be in safe working order;

c. The provider will ensure the following when transporting individuals:

i. Written procedures for reporting incidents will be kept in all vehicles used to provide non-medical transportation services;

d. Vehicles used for individuals who use wheelchairs shall have and will use locking mechanisms to immobilize wheelchairs during travel; and

e. A basic First Aid kit will be kept in all vehicles.

F. Exceptions for use of Public Transportation: The purchase of a pass for travel on public transportation does not require the Public Transportation System to be a Non-Medical Transportation Provider. Only Public Transportation Systems operated in accordance with State of New Mexico Regulations and Licensing Requirements may be used for the provision of Non-Medical Transportation services.

G. General Events Reporting: If the Non-Medical Transportation agency also provides one of the Living Supports Services, (Family Living, Supported Living or Intensive Medical Living), Customized In-Home Supports, Community Integrated Employment, or Customized Community Supports the agency must enter General Events Reporting into Therap. If the Non-Medical Transportation agency does not provide these other services the agency is not required to use GER but still must comply with requirements for reportable incidents.

4. REIMBURSEMENT

A. All Provider Agencies shall maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Providers are required to comply with the Human Services Department Billing Regulations.

B. Billable Unit:

1. The billable unit for non-medical transportation is one mile with a maximum cap of seven hundred fifty (750) dollars.

2. The billable unit for non-medical transportation (Pass/Ticket) is one dollar with a maximum cap of four hundred sixty (460) dollars.

C. Billable Activities:
1. Transportation services between locations (e.g., individual’s home and non-medical services or resources) that support activities or achievements of ISP outcomes.

2. A public transportation pass plus up to ten percent (10%) of the purchase price.

3. Transportation to locations/events stated in the scope of services.

D. Non-Billable Activities:

1. Services furnished to an individual who is:
   a. Not residing in New Mexico;
   b. Not eligible for DDW services;
   c. Hospitalized or in an institutional care setting; or
   d. Receiving Family Living, Supported Living, Intensive Medical Living, or Crisis Supports in an Alternative Residential Setting unless travel criteria are met as outlined in Section: 2.A.2.a-b.

2. Services not included in the:
   a. Scope of Services; or
   b. Individual’s approved ISP.

3. Transporting individual to Customized Community Support-Group or Community Integrated Employment-Group.

4. Mileage incurred to pick up the individual or after dropping off the individual, or any other mileage when the individual is not in the vehicle.

5. Transportation available through the Medicaid State Plan including but not limited to transportation to medical care appointments.

6. Time spent documenting mileage or maintaining the transportation log.
I. ADULT NURSING SERVICES

Adult Nursing Services are designed to meet a variety of health conditions experienced by adults receiving services on the Developmental Disabilities Waiver (DDW) Program. These services are intended to support the highest practicable level of health, functioning and independence for individuals, age twenty-one (21) and older who:

- reside in a Family Living setting;
- receive Customized In-Home Supports;
- require ANS but who do not receive Living Supports; or
- require ANS during participation in Customized Community Supports and/or Community Integrated Employment.

Adult Nursing Services are also available for young adults, age 18 through 20, who are at aspiration risk and who desire to have Aspiration Risk Management (ARM) services and are required in any circumstance where health related needs are present and those services are delivered by non-related Direct Support Personnel (DSP). This includes Substitute Care, Customized Community Supports, Customized In-Home Supports, Community Integrated Employment and people who receive Family Living services from a Surrogate Host Family.

There are two categories of Adult Nursing Service, which are described in detail in the Scope of Services.

The first category is Nursing Assessment and Consultation Services. This core nursing service provides an initial and annual comprehensive health assessment and subsequent consultation from the nurse to the individual, health decision maker/guardian and, as requested, with the team. This activity is required for all participants in Family Living, including young adults from age 18 through 20, and is available to all individuals in the service settings listed above.

The second category, Ongoing Adult Nursing Services, provides focused nursing supports that are based on the needs identified in the comprehensive health assessment. Ongoing Adult Nursing requires prior authorization and is an optional service that can be selected by individuals, their health decision maker or guardians. Several elements of ongoing Adult Nursing Services are required for certain individuals when health related supports are delivered by non-related direct support personnel in settings other than Supported Living or Intensive Medical Living services in order to comply with nursing oversight required by the New Mexico Nurse Practice Act.

Adult Nursing Services support the delivery of professional nursing services in compliance with the New Mexico Nurse Practice Act and in accordance with professional standards of practice. Adult Nursing Services are a model of nursing intended to support the individual and their family.
towards a goal of maximum practicable independence and access to the general health care system, while providing a framework of ongoing DDW nursing supports as needed.

With the exception of ARM services and Assessment and Consultation listed above, children and young adults up to the age of twenty-one (21) receive all other medically necessary nursing services through the Medicaid State Plan Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

1. SCOPE OF SERVICE

A. Nursing Assessment and Consultation Services:

1. Individuals who receive Individual Customized Community Supports and/or Community Integrated Employment and those who receive Customized In-Home Supports have the option to select Nursing Consultation and Assessment Services. Nursing Assessment and Consultation is required if the individual receives health related supports from non-related direct support personnel that require training and oversight by nursing. If selected, they are eligible for up to twelve (12) hours or forty-eight (48) units of services as listed below in I.A.2.a-e and those services indicated in I.A.3;

2. All Adults on the DDW, who reside in a Family Living setting, are eligible for up to twelve (12) hours or forty-eight (48) units of Nursing Assessment and Consultation Service. This is a required service and includes the following:

   a. Completion of an initial and annual Electronic Comprehensive Health Assessment Tool (e-CHAT), Aspiration Risk Management (ARM) Screening, Medication Administration Assessment Tool (MAAT) and any other assessments identified as relevant per prudent nurse practice. Review of the Ongoing Adult Nursing eligibility parameters and identify any Ongoing Adult Nursing Services for which the individual may qualify;

   b. Consultation with the individual, guardian, case manager and, as requested, with their Interdisciplinary Team (IDT), regarding the results of the above assessment and resulting recommendations including a discussion of plans that are required or could be considered and any indicated need for Ongoing Adult Nursing Services:

      i. If the individual receives Family Living from a family member related by affinity or consanguinity, and the individual and/or health decision maker/guardian determine that ongoing Adult Nursing Services as described in Section B of these standards are not desired, the family will provide any needed health supports or interventions based on guidance from the Primary Care Provider (PCP) or specialists. The family is responsible for sharing all information with substitute care providers. If a substitute care provider is a
surrogate (not related by affinity or consanguinity) pertinent Ongoing Adult Nursing Services must be added.

ii. Individuals in Family Living with surrogate or host families must access required components of Ongoing Adult Nursing as stated in this standard.

c. Provision of limited consultation regarding health related issues, as requested by the individual, family/guardian or team; If Ongoing Adult Nursing is not selected, such consultation shall not exceed the remaining balance of twelve (12) hours budgeted for initial/annual Nursing Assessment and Consultation Services;

d. Development of any urgently needed interim Healthcare Plan, PRN Psychotropic Medication Plan, or Medical Emergency Response Plan (MERP) per policy, pending authorization of On-going Nursing Services as indicated by health status and individual/guardian choice. Conduct training with family/Direct Support Personnel (DSP) as needed on these interim MERPs or interim Healthcare Plans. Nurses may combine any clinically appropriate topics into the interim Health Care plans based on prudent nursing practice; and

e. Documentation of all nursing activities in contact logs or progress notes. Nurses will document the results of the Consultation meeting in a nursing progress note and will summarize the individual and/or health decision maker/guardian decision to either pursue prior authorization for Ongoing Adult Nursing Services or to decline these services on the e-CHAT summary sheet. A Decision Consultation form is not needed if this benefit is declined.

3. If the individual is hospitalized or experiences a significant change of condition, the nurse may request the Case Manager to budget an additional eight (8) hours or thirty-two (32) units. These additional hours are used to:

a. Update assessments; care plans or MERPs to reflect the individual’s changed health status;

b. Create any needed interim plans;

c. Complete the Ongoing Adult Nursing eligibility parameters if indicated;

d. Conduct training with family/DSP on these changes as needed;

e. Attend hospital discharge meetings or related IDT meetings;

f. For individuals receiving Ongoing Adult Nursing Services, the nurse must ensure that discharge orders after hospitalization or a stay in a nursing home or rehabilitation center are implemented within twenty-four (24) hours and reflected via revision of the Healthcare Plan(s), PRN Psychotropic Medication Plan(s)
and/or MERPs if needed, within five (5) business days following discharge. Interim Healthcare Plans shall be put in place by the next business day for urgent issues while updating or creating Healthcare Plans, PRN Psychotropic Medication Plans and/or MERPs to reflect discharge orders. For individuals who decline Ongoing Adult Nursing Services despite the change of condition, the individual/family is responsible for implementation of discharge orders in coordination with their healthcare practitioners; and

g. Any further additional nursing hours must receive prior authorization under Ongoing Adult Nursing as outlined below.

4. Ongoing Adult Nursing Services are an array of services that are available singly or in combination to adults who require supports for specific chronic or acute health conditions. Ongoing Adult Nursing Services may only begin after the Nursing Assessment and Consultation has been completed and Prior Authorization has been approved. The services must be agreed upon by the individual and/or health decision maker/guardian and must receive prior authorization for one or more of the categories outlined in this standard. Several elements of Ongoing Adult Nursing services are required if the individual resides with surrogate or host Family Living providers or receives health related supports that require training and oversight by nursing in Customized Community Supports; Community Integrated Employment or Customized In Home supports. The nurse from the Adult Nursing Services Provider agency will complete the designated Ongoing Adult Nursing eligibility parameters in the format provided by DDSD. This shall include any additional required information that supports the need for Ongoing Adult Nursing Services, identification of the specific nursing service(s) proposed, and the anticipated number of hours required to carry out the proposed nursing services. The following services are included:

5. **Healthcare Planning and Coordination:**
   a. Provision of Healthcare Planning and Coordination is required in Family Living with surrogate families and is optional for all other eligible individuals. In addition:
      i. If the individual resides with their biological family (by affinity or consanguinity) and it is determined that Healthcare Planning and Coordination is not a desired service, the family will provide any needed health supports or interventions based on guidance from the PCP or specialists.
      ii. Participation in Customized Community Supports, Customized In Home Supports and Community Integrated Employment may be dependent upon provision of this service in cases in which the individual has a need for health related supports from direct support personnel that require training and oversight by a nurse.
b. Development, training, monitoring, and revision as needed, of Healthcare Plans which are labeled as “required” in the e-CHAT and additional Healthcare Plans labeled as “consider” in the e-CHAT and which the nurse recommends.

i. If the individual or guardian objects to particular Healthcare Plans or aspects of Healthcare Plans, these concerns shall be discussed with the individual and guardian. The nurse will work with the team to have a Decision Consultation Form completed and the Healthcare Plan(s) in question deleted or modified to reflect the individual’s/guardian’s final decision.

ii. The frequency of monitoring will be based on the individual’s needs, assessed risk, and prudent nursing practice.

c. Development, training, monitoring, and revision as needed, of MERPs labeled as “required” in the e-CHAT and additional MERPs labeled as “consider” in the e-CHAT and which the nurse recommends. The Decision Consultation process and form may be used to resolve individual/guardian concerns about MERPs;

d. Participation in annual ISP meeting and other IDT meetings where health issues are on the agenda;

e. Provision of response/consultation, as needed, for unanticipated health related events. The nurse will rely on prudent nursing practice to determine if a face to face assessment is warranted or if urgent or emergent care is needed;

f. Provision of a semi-annual nursing report to the IDT and, at least two (2) weeks prior to the annual ISP meeting, complete and distribute an electronic or paper nursing report regarding the individual’s status and outcomes of Healthcare Plans and MERPs implemented during the year; and

g. Document all related nursing activities.

6. **Aspiration Risk Management (ARM):** ARM is required in Family Living for surrogate/host families and Jackson class members and is optional in Customized In-Home Supports.

   a. Biological Family Living providers who are the Guardian for individuals at moderate or high risk, may opt out of ARM services, after the CARMP has been developed and presented to the individual and Guardian per the ARM Policy and Procedure;

   b. If the individual resides with their biological family (by affinity or consanguinity) and it is determined that ARM is not a desired service, the family will continue to provide any needed health supports or interventions based on guidance from the Primary Care Provider (PCP) or specialists. However, if the individual/biological family is receiving ARM-related therapy services, and
therefore have a Comprehensive Aspiration Risk Management Plan (CARMP), they must also budget this component of Ongoing Adult Nursing services and comply with the ARM Policy and Procedure;

c. The nurse will carry out nurse related responsibilities described in the DDSD ARM Policy and Procedure, including:
   i. Communicating with the PCP and relevant specialists;
   ii. Developing an interim ARM plan for individuals newly identified at risk;
   iii. Participating in collaborative assessments and annual reassessments with relevant therapy and Behavior Support Consultation (BSC) providers;
   iv. Attending IDT meetings related to aspiration risk management;
   v. Developing, training, monitoring, and revising, as needed, nurse sections of the CARMP;
   vi. Developing, training, monitoring and revising as needed a MERP related to the individual’s Aspiration Risk;
   vii. Responding as needed to reports of aspiration signs and symptoms; and
   viii. Documenting all related nursing activities.

