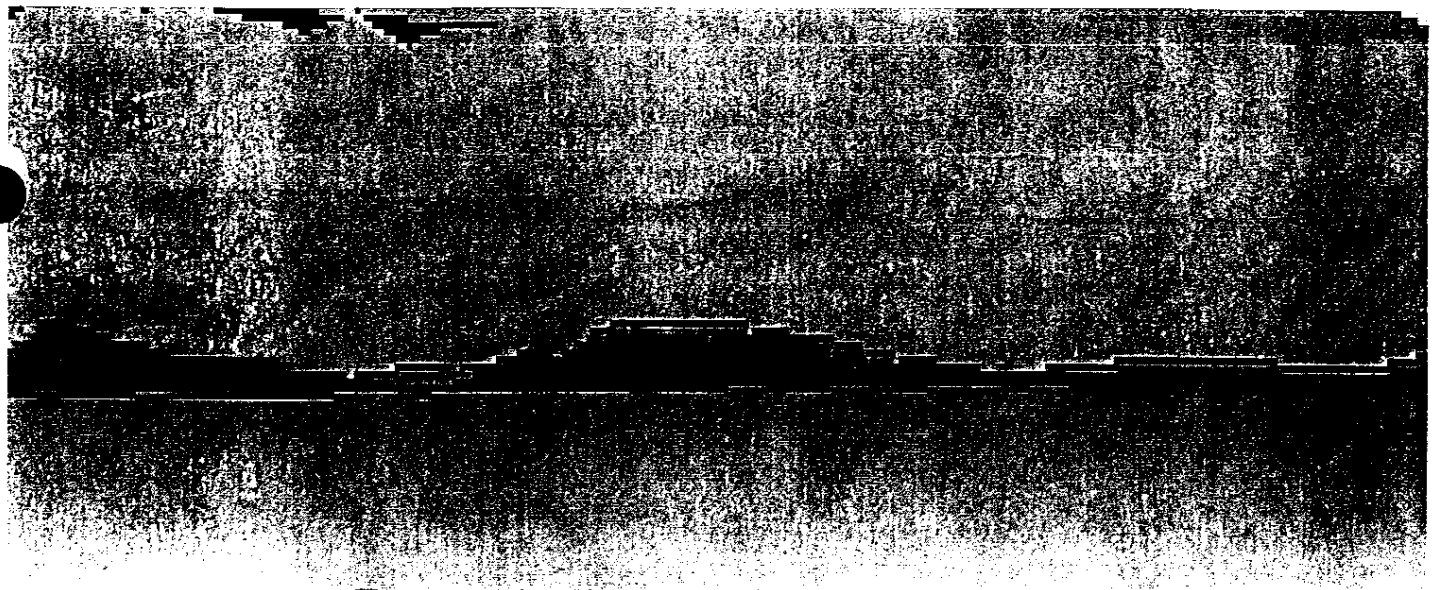
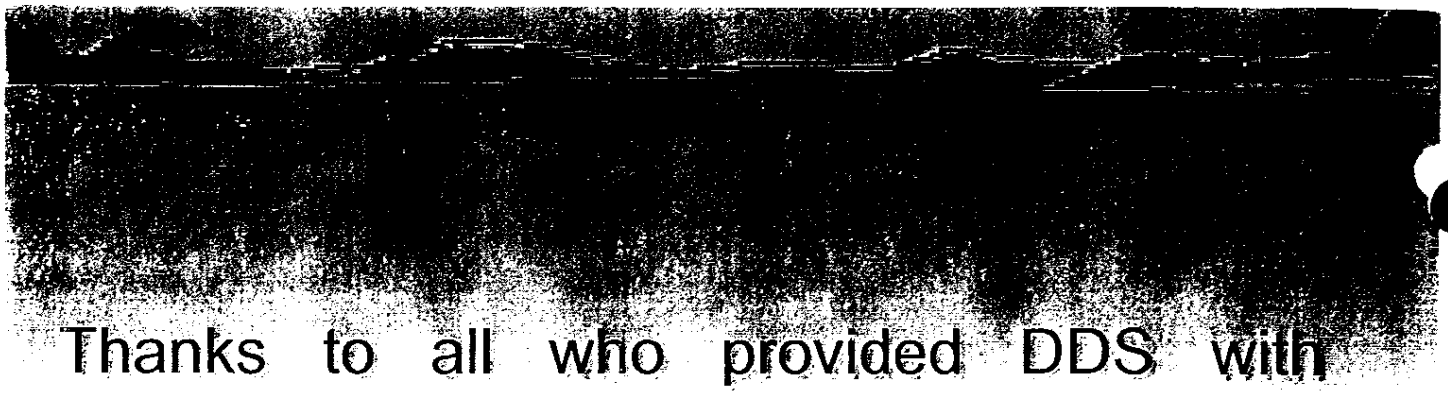


Questions and Answers

Developmental Disabilities Services

Program Quality

October 2002



Thanks to all who provided DDS with thoughtful questions related to the provision of services for individuals with developmental disabilities in Colorado. These questions were generated by agencies at the regional meetings held across the state to train on the revised DDS program quality standards. The responses to the questions submitted are included in this document. Please note that each question has been answered within the context provided, with the understanding that these answers apply in **general** cases. Agencies should continue to reference rules and regulations for further questions or contact any DDS Program Quality staff member to discuss specific situations.