7. Medication Oversight:

   a. Medication Oversight is required in Family Living for surrogate/host families. The nurse is responsible for:

      i. Communicating with the PCP and relevant specialists regarding medications and attend condition specific medical appointments as needed;
      
      ii. Monitoring and documenting the individual’s response and the effectiveness of medication;
      
      iii. Educating individual, guardian, family, and IDT regarding the use and implications of medications as needed;
      
      iv. Monitoring Medication Administration Records (MARs) for accuracy, PRN use and errors;
      
      v. Responding per the DDSD Medication Assessment and Delivery Policy and Procedure, to calls requesting delivery of PRNs from Assist with Medication Delivery (AWMD) trained DSP; surrogate or host Family Living providers
and Certified Medication Aides (CMAs). Family Living providers related by affinity or consanguinity are not required to contact the nurse;

vi. Collaborating with agency supervisors to investigate and correct medication errors; and follow up on pharmacy consultant reports; and

vii. Where CMAs are used, the Registered Nurse (RN) must assure compliance with New Mexico Board of Nursing requirements, including training and ongoing monitoring of CMA skill level and performance and response to CMA requests to deliver PRN medication.

b. Medication Oversight is optional if the individual lives independently and can self-administer their medication or resides with their biological family (by affinity or consanguinity). If it is determined that Medication Oversight is not a desired service, the family will continue to provide any needed health supports or interventions based on guidance from the PCP or specialists. If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. In addition, for Family Living participants the biological family must:

i. Communicate at least annually, and as needed, for significant change of condition with the agency nurse regarding the current medications and the individual’s response to medications for purpose of accurately completing required nursing assessments.

ii. The agency is not responsible for providing a monthly MAR unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.

iii. Medication oversight is not optional if substitute care is provided by a person who is not related by affinity or consanguinity. A MAR is required for the substitute care provider and biological families are encouraged but not required to use the MAR.

iv. Medication oversight is not optional if AWMD supports are provided in Customized Community Supports or Community Integrated Employment.

c. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not assist with the delivery of medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a CMA. Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.
8. **Nurse Delegation:**
   a. Nurse delegation shall be required in Family Living with surrogate/host families or in any Customized Community Supports, Community Integrated Employment, Customized in Home supports, substitute care, or other settings where Adult Nursing is delivered if delegation relationships exist or should be utilized. If the individual resides with their biological family (by affinity or consanguinity), delegation of nursing tasks is only relevant if the individual receives services from persons who are not related by affinity or consanguinity and the individual requires specific nursing functions that may be delegated by a licensed nurse during those services.

   b. Nurses must ensure compliance with the New Mexico Nurse Practice Act, DDSD Policies and Procedures and relevant agency policies and procedures when delegation of specific nursing functions has been granted, including:

      a. Assessing the skill level of the DSP and provision of training to a competent skill level for each delegated task;

      b. Monitoring and observing staff performance, skill level, and the individual’s health status;

      c. Rescinding delegation at any time the nurse determines that the DSP is unwilling or unable to safely perform the delegated task;

      d. Responding as needed to reports of changing condition or needs; and

      e. Documenting all delegation related activities.

9. **Medication Administration by Licensed Nurse:** Medication administration by a licensed nurse is allowed under the following circumstances:

   a. Routine administration of medication when required by DDSD Medication Assessment and Delivery Policy and Procedure, including documentation and oversight of individual’s response to those medications;

   b. As a result of discussion with the PCP, as needed, and as follow-up to pharmacy consultant reports;

   c. To respond as needed to reports of changing condition or needs;

   d. To document all related nursing activities;

   e. In addition to completion of the required designated Ongoing Adult Nursing eligibility parameters, detailed justification for administration of medication by a nurse must be submitted, indicating why medication delivery must be carried out.
by a nurse rather than by a CMA, DSP trained in “Assisting With Medication Delivery”, family member, or natural support trained by the family; and

f. This service is required in Family Living with surrogate/host families.

10. **Coordination of Complex Condition(s) (Optional All):** In addition to typical Healthcare Planning and Coordination described above, the nurse will provide ongoing support and resources to the individual, family and team as evidenced by:

   a. Frequent and ongoing assessment, coordination of health related services and monitoring of the individual’s complex medical conditions;

   b. Communicating with the PCP and relevant specialists as needed;

   c. Analyzing the response to and the effectiveness of interventions and adjustment of the care plan(s), PRN Psychotropic Medication Plan(s), and MERPs as needed;

   d. Educating the individual, guardian, family, and team regarding the implications of the complex condition;

   e. Attending condition specific medical appointments, as needed;

   f. Performing nursing tasks consistent with practitioner orders for interventions or treatments which the nurse is not electing to delegate;

   g. Responding as needed to reports of changing condition or needs;

   h. Serving as a resource for accessing information or supports; and

   i. Documenting all related nursing activities.

**B. Service Limitations:**

1. Adult Nursing Services beyond Nursing Assessment and Consultation must meet eligibility criteria and prior authorization;

2. Individuals cannot receive Adult Nursing Services during Supported Living or Intensive Medical Living Services since nursing is fully bundled into those services;

3. For Medication Administration prior authorized under 1.B.6 in Scope of Services, such administration may only be billed at the LPN rate, regardless of whether the medication was administered by a RN, LPN or CMA. Customized Community Supports- Group agency nurses are expected to administer such medication if needed during that service and so administration in that setting is not eligible for this Adult Nursing service; and
4. Any individual who operates or is an employee of the Adult Nursing Services provider shall not serve as guardian for that individual, except when related by affinity or consanguinity [45-5-31(1) A NMSA(1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

2. SERVICE REQUIREMENTS

A. Adult Nursing Services: Adult Nursing Services are provided by RNs or LPNs that are licensed to practice in the state of New Mexico. LPNs may only work under the supervision of a RN as required by the New Mexico Nurse Practice Act.

B. Individuals Receiving Living Supports- Family Living Services: For individuals receiving Family Living Services, the following requirements apply:

1. Nursing Assessment and Consultation Services, listed in Nursing Assessment and Consultation Services, shall be budgeted and provided for all recipients of Family Living.

2. Healthcare Planning and Coordination is required in Family Living with surrogate/host families. Individuals/health decision makers/guardians may utilize the Decision Consultation process as needed.

3. For individuals receiving Family Living Services from a surrogate family and who take routine or PRN medication, Ongoing Nursing Services for Medication Oversight shall be budgeted and provided. The nurse may choose to delegate medication delivery per the DDSD Medication Assessment and Delivery Policy and Procedure and the New Mexico Nurse Practice Act.

4. For individuals receiving Family Living Services who reside with a surrogate/host family and/or that are Jackson class members and are at moderate or high risk of aspiration, Ongoing Nursing Services for ARM shall be budgeted and provided.

5. For individuals receiving Family Living Services from a surrogate/host family, Nurse Delegation must be requested for those individuals whose Family Living staff is currently in a delegation relationship under DDSD policy and procedures or who require specific nursing functions that, per the nurses’ discretion, need to be delivered under a delegation relationship.

C. For Individuals Receiving Ongoing Nursing Services for Health Care Plans and MERPs:
1. The agency nurse shall create Healthcare Plans for each individual that address all areas identified as “required” as a result of the most current e-CHAT, indicated by an “R” on the e-CHAT summary report and in compliance with the Electronic Comprehensive Health Assessment Tool Policy. At the nurse’s sole discretion, based on prudent nursing practice, Healthcare Plans may also be developed for any or all of the areas that should be “considered” for care planning, indicated by “C” on the e-CHAT summary report. In addition, the agency nurse may develop any other Healthcare Plans that they determine are warranted. Nurses may combine issues into related Healthcare Plans as clinically appropriate. Each Healthcare Plan must:

a. Include a statement of the individual’s healthcare needs and list measurable goal(s) to be achieved through implementation of the Healthcare Plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize, or manage existing health conditions;

b. Contain goals that are measurable. Goals should be revised when an individual has met the goal and has the potential to attain additional goals. Goals may be achievement, maintenance, or palliative in nature;

c. Have interventions/strategies described in the plan that are individualized to reflect the individual’s unique needs, subtle signs and symptoms if applicable, and to provide guidance to the DSP, and are designed to support successful interactions. Some interventions may be carried out by DSP, family, or other team members; other interventions may be carried out exclusively by the nurse. Persons responsible for each intervention/strategy shall be specified in the plan by discipline/title, and, therefore, interventions/strategies shall be written in language easily understood by the person responsible for implementation;

d. Include the individual’s name and date of birth on each page. Each Healthcare Plan shall be signed and dated by the registered nurse author or by the RN supervisor for an LPN authored plans and in case of the CARMP by members of the collaborative team;

e. Health care plans must be created/updated within 5 business days of admission, annual assessment, admission, readmissions or significant change in health status;

f. Ensure that for individuals at moderate or high acuity receiving Adult Nursing Services, each Healthcare Plan or CARMP must be reviewed at least every six (6) months to determine its effectiveness and revised as needed (e.g., as goals are achieved, circumstances changes or new strategies are identified). Such review and revisions must be documented;
g. Ensure DSP are trained prior to working alone on a shift and at least annually regarding when and how to implement the HCP; such training shall be documented, clearly indicating resulting competency level (awareness, knowledge, or skill) for each trainee. Retraining will occur as needed based on the nurse’s judgment and performance by the DSP;

h. Require that if the HCP is revised, the nurse shall assure that DSP are trained and the revised copy is replaced at the service delivery site with the new date indicated and the old version is removed from the service delivery site;

i. Provide that the nurse may designate a competent person to train all or part of a plan that they have authored. The nurse must use prudent nursing practice to determine which sections of a plan may be trained by a designee. A designee may not train any portion of a plan that is a delegated nursing function;

j. Ensure that a summary report of the individual’s current health status, including comments about the care plan review and the individual’s progress towards planned goals, shall be provided to the IDT on at least a semi-annual basis and quarterly for Jackson Class members; and

k. Ensure that Healthcare Plans are updated within five (5) business days after hospitalization or significant change of condition. This includes incorporation of any additional required areas identified in the updated e-CHAT. Interim Healthcare Plans shall be put in place by the next business day for urgent issues while updating to reflect discharge orders.

2. For recipients of Ongoing Adult Nursing Services who have a chronic condition with the potential to exacerbate into a life-threatening situation, a MERP must be written by the nurse or other appropriately designated health professional consistent with the DDSD Medical Emergency Response Plan Policy and Procedures. DSP must be trained prior to working alone on a shift and at least annually regarding when and how to implement the MERP; such training shall be documented, clearly indicating resulting competency level for each trainee. The following requirements shall be met:

a. The MERP shall include the individual’s name and date of birth on each page and the MERP shall be signed by the author;

b. On at least a semi-annual basis, the nurse shall review the MERP to determine how many times it was implemented and whether the MERP needs to be revised. Such review shall be documented; and

c. If the MERP is revised, the nurse shall assure that DSP are trained and the revised copy is replaced at the service delivery site with the new date indicated and the old version is removed from the service delivery site.
D. For Individuals Receiving Any Ongoing Nursing Services.

1. The nurse shall ensure for individuals receiving any Ongoing Nursing services that:

   a. Each individual has a licensed PCP, and receives an annual physical examination and specialty medical care as needed, including an annual dental checkup by a licensed dentist for those with teeth or dentures;

   b. All practitioner orders are carried out until discontinued. If orders cannot be implemented as directed, the ordering practitioner must be notified within three (3) business days. (If the reason an order cannot be implemented is due to individual or guardian refusal, a Decision Consultation Form must be completed in consultation with the practitioner. Based on the final decision the order shall be reinstated, altered or discontinued);

   c. If an RN determines, based on prudent nursing practice, to hold a practitioner order they must document the circumstances and rationale and notify that practitioner by the next business day; and

   d. Practitioner recommendations shall be considered by the individual and their guardian/health decision maker in consultation with the IDT and implemented unless a DDSD Decision Consultation Form is completed indicating an informed decision not to implement the recommendation.

2. Based on the individual’s needs, diagnosis, health care plan and prudent nursing practice, nurses will deliver such direct services necessary to address the individual’s clinical needs, and support health and safety;

3. The nurse may attend physician, specialist visits or other medical appointments as indicated to provide support and planning for complex needs;

4. Oversight and monitoring of the individuals and DSP staff training will be done in accordance with orders, Healthcare Plans and prudent nursing practice;

5. Nurses will provide such education and guidance as necessary, based on the individual’s health needs, diagnosis, health care plan and prudent nursing practice; and

6. Nurses will deliver and document these efforts in designated documents or in progress notes according to DDSD policy.

E. Documentation Requirements For All Adult Nursing Services:

1. Documentation of all professional nursing activities in an accurate manner in accordance with established standards and State and Agency policies and procedures. This includes assessments, plans, progress notes and reports;
2. For individuals receiving Ongoing Adult Nursing services, nurses will provide teams with a semi-annual nursing report that discusses the services provided and the status of the individual over the last six (6) months. This may be provided in an electronic or paper format to the team no later than two (2) weeks prior to the ISP and semi-annually;

3. Nursing visits conducted to monitor health status or to evaluate a change of clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual’s complaints, observations reported or noted by DSP, family, or other team members; objective information including apparent signs/symptoms; vital signs, physical examination, weight and other pertinent data for the given situation (e.g. frequency of seizures, method by which temperature was taken); assessment of the clinical status and plan of action addressing relevant aspects of all active health problems; and follow up on any recommendations of medical consultants;

4. The nurse must complete legible, signed progress notes or logs with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. Any phone interactions with DSP which occur between visits must also be documented by the nurse in a signed progress note/log indicating time, date, reason for the call including complaints reported by the individual or observations reported by the DSP and any instructions given;

5. Documentation may be handwritten, typed and printed or in an electronic format; and

6. Out of sequence charting will be noted according to standard documentation practices.

F. Collaboration With IDT, Clinicians and Others As Needed:

1. When Nursing Assessment and Consultation Services or Ongoing Adult Nursing Services includes attendance at an IDT meeting, the nurse shall attend in person or by phone. If, due to unavoidable scheduling conflict, the nurse cannot attend in person or by phone, the nurse must arrange to have critical health related information provided to the IDT in advance and then follow up with the case manager afterward to identify needed follow up activities;

2. The nurse will collaborate with other clinical service providers such as nurses from Customized Community Supports, Home Health, or Hospice agencies as needed. This collaboration with other agencies requires timely and professional communication and planning to assure maximum consistency across settings;
3. When Hospice services are utilized, DDW agency nurses must develop new or edit existing Healthcare plans and MERP’s to reflect the individual's condition and end of life decisions made by the individual or health decision maker/guardian in order to provide guidance to the DSP regarding hospice or palliative care efforts. The DDW agency nurse is responsible for training the DDW DSP;

4. The nurse will collaborate with other clinicians including those on the IDT, physicians, dentists, and other specialists; and

5. The nurse may attend medical or other appointments as warranted per professional nursing judgment.

G. For Individuals Receiving Ongoing Nursing Services for Medication Oversight or Medication Administration:

1. Nurses will follow the DDSD Medication Administration Assessment Policy and Procedure;

2. Nurses will administer medications when required by DDSD policy such as medications by IV, injection or NG tube, non-premixed nebulizer treatments, or new prescriptions that have an ordered assessment for each dose until the individual is stable;

3. Nurses will be contacted prior to the delivery of PRN medications by DSP, including surrogate Family Living providers, who are not related by affinity or consanguinity that have successfully completed AWMD or CMA training. Nurses will determine whether to approve the delivery of the PRN medication based on prudent nursing judgment;

4. Nurses must complete or oversee the development of the monthly MAR and will review the MAR monthly for accuracy of transcription of orders for the upcoming month, and to be aware of changes to the MAR:

   a. Nurses must also review MARs to identify patterns of medication errors; Nurses may periodically observe delivery of medication by DSP in order to determine accuracy and quality of delivery. The need for and frequency of this observation is up to the individual nurse;

   b. Nurses shall collaborate with agency supervisors to investigate and correct any identified patterns of medication errors. Nurses will periodically review the utilization of PRN medications, looking for appropriate documentation for the response to the medication, resolution of problems, patterns of use, and possible relationships or links with underlying illnesses, conditions or occurrences;
c. Participate in following up on issues identified in the Pharmacy consultant reports as needed; and

d. MARs are not required for individuals served by their biological family if they have opted out of Ongoing Adult Nursing services related to Medication oversight.

5. Nurses will address the individual’s response to their medication regime in the e-CHAT at least annually and more frequently as needed, indicating the delivery method, significant medication changes, and noting presence or absence of positive or negative responses, known interactions or allergies;

6. Nurses will communicate as needed with the pharmacy consultant regarding any actions needed to address findings in the pharmacy report. Nurses may participate in delivery of AWMD training and monitoring; and

7. Nurses must assure compliance with New Mexico Board of Nursing requirements for Supervision of CMAs in agencies where CMA’s are utilized.

H. Discharge Summary: When Ongoing Nursing Services are no longer needed, the nurse shall compose a nursing discharge summary and provide it to the case manager within ten (10) business days of the decision for discharge. The report may be electronic or paper format. The report must note an overview of the individuals stay in service and their overall health status at time of discharge.

I. Change of Providers: When an individual changes providers, or waiver programs, it is the responsibility of both the existing and new provider to ensure that safe and appropriate planning takes place. An IDT meeting to develop a transition plan shall be held to address exchange of health-related information, individual preferences and required documentation, training of staff, and moving logistics.

3. AGENCY REQUIREMENTS

A. Adult Nursing Service Providers are accountable for the appropriate delivery of nursing services identified in the Scope of Service and Service Requirement sections of this standard in order to assure the individual’s health and safety.

B. All providers of Adult Nursing Services must offer and deliver these services in accordance with pertinent sections of the New Mexico Administrative Code, the New Mexico Nurse Practice Act, and DDSD policies and procedures.

C. Adult Nursing Services must be offered and provided by all Family Living providers.

D. All providers of Adult Nursing Services must assure that nurses providing this service hold a current RN or LPN license with the New Mexico State Board of Nursing. LPNs must be supervised by an RN per the New Mexico Nurse Practice Act.
E. All providers of Adult Nursing Services must ensure that nurses working for the agency complete the following training upon hire or assignment to these services within timeframes listed below:

1. DSDD Nurse Orientation and Healthcare Planning modules within ninety (90) calendar days;

2. Observation of the full two (2)-day “Assisting with Medication Delivery” course to gain awareness of expectations for the DSP that assists with medication delivery within one hundred eighty (180) calendar days; and

3. Within twelve (12) months of hire complete training for ARM; Effective Individual Specific Training, and Person Centered Planning.

F. All providers of Adult Nursing Services must designate an RN who is the head nurse for the agency and who is responsible for ongoing supervision of the nursing department. The DDSD Regional Office must be given contact information and notified when turnover occurs. A RN will supervise those services delivered by LPNs and CMAs as required by the New Mexico Nurse Practice Act. Such supervision must include periodic face-to-face interaction and observation.

G. The RN who is the head nurse for the agency must hold a current New Mexico license; must reside in New Mexico or if residing in a neighboring state must not live more than one (1) hour away from the New Mexico border.

H. Agencies that contract for nursing services must ensure that the nurse contractor is available, aware of and in compliance with all nursing standards.

I. Adult Nursing Providers must assure twenty-four (24) hour access to an on call nurse to provide support, consultation or direction to individuals and DSP. An LPN may take call but must have an RN backup for consultation as needed. It is expected that no single nurse carry the full burden of on call duties for the agency.

J. Compliance With New Mexico Nurse Practice Act and DDSD Policies and Procedures Regarding Delegation of Specific Nursing Functions:

1. Provider agencies must develop and implement policies and procedures regarding delegation which must comply with relevant DDSD Policies, Procedures and the New Mexico Nurse Practice Act that is described in the Scope of Service section in this standard. Agencies must ensure that all nurses they employ are knowledgeable of all these requirements;

2. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office;
3. Delegation is a unique relationship between a nurse and a DSP that cannot be mandated and cannot be transferred between nurses or between DSP. If a staff nurse or DSP is no longer employed by the agency, the delegation relationship is nullified; and

4. Delegation is not necessary if the DSP or Family Living Provider is related to the individual by affinity or consanguinity.

K. Nursing Home Drug Control (NMAC 16.19.11) Requirements: Home Health Agencies or Independent Nursing Providers must be aware of and support the NMAC 16.19.11 in appropriate settings. All other Adult Nursing providers must be in compliance NMAC 16.19.11 Nursing Home Drug Control to be licensed by the Board of Pharmacy per current NMAC regulations for twenty-four (24)-hour residential homes serving two (2) or more unrelated individuals (defined as a Licensed Custodial Care Facility) and meet all applicable standards including:

1. The organization of pharmaceutical services;
2. Policies and procedures;
3. Ordering, administration, maintenance and disposal of drugs;
4. Pharmacy license requirements for residences; and
5. Pharmacist Inspection reports for the home.

L. Adult Nursing Services providers must have written policy and procedures that assure compliance with all nursing documentation requirements listed in this standard.

M. Adult Nursing Services providers must have written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Administration Assessment Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.

N. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to
improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:
      
      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
      
      ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

   b. Compliance with Caregivers Criminal History Screening requirements;

   c. Compliance with Employee Abuse Registry requirements;

   d. Compliance with DDSD training requirements;

   e. Patterns in reportable incidents;

   f. Sufficiency of staff coverage;

   g. Patterns in medication errors;

   h. Action taken regarding individual grievances;

   i. Presence and completeness of required documentation; and

   j. Significant program changes.
3. **Preparation of the Report**: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

O. Adult Nursing Services providers will assure required staff has a current and clear criminal background screening.

4. **REIMBURSEMENT**

A. All Adult Nursing Services providers shall maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Adult Nursing Services provider’s records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Adult Nursing Services provider, nature of services, and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.

B. **Billable Unit**: The billable unit for Adult Nursing Services is a fifteen (15) minute unit.

C. **Billable Activities**:

1. All services delivered by a registered or licensed practical nurse that:
   
   a. Are included in the individual’s approved ISP;
   
   b. Are provided in accordance with the Scope of Services;
   
   c. Have received required prior authorization; and
   
   d. Activities included in billable services, activities or situations.

D. **Non-Billable Activities include**:

1. Services furnished to an individual who is:
   
   a. Not residing in New Mexico;
   
   b. Not eligible for DDW services;
   
   c. Hospitalized or in an institutional setting;
   
   d. Under twenty-one (21) years of age; or
e. Receiving Supported Living or Intensive Medical Living Services, or Crisis Supports in an Alternative Residential Setting.

2. Nursing services eligible for payment under the Medicaid State Plan;

3. Respite and non-treatment visits;

4. Time spent on the following activities:
   a. Writing or updating reports, progress notes and logs;
   b. Missed appointments;
   c. Employer activities including administrative duties, employer staff meetings or meetings with supervisors that are not client specific, and routine paperwork including billing documentation;
   d. Professional development or continuing education activities;
   e. Receiving individual-specific training from other professionals;
   f. Traveling to or from any service site; and
   g. Participation in client assessment not performed by the nurse.
CHAPTER 16
NUTRITIONAL COUNSELING SERVICES

I. Nutritional Counseling Services

Allows for the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan that supports the individual to attain or maintain the highest possible level of health. Nutritional Counseling Services are in addition to and shall not duplicate those nutritional or dietary services allowed in the individual’s Medicaid state plan benefit, or other funding source.

1. SCOPE OF SERVICE:

Nutritional Counseling Services shall include but not be limited to:

A. Perform assessment/evaluation of individual nutritional needs annually or as needed due to a change of condition;

B. Participate in collaborative assessment for individuals identified at moderate or high risk for aspiration;

C. Develop a nutritional plan, revising annually or as warranted by change of condition;

D. Educate the individual to manage their own dietary needs via counseling and other nutritional interventions;

E. Provide training and consultation to Interdisciplinary Team (IDT) members, Direct Support Personnel (DSP) and other relevant parties on implementation of the individual’s nutritional plan and/or relevant aspects of the Comprehensive Aspiration Risk Management Plan (CARMP) if applicable; and

F. Monitor the effectiveness of the nutritional plan, adjusting plan content and strategies as indicated.

2. SERVICE REQUIREMENTS


B. Attend any IDT meetings by physical presence or conference call, especially those related to issues with weight, tube feedings, managing endocrine needs, aspiration risk including initial and ongoing CARMP and wound care as well as other IDT meetings when specific dietary related concerns on are the agenda.
C. Nutritional Counseling shall be provided in a manner consistent within professional scope of practice and within established code of conduct.