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Program Quality Protocols and Procedures

1. What are or are there specific criteria for withholding program approval?

The survey team leader generally determines at the time of the survey if, based on the result of the survey, program approval will be renewed or if additional follow-up by DDS will be needed prior to renewal of program approval. (In some instances, the team leader may believe additional review of the information gathered throughout the survey is needed prior to making a decision regarding if program approval is to be renewed based on the findings at the time of the survey.) The criteria for renewal of program approval are:

No Plan of Correction (POC) Required: When the survey results indicate that the agency's practices are in compliance with DDS requirements and no POC is required for the problems identified, if any, program approval will be renewed effective the date of the survey.

No Serious Problems or Patterns: When the survey results indicate that the agency has deficient practices for which a POC is required, but there are no serious problems (e.g., un-addressed safety risks and hazards, inadequate employee/provider screening, lack of programming, etc.) and problems are not pervasive, then program approval is usually renewed effective the date of the survey (prior to receipt of the POC). The team leader may also consider the agency's history of successfully implementing POCs in the decision to renew program approval.

*Serious Problems or Patterns: When the survey results indicate serious problems or multiple problems that were pervasive for persons reviewed, program approval will not be renewed. Program approval may be renewed subsequent to receipt of an acceptable POC **and** if the team leader determines that no follow-up will be required. The effective date of program approval will be the date of the POC.*

Serious Problems or Patterns and Follow-up Required: When the survey results and/or review of the agency's POC indicate that follow-up is needed, program approval will not be renewed until such follow-up is completed. Follow-up may require the agency to submit additional information in support of the POC or to demonstrate that certain corrections have been made or an on-site visit by DDS. Such follow-up is usually scheduled 90-120 days from the date of the survey. Upon submission of the requested documentation or completion of the follow-up visit(s), and the team leader determines that the agency has made adequate progress in correcting the problems identified in the survey, program approval will be renewed effective the date the additional information was submitted or the on-site visit(s) were completed.

2. Is there a list of critical requirements?

DDS developed a list of critical requirements many years ago. The primary intent of these was to help surveyors make decisions regarding renewal of program approval and these were shared with agencies. DDS discontinued the use of the list of critical requirements and the development of these for new standards after these were found not to be as helpful as expected in making survey decisions.

Decisions regarding renewal of program approval based on a survey take a variety of factors into consideration, only one of these being which specific standards were not met (examples of other factors include, but are not limited to, reason for deficiency, pattern of problems, documentation versus practice, etc.). Such decisions cannot be made using a simple formula or recipe. Persons' health, safety and welfare are, of course, always critical considerations. However, all requirements are seen as important or they would not be included.

All survey reports are reviewed by a Program Quality (PQ) Section manager and renewal of program approval signed by the DDS Assistant Director or her designee. When Program Approval is not renewed, the rationale for the decision is discussed with a supervisor/manager and the report receives additional scrutiny.

3. What authority basis does DDS have to set expectations over and above rules and regulations?

The great majority of standards are based directly on rules and/or statutes. The Rule on which a standard is based is given in parentheses at the end of the standard. It is quite rare that a standard is written that is not directly based on a rule. (For example, there are 100 standards for IRSS; only 3 standards did not have a specific rule cited on which it was based.) The standards with no rule citation are generally necessary to determine compliance with a rule/standard and maybe on occasion based on best practice and pure common sense (e.g. that the agency keeps a record of grievances and complaints). DDS does have the authority to interpret rules and, to some extent, determine expectations for how it is to be implemented.
HCP&F rules also provide for DDS to develop rules and standards applicable to a program.

4. We have seen instances of surveyors citing deficiencies from interpretive guidelines—how is that possible?

Interpretive guidelines outline DDS' expectations for meeting a standard/rule (as well as make some recommendations). It is possible that a deficiency may be written although the agency may see the standard as met. The surveyor could determine that the intent of the standard as outlined in the interpretive guidelines is not met. For example, a standard for safety plans in IRSS is that there are two escape routes from floors used for sleeping. Although a person's plan may name two such routes, unless s/he can actually use these in case of a fire, a surveyor would determine that the standard was not met.
PQ management staff reviews all survey reports to ensure that deficiencies are, in fact, based on standards. If an agency has a question regarding a deficiency written, DDS encourages that this be brought to the attention of Program Quality staff for resolution.