D. Service Limitations:

1. Nutritional Counseling Services are included in reimbursement for Family Living, Supported Living, and Intensive Medical Living Services and are therefore not reimbursable separately for individuals receiving those services.

2. Nutritional Counseling is provided individually, not with a group of recipients.

3. Nutritional Counseling may be provided in the same setting and at the same time as another service.

3. AGENCY REQUIREMENTS

A. Reporting: Progress Reports: The Nutritional Counseling Provider must submit a written semi-annual report to the Case Managers and IDT members that summarizes progress toward nutritional goals outlined in the nutritional plan and/or CARMP. This report shall address the extent to which nutritional interventions are successful in supporting the individual’s health (e.g. has increased fiber been successful in reducing chronic constipation, has caloric intake been successful in reaching/maintaining target weight, has specialty diet contributed toward improved management of chronic disease). These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point.

B. Providers of Nutritional Counseling Services ensure that employees delivering this service maintain:

1. Relevant licensure or certification requirements; and

2. Act within their recognized professional code of conduct.

C. Client Records: The Nutritional Counseling Provider shall develop, maintain, and supply the following documents as requested or required for individuals receiving services:

1. The initial and annual evaluation or assessment;

2. Nutritional plan;

3. Semi-annual report;

4. Input given regarding collaborative CARMP, teaching and support strategies, Healthcare Plans, or other support plans as relevant;
5. Progress notes regarding contacts, consultation, and monitoring;

6. Rosters for training delivered;

7. Consent to release information as applicable; and

8. Signed secondary freedom of choice form, selecting the Nutritional Counseling Provider.

4. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance:

   b. The entities or individuals responsible for conducting the discovery/monitoring process;

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:

      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
ii. Outcome statements for each life area are measurable and can be readily
determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report
annually from the QA/QI Plan by February 15th of each calendar year. The report must
be sent to DDSD, kept on file at the agency, and made available upon request. The
report will summarize the listed items above.

5. **REIMBURSEMENT**

A. **Required Records:** The Nutritional Consultation Services Provider must maintain all
records necessary to fully disclose the type, quality, quantity and clinical necessity of
services furnished to individuals who are currently receiving services. The Nutritional
Consultation Services Provider Agency records must be sufficiently detailed to
substantiate the date, time, individual name, servicing provider, nature of services, and
length of a session of service billed. Providers are required to comply with the New
Mexico Human Services Department Billing Regulations.

B. **Billable Unit:** The billable unit for Nutritional Consultation Services is a fifteen (15)
minute unit.

C. **Billable Activities:**

1. Nutritional Counseling Services delivered consistent with the scope of service,
including attendance at IDT meetings; and

2. Included in the individual’s approved ISP.
D. Non-Billable Activities:

1. Services furnished to an individual who is:
   a. Not residing in New Mexico;
   b. Not eligible for DDW services;
   c. Hospitalized or in an institutional care setting; or
   d. Receiving Family Living, Supported Living, or Intensive Medical Living services.

2. Services not included in the:
   a. Scope of Services; or
   b. Individual’s approved ISP.

3. Time spent on the following activities:
   a. Missed appointments;
   b. Writing or updating reports, progress notes, and logs;
   c. Employer activities including administrative duties, employer staff meetings or meetings with supervisors that are not client specific, and routine paperwork including billing documentation;
   d. Professional development and continuing education activities; and
   e. Traveling to or from any service site.
CHAPTER 17
PERSONAL SUPPORT TECHNOLOGY

I. Personal Support Technology

Personal Support Technology Service is an electronic monitoring device or system that supports individuals with developmental disabilities to be independent in the community or in their place of residence with limited assistance or supervision by paid staff. Examples of electronic monitoring devices include but are not limited to electronic medication boxes, electrical vital signs monitors, and remote video cameras.

1. SCOPE OF SERVICE

   A. Personal Support Technology shall include, but is not limited to:

   1. Installation of electronic devices;
   2. Rental of electronic device;
   3. Maintenance fee for the electronic device;
   4. Daily/monthly monitoring charges;
   5. Educating the individual and their family or direct support personnel in the use of the device; and
   6. Staff paid to provide assistance in response to events identified through monitoring, unless a natural support has been pre-arranged to provide such response.

2. SERVICE REQUIREMENTS

   A. Response to the need for assistance: When the monitoring service/device indicates that the individual with developmental disabilities needs assistance, on-call supports shall be promptly available to provide assistance. Such response may consist of an on-site visit, phone guidance to the individual, or calling 911 on behalf of the individual, depending upon the nature of the situation. On-call supports shall be delivered by paid staff of the Personal Support Technology Provider unless a natural support has committed to provide such response when needed.

   B. Exclusions and Restrictions: Non-Waiver funds shall not be permitted to upgrade or augment the monitoring system.

   C. General Events Reporting: The Personal Support Technology Provider shall enter General Events Reporting into Therap if response to need for assistance from paid staff

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includes calling 911 or relates to one of the other significant events requiring GER submittal.

3. AGENCY REQUIREMENTS

A. Personal Support Technology Service providers must make available consumer friendly informational materials that outline their products, product reliability and costs.

B. The Personal Support Technology Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

C. Provider/Agency Records: The Personal Support Technology provider will maintain documentation in the form of a log to include:

1. Proper identification included on all pages of documents;

2. Description of expenditures including signature of authors on all documents;

3. Expenditure amounts for the following categories:
   a. Installation cost;
   b. Rental costs;
   c. Maintenance expenditures;
   d. Monitoring charges; and
   e. Response (fifteen (15) minute increments) for staff that support the individual when the device is activated.

4. Receipts for all above must be maintained including any estimates that have been received;

5. Upon request the Personal Support Technology Provider will submit a copy of the Personal Support Technology response log to the Case Manager; and

6. The Personal Support Technology Provider shall develop and implement policies and procedures that comply with these standards.

4. REIMBURSEMENT

A. All Personal Support Technology/Onsite Response Provider Agencies shall maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The provider agency
records shall be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. **Billable Unit:**

1. The reimbursement unit for installation, rental, and/or maintenance of electronic devices is one (1) dollar.

2. Reimbursement for staff to respond when individual needs assistance is a fifteen (15) minute unit equal to the rate established for Customized In-Home Supports Aide.

C. **Billable Activity:**

1. Purchase of monitoring device(s);

2. Installation of monitoring device(s);

3. Educating individual and their family and/or direct support personnel on use of monitoring device(s);

4. Monitoring of the individual’s status via installed devices; and

5. On call response when the device is activated indicating a need for assistance.

D. **Service Limitations:** This service is limited to a one time installation fee and ongoing monitoring up to $2,500 per ISP year.

E. **Non Billable Services, Activities or Situations:**

1. Services provided to an individual who is:
   
   a. Not residing in New Mexico;
   
   b. Not eligible for DDW services; or
   
   c. Hospitalized or in an institutional care setting.

2. Services not included in the:

   a. Scope of Services; and

   b. Individual’s approved ISP.
CHAPTER 18

PRELIMINARY RISK SCREENING AND CONSULTATION RELATED TO INAPPROPRIATE SEXUAL BEHAVIOR (PRSC)

I. Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior (PRSC)

This service is part of a continuum of behavior support services (including Behavioral Support Consultation (BSC) and Socialization and Sexuality Services) that promote community safety and reduce the impact of interfering behaviors that compromise the quality of life. This service is provided by a trained licensed mental health professional that is approved as a Risk Evaluator by the Bureau of Behavioral Support (BBS) for this service. The PRSC service provides, through a structured risk screening process:

   A. Identification of individual level and type of risk for inappropriate sexual behavior;

   B. Strategies for risk management under the least restrictive supervision conditions; and

   C. Technical assistance related to the management of risk.

1. SCOPE OF SERVICE

   A. Identification of level of risk may include the following components:

      1. Preliminary risk screening and preliminary risk screening report;

      2. Consultation notes;

      3. Periodic case review; and

      4. Case consultation with Bureau of Behavioral Support (BBS) staff, consultant(s) or a designee.

   B. Technical assistance provided by the Risk Evaluator may include, but is not limited to:

      1. Development and refinement of risk management strategies;

      2. Determination of periodic need to review risk based on the clinical expertise of the Risk Evaluator in risk screening/management and the individual’s circumstances;
3. Assistance to the Behavior Support Consultant or team for an individual requiring a Risk Management Plan (RMP);

4. Recommendations regarding reduction of supervision; and

5. Consideration of risk associated with vulnerable others (e.g., related to current roommates or changes in roommates, attendance at day programs, etc.)

C. Prior Authorization: Must be obtained through the BBS in accordance with Policy S-001a and Procedure SP-001a: Support for Individuals with Intellectual/Developmental Disabilities (I/DD) Who Exhibit or Have Exhibited Sexually Inappropriate/Offending Behavior.

D. Requirements for the Risk Evaluator: The Risk Evaluator must:

1. Engage in activities necessary to collect information to complete a preliminary risk screening report, revised report, and/or consultation notes per the BBS-approved templates including recommendations regarding measurable goals and a system of implementation; and

2. Interface with BBS following completion of a screening or periodic case review in the following ways:
   a. Provide reports and/or consultation notes to the referring team and BBS in a timely fashion; and
   b. Participate in any mandated BBS-sponsored trainings and meetings.

2. SERVICE REQUIREMENTS

A. Qualifications for the Risk Evaluator: This service is provided only by a Risk Evaluator approved by the BBS. Each professional shall provide documentation to BBS of completion of the following qualifications to be considered for provider application approval:

1. A master’s or doctoral degree in a counseling or counseling-related field from an accredited college or university;

2. A current independent practice license, through the Board of the New Mexico Regulation and Licensing Department (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners) in a counseling or counseling-related field;

3. At least two (2) years of clinical experience working with individuals with intellectual/developmental disabilities;
4. At least one (1) year of clinical experience working with individuals with intellectual/developmental disabilities who have inappropriate sexual behaviors;

5. Have demonstrated a willingness to work collaboratively with BBS, consultants, and teams; and

6. Have demonstrated a commitment to maintaining competency (through documented reading, conference attendance or training) of best practice in the field of risk screening and management of individuals with intellectual/developmental disabilities who exhibit sexually inappropriate or offending behavior.

B. Pre-requisite Requirements: The professional shall provide documentation to BBS of completion of the following activities:

1. Notification to BBS in writing of interest in providing the service;

2. Participation in an initial interview with BBS or designated BBS consultant to determine whether qualifications have been met to be accepted into pre-requisite training; and

3. Participation in at least two (2) screenings with a BBS-approved Risk Evaluator (i.e., reviews information prior to screenings, attends screenings, debriefs, reads, and discusses consultation notes or report with the Risk Evaluator).

C. Preliminary Competency Review: After meeting the qualifications and pre-requisite requirements, the professional will complete the provider application for the service and interview with BBS for a preliminary competency review to determine whether Provisional (twelve (12) months) Provider Approval will be granted.

D. Provisional Approval: If granted Provisional Provider approval, to become a BBS-approved Risk Evaluator within twelve (12) months, the provisional Risk Evaluator will:

1. Facilitate at least four (4) risk screenings with on-site supervision by a BBS-approved Risk Evaluator (case preparation, interview(s), draft consultation notes or report, and feedback to teams);

2. Complete at least twenty (20) hours of additional supervised independent training and reading related to risk screening and treatment of individuals with intellectual/developmental disabilities who exhibit sexually offending behaviors;

3. Demonstrate continued ability to work collaboratively with BBS and teams; and

4. Participate in a competency review with BBS to determine whether requirements for full BBS approval in this area have been met.
E. **Supervision and Training Requirements for BBS-approved Risk Evaluators:**

1. Participate in ongoing supervision as per Procedure SP-001a: Support for Individuals with Intellectual/Developmental Disabilities (I/DD) Who Exhibit or Have Exhibited Sexually Inappropriate/Offending Behavior. Depending on the competency of the Risk Evaluator, supervision may be a combination of telephone and on-site contact, report and document review, and continued on-site co-facilitation of risk screenings; and

2. Participate in regular, mandatory update trainings at least annually with the BBS-designated trainer.

F. **Service Limitations:**
   
   1. Receiving BSC from the Risk Evaluator.

3. **AGENCY REQUIREMENTS**

   **A.** The PRS Provider Agency shall comply with all applicable federal, and state rules as well as DOH / DDSD policies and procedures.

   **B.** The agency providing the PRSC service is required to submit the following information to the BBS:

   1. Documentation that the designated Risk Evaluator has met qualifications and completed all requirements; and

   2. Assurance that the qualified BBS-approved Risk Evaluator will provide the service personally.

   **C.** **Quality Assurance and Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

   1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or process related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the
individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process:

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. For PRSC services, QA/QI plan benchmarks and review activities should include at least the following:

a. Adherence to BBS standards, policies and procedures regarding delivery of services, in the:

1. timeliness and quality of the documentation;

2. extent that PRSC services are delivered in accordance with the individual’s ISP (do the services support the individual’s vision, meaningful day and desired outcomes? If not, why not?); and

3. effectiveness of the implementation, in part, indicated by trends in achievement of the individual’s desired outcomes.

b. Compliance with DDSD training requirements;

c. Analysis of trends in data (individual and/or systemic) including, if applicable, incidents related to sexually inappropriate and offending behavior; and

d. Descriptions of actions taken:

1. regarding individual grievances; and

2. to make significant systemic improvements.

e. The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. REIMBURSEMENT
A. All Provider Agencies providing the PRSC service must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Preliminary Risk Screening Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. Billable Unit: The billable unit is a fifteen (15) minute unit/rate specified in the current Medicaid Supplement Rate Tables for the DDW. There are two rates for the PRSC:

1. **The Standard Rate;** and

2. **The Incentive Rate:** The Incentive rate may be applied to PRSC services that are provided in a county or area designated by the DDSD as underserved for DDW PRSC services. An official list of such counties/areas will be published by the DDSD according to established criteria and revised/distributed at least annually.

C. Billable Activities: Billable activities may include:

1. Facilitation of risk screening meetings;

2. Consultation with team members, including attendance at IDT meetings subsequent to the risk screening meeting;

3. Interview of the individual being evaluated;

4. Review of relevant records;

5. Consultation with BBS staff or BBS consultant;

6. Consultation to teams and BSC on implementation of recommendations, development of risk management strategies and/or Risk Management Plans; and

7. Other activities directly related to evaluating and managing risk as outlined in the Scope of Services and the individual’s ISP.

D. Non-Billable Services, Activities or Situations:

1. Services furnished to an individual who is:
   a. Not residing in New Mexico;
   b. Not eligible for DDW Services;
c. Hospitalized or in an institutional care setting; or

2. Activities eligible for payment under the:
   a. BSC Service of the DDW; and
   b. The Medicaid State Plan including mental health services provided by counselors, therapists, psychotherapists or psychiatrists.

3. Time spent on the following activities:
   a. Writing progress notes or logs;
   b. Participating in client assessments not performed by the Risk Evaluator;
   c. Missed appointments;
   d. Employer activities including administrative duties, routine paperwork including billing documentation, employer staff meetings, or meetings with supervisors that are not client specific;
   e. Professional development or continuing education; and
   f. Traveling to or from any service site.
CHAPTER 19
RESPITE SERVICE

I. Respite Service

Respite is a flexible family support service. The primary purpose of respite is to provide support to the individual and give the primary-unpaid caregiver time away from their duties. Respite services include assisting with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating), enhancing self-help skills, increasing social and community awareness; providing opportunities for leisure, play, neighborhood involvement and other recreational and social activities; and providing opportunities for the individual to make their own choices with regard to daily activities.

1. SCOPE OF SERVICE

   A. General: The scope of respite services include, but are not limited to, the following:

      1. Training and assistance for community integration, including implementation of preferential meaningful activities;

      2. Assistance in developing and/or maintaining social, spiritual and individual relationships, including the development of generic and natural supports of the individual’s choosing;

      3. Assistance in implementing Therapy Written Direct Support Instructions (WDSI), Comprehensive Aspiration Risk Management Plan (CARMIP), Medical Emergency Response Plan (MERP), Positive Behavior Support Plan (PBS), Healthcare Plans, and Behavior Crisis Intervention Plan (BCIP) (if any);

      4. Assistance in implementing health maintenance supports and accessing medical urgent care when needed; and

      5. Assistance with medication management needs to include only reminding, observing and monitoring self-administration of medication. Medication administration is not a respite service and must be arranged for separately by the primary caregiver.

2. SERVICE REQUIREMENTS

   A. General Requirements:

      1. Respite services are available to any individual of any age living with an unpaid primary caregiver including Customized In-Home Supports living with Family unpaid.
2. The use of respite services is determined by the primary caregiver in consultation with the Interdisciplinary Team (IDT) and recorded in the individual’s Individual Service Plan (ISP).

3. If respite is the only service included in the ISP other than Case Management, for an adult age twenty-one (21) or older, the following requirements must be met:

   a. The IDT shall complete a Decision Justification Document to explain why respite alone is the appropriate service delivery approach for the individual. This document must be attached to the ISP; and

   b. The respite provider agency must submit quarterly progress reports to the Case Manager that describe progress on the action plan(s) and desired outcome(s).

B. Service Provision: Respite is provided on an one-to-one (1:1) basis or in groups of no more than five (5).

C. Service Restrictions: Individuals receiving Family Living, Supported Living, Intensive Medical Living Services, and Customized In-Home Supports living independently (not with a family or natural support) may not access respite.

D. Respite Services Delivery Location: Respite may be provided in:

   1. The individual’s home or provider’s home;

   2. A community setting of the individual’s or family’s choice (e.g., community center, swimming pool, park); or

   3. A location in which other individuals are provided care (e.g., a respite home).

3. AGENCY REQUIREMENTS

   A. Provider Agency Accounting for Individual Funds: Each individual served will be presumed able to manage their own funds unless the ISP documents justified limitations or supports for self-management and, where appropriate, reflects a plan to increase this skill. All Respite Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual’s SSI payments or other personal funds, including accounting for all spending by the Provider Agency. The Respite Agency must provide an individual accounting of any personal funds used on a monthly basis, including receipts for expenditures in the community.

   B. Staff Requirements:

      1. DSP staff are required to meet the following requirements:

         a. Be at least eighteen (18) years of age or older.
b. Complete a minimum forty (40) hour initial training program. The required training is outlined in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy.

c. Participate in ongoing training at a minimum of ten (10) hours per year after the first year.

d. Have current CPR and First Aid certification.

e. Complete individual-specific training as outlined in the ISP for individuals they serve.

f. Comply with the Caregivers Criminal History Screening Program (CCHSP) regulation for required employees/subcontractors.

g. Ensure compliance with the Employee Abuse Registry requirements.

C. Transportation: Respite provider agencies shall have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD Policy and Procedures.

D. Staffing Restrictions:

1. Respite services shall not be provided by a primary caregiver or any other person who resides in the same dwelling as the individual served.

2. When respite services are provided overnight, Direct Support Personnel (DSP) may sleep when the individual is asleep, but only when the IDT members agree to this and the environment is safe and secure.

3. Respite services may be accessed for individuals living with a family or with natural supports. The individual may only access up to half (50%) of the total dollars available in the NM DDW service package for Respite services.

E. Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure
performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:

   i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

   ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and
3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

4. **REIMBURSEMENT**

   A. All Provider Agencies shall maintain all records necessary to fully disclose the type, quality, and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.

   B. **Reimbursement Rates:** There are two rates for respite, individual and groups of less than or equal to five (5).

   C. **Billable Unit:** The billable unit of service for respite is fifteen (15) minutes.

   D. **Billable Activities:**

      1. All direct support personnel activities that are:

         a. Provided face to face with the individual, including receipt of required individual specific training where the individual is present;

         b. Provided in accordance with the Scope of Service; and

         c. Not included in non-billable services, activities or situations.

   E. **Non-Billable Activities:**

      1. Services furnished to an individual who is:

         a. Not residing in New Mexico;

         b. Not eligible for DDW services;

         c. Hospitalized or in an institutional care setting; and

         d. Receiving Family Living, Supported Living, Intensive Medical Living Services, Crisis Supports in an Alternative Residential Setting, or Customized In-Home Supports (unless the individual resides with their family).
2. Services not included in the Scope of Services, or when Respite is not included as a service on the individual’s approved ISP.

3. Time spent on the following activities:
   a. Travel to or from the individual’s residence, except when the individual is being transported in accordance with the Scope of Service;
   b. Attendance at training or other personnel development activities except required individual specific training which occurs face to face with the individual;
   c. Missed appointments;
   d. Preparation or other activities that are not face to face with the individual;
   e. Writing or updating reports, progress notes and logs; and
   f. Employer activities, including administrative duties, employer staff meetings or meetings with supervisors that are not client specific, and routine paperwork including billing documentation.
CHAPTER 20
SOCIALIZATION AND SEXUALITY EDUCATION

I. Socialization and Sexuality Education

Socialization and Sexuality Education provides classes to individuals with intellectual/developmental disabilities (I/DD) that teach social and sexuality skills needed to make the strongest connection possible between individual personal values and choices about relationships and sexuality. Socialization and Sexuality Education involves therapists, teachers, nurses, family members, guardians, friends, advocates, natural supports and/or other professionals who support the social and sexual lives of individuals with I/DD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes.

1. SCOPE OF SERVICE

   A. General Requirements: The scope of services for Socialization and Sexuality Education includes but is not limited to:

      1. Provide adult education, using the Friends and Relationships Course curriculum, about the social skills and sexual knowledge needed to develop and maintain meaningful relationships, including romantic relationships;

      2. Collaborate with members of the individual’s Interdisciplinary team (IDT) to:

         a. Secure a support person to attend classes with the student, and to continue support for skills learned in class outside of the classroom; and

         b. Integrate classroom goals and learning objectives into the individual student’s Individual Service Plan (ISP) and Positive Behavior Support Plan (PBSP) if applicable.

      3. Recruit individuals who have attended classes and demonstrated leadership skills to be trained and hired as self-advocate peer mentors; and

      4. Emphasize course content on how to assert participants’ rights to be free from aversive, intrusive measures; chemical, mechanical, and programmatic physical restraint; isolation; incarceration; and neglect, abuse, and exploitation.

2. SERVICE REQUIREMENTS

   A. Friends and Relationships Course Teacher Qualifications:

      1. Specific qualifications for professionals seeking approval to teach the Friends and Relationships Course are delineated in the following DDSD Policies and Procedures:
a. S-004: Friends and Relationships Course Teacher Certification Policy.

b. SP-004: Friends and Relationships Course Teacher Certification Procedure.

2. Course Teachers shall meet the following qualifications:

a. Master's degree in Psychology, Counseling, Special Education, Social Work or related field; or

b. Registered Nurse (RN) or Licensed Practical Nurse (LPN); or

c. Bachelor’s degree in Special Education; or

d. Other interested persons (e.g., parents, guardians, direct support personnel) who have supported at least one individual through the entire three (3) series of classes as approved by the Bureau of Behavioral Support (BBS) Chief or Clinical Director; and

e. Complete student pre-requisites and student teacher training requirements, resulting in the approval to teach.

B. **Student Teacher Pre-requisites:** Prior to being considered for approval as a student teacher, interested individuals shall successfully complete the following pre-requisite requirements:

1. Attend all classes and support an individual to complete Series I - III of the Friends and Relationship Course taught by a certified BBS class trainer; or

2. With prior written approval of the BBS Chief or Clinical Director, complete a combination of class attendance and equivalent training Two (2) Day Friends & Relationships Educator Training and/or prior supervision or training); and

3. Upon completion of requirements, submit a written request to the BBS Chief or Clinical Director requesting a review of supervised teaching experience and approval to student teach.

C. **Student Teacher training:** Prior to being considered for approval as a Lead Teacher, approved student teachers shall successfully complete the following requirements:

1. Prior to teaching classes, negotiate a supervision contract with a BBS-certified Lead Teacher as per SP-004: Friends and Relationships Course Teacher Certification Procedure;
2. Student teach all classes in each series under supervision, facilitate trainings with support people related to each series, participate in supervision per SP-004, and participate in any training required by BBS; and

3. Upon completion of requirements, submit a written request to the BBS Chief or Clinical Director requesting a review of supervised teaching experience and approval to teach independently.

3. AGENCY REQUIREMENTS

A. Prior to receiving approval from the BBS to provide the service the agency shall identify:

1. At least one BBS-certified Lead Teacher to teach the class;

2. At least one (1) self-advocate mentor to support the class; and

3. A location in a community setting (i.e., community center, college) where classes will be held.

B. Class Organization - The agency shall:

1. Coordinate with the BBS to determine what area of the state or region there is a need for a class. The BBS Regional Behavior Specialist or designated BBS staff member in each region will maintain a list of potential students.

2. In collaboration with BBS:
   a. Set the class schedule. Classes will be held across three (3) terms: fall (Labor Day to Thanksgiving); Winter (New Year’s Day to end-of-March); and Spring (April to end-of-May);
   b. Engage in all activities necessary to disseminate information about scheduled classes to case managers, behavior support consultants, parents, guardians, and other key team members in a timely way to ensure student registration and attendance;
   c. Enroll students in class and maintain a list of the individual’s name and name and number of the support person(s) who will support the student in class;
   d. Maintain sign-in sheets for individuals and support people attending each class; and
   e. Upon completion of each series, submit a list of graduates to BBS.
3. Ensure that no more than 25 individuals with Developmental Disabilities are registered for each class, not counting any persons attending to support those individuals regardless of funding source.

C. **Quality Assurance/Quality Improvement (QA/QI) Plan**: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan**: The QA/QI Plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI Plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI Plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

   a. Activities or process related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance.

   b. The entities or individuals responsible for conducting the discovery/monitoring process:

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured.

2. In addition to an annual review of Socialization/Sexuality Education Services, the QA/QI plan should include a satisfaction survey of individuals completing each series (along with selected IDT members); this information should then be used as another source of data regarding service improvement opportunities.

3. Reviews should address at least the following:

   a. Adherence to BBS standards regarding delivery of Socialization/Sexuality Education, including the accessibility and convenience of classes and the effectiveness of services (which may be, in part, measured by the achievement of outcomes);

   b. Extent to which Socialization/Sexuality Education is delivered in accordance with the individual’s ISP;
c. Compliance with DDSD training requirements (with regard to the classes); and
d. Actions taken to make improvements, and the results of those actions.

4. The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize:

   a. Number of individuals referred for each series and the number completing each series;
   b. Summary of satisfaction scores for each series;
   c. Actions taken regarding individual grievances/dissatisfaction with service;
   d. A description of what quality improvement initiatives were undertaken and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
   e. Significant program changes made as a result.

5. REIMBURSEMENT

   A. All provider agencies shall maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual’s name, servicing provider agency, nature of services, and length of session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

   1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following:

      a. Date, start, and end time of each service encounter or other billable service interval;
      b. A description of what occurred during the encounter or service interval; and
      c. The signature or authenticated name of staff providing the service.

   B. **The Billable Unit:** The billable unit for Socialization and Sexuality service is a flat fee for each individual per classroom series. The rate is specified in the current Medicaid Supplement Rate Tables for the DDW. Half of the fee may be billed upon registration of each individual, and the other half upon the individual’s completion of each series. If an
individual misses a class or two, the agency will provide a way to “make up” the class time during the current or the next relevant series.

1. Reimbursement for this service includes planning, advertising the series’ schedules, enrolling individuals, teaching classes, provision of materials and course supplies, keeping records and reporting on classes; hiring (a) teacher(s) and self-advocate mentor(s); collaborating with BBS; and other administrative duties, as necessary.

2. The fee for this service includes up to four (4) hours per series for individualized needs assessment, consultation, meeting attendance (via phone or in person), and provision of information and supplemental or modified educational materials as needed.

3. Authorization shall not exceed three (3) series per individual per budget year, which, if accomplished sequentially within the budget year, allows for one-time completion of Series I, II, and III. The individual will not be required to complete the series sequentially, although it is certainly advisable, but may proceed at their own pace, repeating series as needed; the lifetime capitation of this service per individual must not exceed completion of six (6) series (e.g., Series I, II, and III two times).

4. There are two applicable rates:
   a. **Standard Rate;** and
   b. **Incentive Rate:** The Incentive rate may be applied to Socialization and Sexuality services that are provided in a county or area designated by the DDSD as underserved for DDW Socialization and Sexuality services. An official list of such counties/areas will be published by the DDSD according to established criteria and revised/distributed at least annually.

C. **Non-Billable Services, Activities, or Situations:**

1. Services to an individual who:
   a. Does not reside in New Mexico;
   b. Is not eligible for the DDW; or
   c. Is hospitalized or in an institutional care setting.

2. Activities eligible for payment under the:
   a. BSC Service of the DDW; and
   b. The Medicaid state plan including mental health services provided by counselors, therapists, psychotherapists or psychiatrists.

3. Services not included in the Scope of Services.
CHAPTER 21
SUPPLEMENTAL DENTAL CARE

I. Supplemental Dental Care

Supplemental Dental Care provides one routine oral examination and cleaning to adults on the Developmental Disabilities Waiver (DDW) for the purpose of maintaining and/or preserving oral health. Supplemental Dental Care provided through the DDW is for adults who require more than the number of cleanings in an ISP year than is available through the Medicaid State Plan.

1. SCOPE OF SERVICE

   A. Supplemental Dental Care must include:

      1. Oral examination; and
      2. Routine dental cleaning.

2. SERVICE REQUIREMENTS

   A. Service Criteria: The need for an additional routine oral examination and cleaning in addition to what is allowable under the Medicaid State Plan to maintain and/or preserve oral health.

3. PROVIDER AGENCY REQUIREMENTS

   A. Provider Agency:

      1. The Supplemental Dental Care Provider will ensure that a licensed dentist per New Mexico Regulation and Licensing Department provides the oral examination.

      2. The Supplemental Dental Care Provider will ensure that a dental hygienist certified by the New Mexico Board of Dental Health Care provides the routine dental cleaning services.

      3. The Supplemental Dental Care Provider will function as a payee for the service.

   B. Reporting Requirements: Upon request, the Supplemental Dental Care provider must submit a copy of the documentation of service delivery for individuals accessing the service to the case manager.

   C. Interdisciplinary Team (IDT) Coordination: A Supplemental Dental Care provider is not required to attend IDT meetings.
4. REIMBURSEMENT

A. All Supplemental Dental Care Providers must maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals. Providers are required to comply with the Human Services Department Billing Regulations.

B. Billable Unit: The billable unit for this service is one (1) visit up to a set dollar amount specified in the current Medicaid Supplement Rate Tables for the DDW. Only one (1) visit per Individual Service Plan (ISP) year is allowed.

C. Billable Activities: Skilled dental services provided by a licensed dentist or a certified dental hygienist.

   1. The Supplemental Dental Care Provider may include a service fee up to ten percent (10%) of the cost of the services to cover administrative costs.

D. Non-Billable Activities: Any activity that does not meet the service description of the scope of work is considered to be a non-billable activity.
CHAPTER 22

THERAPY SERVICES

I. Therapy Services

Within the Developmental Disabilities Waiver (DDW), therapy services are to be delivered consistent with the Participatory Approach Philosophy and the Collaborative-Consultative model of therapy. The Participatory Approach Philosophy and the Collaborative-Consultative model of therapy support emphasize increased participation, independence and community inclusion in combination with health and safety. Therapy services are designed to support achievement of Individual Service Plan (ISP) outcomes and prioritized areas of need identified through therapeutic assessment.

Physical Therapy (PT), Occupational Therapy (OT), and Speech, Language Pathology (SLP) are skilled therapies that are recommended by an individual’s Interdisciplinary team (IDT) members and a clinical assessment that demonstrates the need for therapy services. A licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services.

Skilled therapy services shall reflect the purpose of therapy which is to support the individual’s functioning related to health, safety, achievement of ISP outcomes, and increasing participation and independence during daily routines and activities.

1. SCOPE OF SERVICE:

   A. Conduct initial and annual assessment and evaluation and make recommendations to the IDT regarding the therapy support needs of individuals referred.

   B. Develop, implement, and revise as necessary, the Therapy Intervention Plan (TIP) that is based on assessment results, ISP outcome needs, and addresses the purpose of therapy.

   C. Treat a specific condition clinically related to an individual’s Intellectual/ Developmental Disability (I/DD).

   D. Develop and revise as necessary Written Direct Support Instructions (WDSI) to guide families and Direct Support Personnel (DSP) to integrate therapy instructions into the individual’s daily life routines and activities.

   E. Support the individual in achieving the individual’s ISP visions, outcomes, and action plans utilizing skilled therapy services.

   F. Develop, implement, and revise as necessary Assistive Technology (AT), and environmental modifications to support the individual’s daily functioning as consistent with “Guidelines for the Provision of Assistive Technology Services”.

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G. Train DSP/family and all relevant individuals on WDSI, AT and other therapy strategies.

H. Monitor and measure effectiveness of therapy activities listed in this scope of services.

I. Provide skilled consultation services related to the activities listed in this scope of services.

J. Collaborate with IDT members, Primary Care Provider (PCP), relevant medical or professional personnel, other therapists or therapy assistants, and agency provider personnel for provision of skilled therapy services, and transitioning of therapy services in accordance with these standards.

K. Attend specialized medical or employment related appointments to obtain needed clinical information and provide skilled input as clinically indicated to support therapy objectives.

L. Implement the DDSD Aspiration Risk Management (ARM) Policy and Procedure as it relates to the role of therapists.

2. SERVICE REQUIREMENTS

A. General Requirements

1. Eligibility for Medicaid DDW Therapy Services:

   a. All adults, aged 21 years and over, allocated to the DDW are eligible for an evaluation to determine the need for therapy services. It is the responsibility of IDT members to recognize the potential need for therapy services according to the specific needs of the individual and the potential benefit of each service;

   b. Young adults, aged 18 through 20 years, allocated to the DDW are eligible for therapy services only as identified in the Aspiration Risk Management (ARM) Policy and Procedure. It is the responsibility of nursing services to screen young adults for aspiration risk and initially determine the need for ongoing ARM services from the DDW program. Other therapy evaluation and recommended therapy services for young adults must be obtained through the Medicaid State Plan (Early Periodic Screening Diagnosis and Treatment—EPSDT), rather than through the DDW; and

   c. Children and youth younger than 18 years must obtain therapy evaluation and any needed therapy services through the Medicaid State Plan (Early Periodic Screening Diagnosis and Treatment – EPSDT) rather than through the DDW.

2. Referral for Medicaid DDW Therapy Evaluation:
a. Individuals referred for Aspiration Risk Management (ARM) therapy services only, will receive assessment and evaluation services as described in the ARM Policy and Procedure. Prior authorization is required;

b. The IDT members may refer the individual to the appropriate discipline(s) for assessment, evaluation, and recommendation(s) regarding therapy service(s);

c. The IDT must identify areas of concern to be included in the assessment;

d. The therapist(s) will complete a written initial evaluation report;

e. The IDT determines if a prior authorization for the recommended therapy will be requested following review of the evaluation report; and

f. If prior authorization is requested:

i. The recommending therapist submits a Therapy Services Prior Authorization Request (TSPAR) form and supporting documentation to the case manager who in turn submits the TSPAR to the TPA.

ii. The recommending therapist must maintain a copy of the TSPAR and all documentation supporting units requested, and provide copies upon request for quality assurance review purposes.

iii. The prior authorization packet is reviewed by a third party assessor (TPA); and

iv. The Case Manager will revise the individual’s budget to reflect therapy services authorized.

3. All referrals to therapy for assessment and/or services shall be documented in the individual’s ISP.

4. Referral to Medicaid State Plan or other medical coverage plans for adult Therapy Services:

a. When covered medically necessary therapy services are indicated for adults with rehabilitation/therapy needs related to illness or injury, a referral for services through the Medicaid State Plan or other medical coverage plans, shall be obtained from the PCP or physician;

b. When therapy services are delivered by the Medicaid State Plan, the IDT shall consider integration of therapy strategies, as appropriate, into daily life, including DSP training and monitoring. Non-duplicative Therapy services provided by the
DDW may continue concurrent with Medicaid State Plan or other covered therapy services; and

c. All referrals to the Medicaid State Plan or other covered therapy services for therapy assessment or treatment shall be documented in the individual’s ISP, indicated in the Health and Safety section of the ISP narrative, and should indicate the action needed and responsible party to make the referral on the Health and Safety Action Plan page.

B. Therapy Service Model: Following assessment and evaluation, all therapy must be provided in accordance with the Collaborative-Consultative Model of service delivery and must meet clinical criteria for prior authorization.

   a. In this model DSP and/or natural supports implement WDSI as designed and trained by the therapist, with the goal to support the individual’s functioning regarding health, safety, achievement of ISP outcomes and greater participation and independence during daily routines and activities. The role of the therapist is to design and train supportive/adaptive strategies through direct collaboration with the individual, DSP and other members of the IDT. Ongoing routine implementation of WDSI is the role of DSP, not the therapist. Therapy Services in this model shall occur in natural environments and focus on naturally occurring activities of a functional nature that occur during daily routines. Natural environments may include home, work, locations where the individual receives Customized Community Supports, and other integrated community locations.

   b. Skilled therapy treatment, aka direct treatment, may be provided to individuals based upon assessment findings. Skilled treatment services are used to treat a specific clinical condition or to provide services that require the skill of a licensed therapist. These services are not the role of non-therapists, cannot be delegated, and may not be included in a WDSI. Skilled therapy treatment must always be provided in conjunction with the Collaborative-Consultative Model of service delivery.

   c. Therapists shall consider fading ongoing direct therapist involvement when implementation of strategies is correct and stable and skilled therapy treatment is no longer indicated. Ongoing training and monitoring may also be needed.

C. Principles of Therapy: Principles of Therapy shall include:

1. IDT Determination and Participation: Therapy services shall include IDT determination and participation as follows:

   a. Specific therapy services being requested for prior authorization must be determined in consultation with the IDT.
b. Therapists shall participate in Annual and any ARM-related IDT meetings by physical presence or conference call. Therapists shall participate in other IDT meetings when specific therapy related concerns are on the agenda.

c. If real-time participation is not possible, the therapist is expected to interact with the Case Manager as follows:

i. Prior to the meeting: Notify that the therapist will not attend the meeting, provide applicable therapy reports within required timelines and provide other input relevant to the topic of the meeting;

ii. After the meeting: Obtain a meeting summary, determine assignments IDT members may have requested of the therapist; and submit additional relevant documentation to the IDT within required timelines.

d. Therapists will contribute their expertise to support the individual’s achievement of their vision, desired outcomes, and action plans as identified in the ISP.

2. Participatory Approach: The “Participatory Approach” asserts that no one is too severely disabled to benefit from AT and other supports that promote participation in life activities. The Participatory Approach rejects the premise that an individual shall be “ready” or demonstrate certain skills before AT can be provided to support function. All therapists are required to consider the Participatory Approach during assessment, treatment planning, and treatment implementation by considering what AT or adapted strategies could be explored that would promote the individual’s more immediate participation.

3. Person Centered: Services shall be person centered as follows:

a. Therapy services shall be based upon each individual’s needs, tolerance for activity, preferences, and abilities.

b. Services shall be designed to support functional participation and self-advocacy in fulfilling roles with family, friends, and members of common interest groups.

c. Interventions will be determined by the individual, whether their preferences are expressed independently, with assistive devices or interpreted by others and in a culturally-appropriate, age-appropriate, and gender-appropriate context.

D. Integrating Therapy Strategies into Daily Life:

1. The therapist shall consider strategies to support activities of daily life through:

a. Development of WDSI addressing a variety of topics including health and safety needs. Living Supports, Customized Community Supports, and Community
Integrated Employment providers shall reference relevant portions of the WDSI in Teaching and Support Strategies. Therapists will provide phone consultation if providers have questions about which aspects of the WDSI pertain to specific Teaching and Support Strategies.

b. WDSI developed by the licensed therapist shall be implemented by IDT members throughout all appropriate life activities.

E. **Collaboration with other provider agencies:** Therapists will necessarily interface with providers of different types including Living Supports agencies, Customized Community Supports agencies, Community Integrated Employment agencies, and other therapy and BSC agencies in order to get input for assessment, Therapy Plan, and WDSI development, training and monitoring purposes.

F. **Provider Agency-Therapist Collaboration:**

1. Therapists, Living Supports, and/or Customized Community Supports agency designees shall collaborate to schedule timely and mutually beneficial/manageable training sessions regarding WDSI. When possible, training should be scheduled in appropriate groupings to maximize time efficiency for all participants. It is acknowledged that some topics may require one to one (1:1) training in order to ensure competence for strategies that could impact health and safety.

a. Therapists, Living Supports, Community Integrated Employment and/or Customized Community Supports agencies have a mutual responsibility to ensure that therapy appointments occur as scheduled.

b. Living Supports and/or Customized Community Supports agencies have a responsibility to ensure that DSP shall be available to participate in therapy sessions, as requested.

c. Therapists are accountable to provide appropriate training and support as requested by agencies. Living Supports and/or Customized Community Supports agencies are accountable to ensure that DSP implement recommended WDSI as trained.

d. Living Supports and/or Customized Community Supports agencies are responsible to communicate to each individual’s therapist(s) regarding the following:

   i. New or existing DSP that require training;
   
   ii. Status of AT (through use of the AT Inventory monitoring process); and
iii. Significant change in condition and/or other issues that affect therapy services.

G. Therapist-Therapist Collaboration: Therapists are expected to communicate and be responsive to other therapy or BSC service providers within the IDT in order to provide the most effective services to the individual. Collaboration/Consultation must also occur between OTs and Certified Occupational Therapy Assistance (COTAs) and between PTs and PT Assistants. When a young adult is receiving Aspiration Risk Management services and attending school, the DDW therapists may consult with school therapists to share the strategies contained within the Comprehensive Aspiration Risk Management Plan (CARMP), as they relate to activities in the school routine, not to exceed 6 hours/ISP term.

1. Purposes for collaboration and consultation include the following:
   a. To ensure consistent approaches and to coordinate therapy interventions;
   b. To share information as it pertains to the individual receiving services;
   c. To perform specialty evaluations such as ARM; and
   d. To provide crossover training and respond to special requests for assistance.

H. Specific Therapy Service Provisions:

1. Collaborative-Consultative Therapy Model Activities:
   a. Assessment:
      i. Therapists shall assess individuals within the discipline specific scope of practice and the DDW scope of services;
      ii. Assessment procedures shall be individualized, functionally based, and consider functional environments. Assessment may be targeted strictly to a particular IDT request such as environmental modification, AT, sensory processing, or employment adaptation. Not all assessments must be comprehensive in nature;
      iii. Other IDT members shall be consulted to obtain information, as appropriate;
      iv. An initial assessment shall be completed within 30 calendar days following therapist’s receipt of the approved prior authorization/billing authorization; and
v. The subsequent evaluation report shall be submitted to the IDT within the following fourteen (14) calendar days (See Therapy Documentation Guidelines on the DDSD website).

b. Written Direct Support Instructions (WDSI):

i. Therapists shall develop specific WDSI that reflect their area of expertise toward accomplishing action plans and support the team to reference the WDSI in relevant sections of the ISP and associated Teaching and Support Strategies. As such, therapists will make themselves available by phone to answer questions about which aspects of the WDSI are relevant to which sections of the ISP and to specific Teaching and Support Strategies. New WDSIs are due following strategy development and before DSP implementation.

ii. Ongoing, continued or maintenance WDSIs should be reviewed and revised as needed and distributed at least three weeks prior to the new ISP effective date. These WDSIs may be revised and re-distributed as needed within the ISP annual cycle. All WDSIs shall be distributed to the case manager, to IDT members responsible for developing Teaching and Support Strategies and to all agencies where the instructions will be implemented.

iii. Therapists are required to develop WDSI to guide the DSP’s integration of therapy instructions into the individual’s daily life routines. Therapists must use professional judgment to determine what strategies are appropriate (not skilled therapy services) and safe for DSP to implement. WDSI become the basis for training sessions with DSP and should outline the areas that DSP will be trained on.

iv. WDSI are based on therapy assessment as well as interactive trials of various strategies with the individual and DSP to determine effectiveness. Development of WDSI shall be prioritized by the therapist utilizing professional judgment to consider the individual’s needs and preferences in the areas of health, safety, and increased participation/independence.

c. Training by Therapists of IDT members:

i. Family members and/or DSP are to implement WDSI designed by the therapist and directed toward supporting function regarding health, safety, achievement of ISP outcomes, and greater participation/independence during daily routines and activities.

ii. Family and/or DSP, in all relevant settings, are required to be trained at least annually on all WDSI. Training may occur more frequently, as needed,
according to the therapist’s judgment or as requested by family, DSP, or IDT.

iii. Therapists may, according to their clinical judgment, designate an agency staff to provide ongoing training of DSP in their agency following verification of competence by the therapist. The designee must agree to be a designated trainer and the Individual Specific Trainer Designation Record Form must be completed and submitted to the designee’s personnel file. Trainer designation should be specified in the Individual Specific Training (IST) section of the ISP under “who provides the training” as “therapist or designee”.

iv. Therapists may provide targeted assessment and brief intervention for targeted needs. The therapist may develop WDSI as part of these services. After initial training the therapist may, according to their clinical judgment, transfer training and monitoring responsibilities to another therapist on the team or to the Living Supports and/or Customized Community Supports agency.

v. Customized Community Supports, Living Supports supervisors, and Community Integrated Employment supervisors are required to notify therapists, or the designated trainer if applicable, if new staff members need to be trained.

vi. The individual should be present during training sessions whenever appropriate. The presence of the individual is necessary for effective training on such programs as the CARMP.

d. Monitoring of Implementation: Therapists shall monitor implementation of WDSIs to assure that implementation is appropriate and the WDSI is effective for the intended purpose. This process will reveal the need for additional training or revision of WDSIs.

e. Fading: Therapists shall routinely consider whether services may be faded, following development and training of WDSI. Monitoring of implementation provides the therapist with information regarding the appropriateness and degree of fading for each aspect of the WDSI. Fading may occur one section at a time (See Additional Therapy Considerations below).

I. Assistive Technology Development:

1. Refer to the “Guidelines for the Provision of Assistive Technology Services to Individuals with Developmental Disabilities” found on the DDSD web site regarding detailed therapist responsibilities for AT. Therapists are responsible for
being familiar with the AT related to that therapist’s practice area and used by individuals on that therapist’s caseload.

2. Therapists shall facilitate procurement, repair or replacement of AT that is identified as needed to improve, prevent loss or maintain functioning.

3. Therapists shall add to and/or remove AT from the AT Inventory when new AT is initiated and/or discontinued from recommended use.

4. Therapists shall respond to needs identified during AT Inventory monitoring.

J. **Monitoring:** Monitoring of therapy services may include observation, data collection, and interviews as well as “hands-on” intervention. It is required in the following areas, as they relate to an individual’s services:

1. Implementation of WDSI(s) to determine the effectiveness of the strategies, the individual’s response to DSP support, the need for revision and/or retraining; readiness for fading, unless after short-term targeted intervention, monitoring responsibilities have been transferred to another IDT member;

2. Progress of an individual toward the achievement of therapeutic goals and objectives including those that relate to specific desired outcomes in the ISP;

3. AT devices- to ensure availability, proper functioning and use in the settings where the device(s) are to be used; and

4. Overall functioning of the individual- to report obvious therapy related changes to appropriate IDT members, as indicated.

K. **Additional Therapy Activities:**

1. Clinical Documentation: Therapists shall prepare reports and clinical documentation related to the provision of therapy. Specific required reports and related content are found in the Therapy Documentation Guidelines posted on the DDSD Clinical Services Bureau web site. Therapists shall be familiar with and follow these guidelines.

L. **Requirements for Transition and Discontinuation of Therapy Services:**

1. Transitioning of Therapy Services: Therapists and therapy agencies are responsible for an orderly and smooth transition of therapy services when a transition of services to a new therapist is necessary due to extended illness, intractable scheduling conflicts, therapist change in residence or practice area, an individual’s need for specialty therapy services, when the individual/guardian exercises freedom of choice
to change therapy providers, or other situations that would necessitate transitioning of services for the benefit of the individual receiving services.

2. Transitioning of therapy services to a new agency:
   
a. The therapist shall provide a written transition of therapy notice to the Case Manager and the individual/guardian at least thirty (30) days prior to the anticipated transition or as soon as possible due to unforeseen circumstances.

b. The therapist must complete and distribute a Discontinuation of Therapy Services report (See Therapy Documentation Guidelines on the Clinical Services Bureau web site).

c. The therapist shall provide the new therapist with copies of the current therapy intervention plan and other therapy documentation (not including contact notes) for the past twelve (12) months. The new therapist shall also obtain a copy of the current ISP from the case manager.

d. Whenever possible, the transitioning therapist will collaborate with the new therapist. The new therapist will be provided with the transitioning therapist’s contact information for consultation as needed to provide an orderly and smooth transition of therapy services.

3. Transitioning of therapy services when new therapy agency is not available:
   
a. Therapists may not discharge an individual until all requirements are met, including that, in no instance, may an individual be discharged from therapy services until the IDT has met and developed an interim plan.

4. Discontinuation of Therapy Services: Therapy delivered according to the Collaborative-Consultative Model may be discontinued according to the following considerations:

a. Therapy services may be discontinued when fading has been successful, there are no other services recommended by the therapist and no additional services are requested by the IDT, the individual/guardian no longer desires therapy services, or when additional therapy services are not authorized.

b. Short term targeted therapy may be discontinued when the individual’s needs that were originally identified by the IDT are met. A discharge report shall be completed and provided to the IDT. It does not require an IDT meeting to discuss short term targeted therapy discharge.
c. Any ongoing therapy service being considered for discontinuation must be discussed by the full IDT prior to exit of that service. The IDT shall consider the following and complete the Ongoing Therapy Discharge Plan form regarding:

i. The status of goals and objectives identified by the current Therapy Intervention Plan for that service;

ii. The status of WDSI from that service;

iii. Components of ISP Teaching and Support Strategies that relate to that service;

iv. CARMP components developed, trained or monitored by that service;

v. Assistive technology identified on the AT Inventory as being supported by that service; and

vi. Referral to PCP for consideration of health and safety related therapy needs that may be provided by other insurance.

d. The IDT completion of the Ongoing Therapy Discharge Plan form will address integrating appropriate strategies developed by the therapist into the ISP Teaching and Support Strategies and/or transferring the training and monitoring responsibilities to another entity (i.e. another current therapy provider, as appropriate; supervisor at the Living Supports and/or Customized Community Supports agency). If a therapy service is discontinued, strategies developed by the therapist will no longer be identified with that therapist’s name but may be integrated into the ISP as described above.

e. Any therapy service that is discontinued must complete and distribute a Discontinuation of Therapy Service Report (See Therapy Documentation Guidelines on the Clinical Services Bureau website).

f. A therapy service that is discontinued may be re-initiated only when the IDT provides a clearly documented rationale regarding the renewed need for the service that meets established clinical criteria for prior authorization. The rationale may include a documented loss of function since discharge; the introduction of new ISP outcome that requires additional therapeutic support; or a current recommendation or evaluation report from outside the DDW, (SAFE, TEASC, etc.) that states the need for specific services not currently available on the IDT.

M. Therapy Services Staffing Ratio Requirements:
1. Individual Therapy: The therapist-to-client ratio for individual therapy is at least one (1) therapist to one (1) DDW participant (1:1 ratio) for the period of the therapy service.

2. Co-Treatment: Co-treatment may be provided when there is a functional and/or clinical need for more than one therapy discipline to meet during a session to address the needs of one individual. This treatment is utilized when multiple areas of expertise are required to meet a desired outcome. Co-treatment may be utilized for a defined time period, for a specific objective and identified in the Therapy Intervention Plan.

N. Standards and Licensing: Therapy services shall be provided in compliance with the applicable NM Licensing Board/Practice Acts and in accordance with all other applicable State and Federal standards, guidelines, regulations, rules, and statutes.

O. Therapist Qualifications: All therapists are required to possess at least one (1) of the following qualifications:

1. Physical Therapy Services:
   a. A physical therapist, or a physical therapy assistant, licensed by the New Mexico Regulation and Licensing Department, may provide billable PT services in accordance with the American Physical Therapy Association’s scope of practice. A PT providing services under the DDW shall follow supervision provisions of New Mexico’s PT licensure standards.

   b. A student physical therapist or a student physical therapist assistant may provide physical therapy services if a formal academic intern agreement is signed by the therapy Provider Agency and the university and 100% on-site supervision is provided for evaluation and treatment services by a licensed physical therapist or physical therapy assistant who is an approved DDW therapist.

2. Occupational Therapy Services:
   a. An OT or COTA with a current and active license issued by the New Mexico Regulation and Licensing Department may provide billable occupational therapy services in accordance with the current New Mexico Occupational Therapy Licensing Board, the New Mexico Occupational Therapy Practice Act, and applicable American Occupational Therapy Association (AOTA) requirements.

   b. A Level II Student Intern from an AOTA-accredited university may provide OT services on behalf of an OT Provider Agency, if a formal academic intern agreement is signed by the Therapy Provider Agency and the student’s university. An OT Student must receive 100% on-site supervision during client evaluation and treatment by a DDW OT (for OT students) or a DDW OT and

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COTA as applicable (for OTA students). The supervising OT shall review and approve all support services such as non-direct AT services. The supervising OT shall review and sign all therapy related reports/documentation completed by the Level II Student Intern.

c. An OT Aide/Technician or a Level I Student Intern is not permitted to provide billable occupational therapy services to a DDW participant.

3. Speech Language Pathology Services:

a. A SLP, with a current and active license, issued by the New Mexico Regulation and Licensing Department, may provide billable speech therapy services in accordance with the American Speech and Hearing Association (ASHA) scope of practice.

b. A clinical fellow with clinical fellow licensure issued by the New Mexico Regulation and Licensing Department may provide billable speech therapy services with supervisory experiences as detailed in their Clinical Fellowship Plan accepted by ASHA.

c. The clinical fellowship supervisor shall be knowledgeable about current clinical best practices with Intellectual/Developmental Disabilities (I/DD) population and these DDW Therapy Standards. All services provided are required to be within the ASHA scope of practice. A copy of the clinical fellow temporary license shall be submitted to the DDSD Provider Enrollment Unit with required provider application materials.

d. The approval to provide services shall be obtained prior to the initiation of therapy services by the clinical fellow. Proof of permanent New Mexico SLP licensure shall be submitted to PEU within eighteen (18) months or at the successful completion of the Clinical Fellowship Plan, whichever occurs first.

e. A graduate student intern from an ASHA accredited university may provide billable services in cooperation with a speech language pathology Provider Agency, if a formal academic intern agreement is signed by the therapy Provider Agency and the university and 100% on-site supervision is provided for evaluation and treatment services by a licensed SLP who is an approved DDW therapist.

f. All required clinical documentation shall be signed by the student intern and the supervising DDW therapist.

g. Academic intern agreements shall be approved annually (this approval is for a term of one (1) year).
h. Approval to work as an intern may be granted twice (for two (2) one-year terms) for any individual.

i. A Speech Language Assistant (SLA) is not permitted to provide billable speech therapy services to DDW participants.

3. AGENCY REQUIREMENTS

A. Consumer Records: The Therapy Provider Agency shall maintain a confidential case file for each individual served. The individual case file may be maintained in either hard copy or electronic format and is required to include the most current copies of:

1. Current ISP including all teaching and support strategies and individual specific training requirements;

2. All documentation generated by therapists representing the agency, including the following:
   a. Initial therapy evaluation report;
   b. Therapy re-evaluation reports inclusive of progress made;
   c. Semi-annual therapy progress report;
   d. Billable activity notes; and as required;
   e. Therapy intervention plan;
   f. WDSI(s);
   g. CARMP;
   h. Training rosters;
   i. Discontinuation of therapy report;
   j. Trainer designation forms signed by therapist, and
   k. Other documentation generated by the therapist.

3. All related consultation reports, as determined to be needed for reference by the therapist, i.e., video fluoroscopy, orthotist, Transdisciplinary Evaluation and Support Clinic (TEASC), Supports and Assessment for Feeding and Eating (SAFE), Adult Special Needs Clinic; and
4. Consent for release of information external to the IDT, as needed.

B. **Required Documentation:** The therapy provider agency is required to maintain the following information/data and is responsible for timely submission to DDSD upon request:

1. The number of DDW participants served;

2. A listing of all individuals by name and social security number who have received therapy services;

3. Copies of current New Mexico professional licensure for each therapist providing therapy services;

4. Initial or revised provider agency policies related to therapy services; and

5. Service documentation and records requested for a DDSD or Division of Health Improvement (DHI) quality assurance review.

C. **Financial Information:** The Therapy Provider Agency is required to maintain the following financial information:

1. Therapy Provider Agencies shall establish and maintain separate financial reporting and accounting activities that are in accordance with state requirements.

2. Therapy Provider Agencies shall have an established automated data system for financial and program reporting purposes. Note: Secured internet access is required to access the Medicaid billing system.

D. **Administrative Requirements:** Therapists’ Administrative Requirements are as follows:

1. Therapy Provider Agency shall establish and maintain policies and procedures including, but not limited to HIPAA, Incident Reporting, and ongoing QA/QI designed to ensure compliance with DDSD Standards by all employees and subcontractors.

2. The Therapy Provider Agency shall convey all information received from DDSD that is relevant to service delivery to their employees, contractors, etc. in a timely manner.

3. All OTs, PTs and SLPs serving individuals participating in the DDW are required to attend training regarding the Therapy Standards/Participatory Approach, one (1) day “Person-Centered Planning” and Aspiration Risk Management during the first twelve (12) months of therapy services provision through the DDW. Therapists must attend other required trainings, as announced. Not later than the twenty-fifth (24) month of
therapy service provision the therapist shall also complete the “Effective Individual Specific Training” course.

4. All Therapy Provider Agencies are required to report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy.

5. Therapists providing therapy under the DDW through a Therapy Provider Agency are responsible to provide all required documentation to that Provider Agency.

E. Quality Assurance/Quality Improvement (QA/QI) Plan:

1. Therapy Provider Agencies must develop and maintain an active Quality Assurance/Quality Improvement Plan (QA/QI) incorporating processes directed at QA and QI, in order to assure the provision of quality Therapy services. The components of the plan are identified in the Agency Provider Application. This includes the development of a QA/QI plan based on routine reviews of services delivered, data collection and analysis, and a process to improve services, whether individual or systemic. The QA/QI Plan is submitted with the Agency Provider Application, and is reviewed and approved by the Clinical Services Bureau Director or his/her designee.

2. The QA/QI Plan is a critical operational feature that a Therapy agency uses to determine whether staff or contracted therapists (OT, PT, SLP and including COTAs or PTAs) operate in accordance with state and federal regulations, relevant DDSD policies, standards and guidelines, achieving desired outcomes, and identifying areas for improvement.

   a. The QA/QI plan should describe the agency’s plan for the quantity of records to review (sample size is based on caseload); the planned collection methods; how the collected data is intended to improve the delivery of therapy services; and methods planned to evaluate whether implementation of improvements are working.

   b. The QA/QI plan will include the agency’s decision for the term of the activities and the due dates of the annual QA/QI plan report. The agency may determine to follow a calendar year, business fiscal year, or an annual cycle based on the provider renewal date.

      i. Agencies with existing QA/QI plans must review and revise those plans to identify a due date for their annual QI report.

   c. The QA/QI Plan may be revised as needed by the Therapy Provider Agency based on agency changes and information gained through their QA/QI process.
3. All QA/QI activities will be summarized in an Annual QA/QI Plan Report. This report is a summary of the agency’s QA/QI activities and captures the agency’s review of services which are based on a variety of collection methods. The agency is required to review a sample of records and to address at least the following:

   a. Compliance with DDSD standards regarding the content and timeliness of documentation of therapy services. The agency may select an element of documentation to review based on internal audit of records. (i.e.: completion of WDSI);
   
   b. Review of therapy goals/objectives to determine if they are relevant measurable and achieved;
   
   c. Extent to which therapy activities support relevant ISP outcomes;
   
   d. Compliance with DDSD training requirements for therapists;
   
   e. Additional topics selected by the agency (if any);
   
   f. Analysis of trends in data (individual and/or systemic) and
   
   g. Descriptions of actions taken to make improvements, and results of those actions.

4. The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

   a. CSB may direct Therapy Provider Agencies to focus on specific quality areas as warranted based on systemic or individual agency issues.

F. Service Limitations:

1. The number of units of therapy services available to each individual is constrained by the limits of the Professional Services budget category applicable to the individual, including any additional units authorized for aspiration risk management and/or significant change in condition/circumstances related services.

   a. Services delivered by PTAs and COTAs shall be limited to the therapy services assigned by and pursuant to a therapy intervention plan of a supervising therapist.

4. REIMBURSEMENT

A. Therapy Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who
are currently receiving services. The Therapy Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

B. Billable Unit:

1. The billable unit for therapy services is fifteen (15) minutes with a rate based on whether services are delivered in a standard or incentive service area.

2. The billable unit for an initial therapy assessment is one assessment.

3. The PTA or COTA rate shall be billed for all services delivered by a PTA or COTA.

C. Billable Services:

1. Therapy activities that are:
   a. Listed in the Scope of Services;
   b. Included in the individual’s approved ISP;
   c. Provided in accordance with the therapist’s license, Scope of Services, and other DDSD requirements, including necessary prior authorization; and
   d. Not included in non-billable services, activities or situations.

2. Attendance at IDT meetings.


4. Co-treatment provided collaboratively with another therapist.

D. Non-Billable Services:

1. Services furnished to an individual who is:
   a. Under the age of eighteen;
   b. Under the age of twenty-one for any therapy service with the exception of Aspiration Risk Management procedures;
   c. Not residing in New Mexico;
d. Not eligible for DDW services; and

e. Hospitalized or in an institutional care setting.

2. Services not included in the:

   a. Scope of Services;
   
   b. Individual’s approved ISP; and
   
   c. Prior authorization, except for initial therapy assessment.

3. Time spent on the following activities:

   a. Participating in client assessment not conducted by the therapist;
   
   b. Missed appointments;
   
   c. Writing or updating Semi-Annual Progress Reports and contact notes;
   
   d. Travel to and from any service delivery site;
   
   e. Employer activities including administrative duties; employer staff meetings or
      meetings with supervisors, and routine paperwork including billing
documentation;
   
   f. Attending training seminars for professional development or to meet therapist
      training requirements of these standards; and
   
   g. Providing general non-client specific training seminars.

4. The therapist shall not bill therapy services to implement established WDSI and/or to
   implement strategies that are appropriate for a WDSI other than in the context of
   training DSP/IDT, monitoring and reassessment.