5. What is DDS doing to ensure consistency amongst surveyors?

When new standards are written, as has been the case recently, all DDS surveyors review and discuss these as to their intent and interpretation. The PQ section also holds regular meetings and questions concerning the applicability of a certain standard to specific situations are frequently brought to these meetings (staff are asked to do so) and are discussed at length. When agencies/programs bring concerns regarding differences in interpretation by surveyors of a requirement to the attention of Program Quality staff, these are specifically discussed and resolved by the Program Manager meeting with surveyors, as needed. Surveyors are also encouraged to bring to their manager any inconsistencies that they may become aware of and/or questions regarding an interpretation of standards for resolution.
All survey reports are reviewed by a PQ Program Manager. One purpose of this is to help ensure uniformity in how standards are interpreted and deficiencies written.

It should be noted, however, what may appear as inconsistencies among surveyors may not always be so. There may be differences in situations leading to problems. Some standards are not simply black and white and their applicability does need to be situation specific.

6. How is a representative sample determined?

GRSS Survey Sample: The survey sample includes at least two persons receiving services in the particular group home. Since group homes serve 4 to 8 persons, this constitutes a 25% to 50% sample. The individuals will be selected based on specific needs of the person and the services required (e.g., use of psychotropic medication, challenging behaviors, etc.).
More than two persons may be reviewed if needed to ensure that all areas of standards are covered. At least two persons, if applicable, will be reviewed for each area, e.g., rights suspension, psychotropic medications, challenging behaviors, etc.

IRSS Survey Sample: A sample of approximately 20% (depending upon the size of the program) of persons receiving services is selected. The sample may be a larger percentage for small agencies and somewhat less than 20% for very large agencies.
The sample selection takes into account factors such as service area, if the program serves persons from more that one CCB, service model (e.g., apartment program, Host Homes), funding source (state and Medicaid), gender, and level and types of supports and services needed by individuals.
The survey sample will ensure that all areas of standards are adequately covered (e.g., rights suspensions, therapies, accessibility issues, psychotropic medications, etc.). When possible, the sample will include at least two persons with each such issue.
Generally, roommates are not included in the sample (this is to maximize the number of sites visited).

DHSS Survey Sample: Selection of a sample for day habilitation services and supports is very similar to how a sample for an IRSS survey is selected. A sample of approximately 20% (depending upon the size of the program) of persons receiving services is selected. The sample may be a larger percentage for small programs and somewhat less than 20% for very large agencies.
The sample will be balanced for factors such as geographic location, gender, service location, service model (e.g., integrated activities, non-integrated activities, etc.), funding source (state and Medicaid) and level and types of supports and services needed by individuals.
The survey sample will ensure that all areas of standards are adequately covered (e.g., rights suspensions, therapies, accessibility issues, medications, etc.).
All agency operated facilities where DHSS programs are conducted will be visited, as will a sample of non-agency operated facilities (e.g., integrated work sites).

Support Services Survey Sample: A sample of 10%-20% (depending upon the size of the program) of persons receiving services will be selected. The sample generally will not exceed 50 persons. For small programs such as CES, the sample may exceed 20%. A minimum of two persons will always be included in the sample.
The sample will be balanced for factors such as geographic location (e.g., Steamboat Springs and Craig), gender, types of services and supports provided (home modifications, mentorship, professional services, etc.), funding source (state and Medicaid), adults living independently versus living in a family home.

If there are services and supports provided which are subject to other regulatory requirements (e.g., ISSPs with restrictive procedures, assistance with medications, g-tube services, therapy services by unlicensed staff), the survey sample is selected to ensure review of the agency's practices in those areas.

The survey sample is also selected to ensure that a representative number of persons served by each service provider are included in the survey.

CCB/CMA Survey Sample: As for other surveys, the sample will depend on the size of the CCB/CMA. Generally it is to consist of about 10% of persons receiving services. For a smaller CCB or RC, a larger percentage is selected in order to make decisions on findings; for a very large agency, the sample could be smaller than 10%. The maximum number in the sample is usually not greater than fifty (50) individuals.
The sample will be balanced for factors such as geographic location (e.g., Sterling and Limon), gender and types of services and supports being received. The sample will include persons from all programs funded by the CCB or RC (comprehensive services, support services, early intervention, family support services).
If the CCB contracts with other program approved service agencies then the survey sample will also ensure that a representative number of persons served by each service provider is included.
The sample will include some persons receiving case management only (persons on the waiting list for services but not currently receiving comprehensive or support services).

DDS will select a sample for all programs, except GRSS, prior to the survey based on information available through our office and information requested from the agency. As described above, this will be a stratified random sample by persons' characteristics, provider, etc., as appropriate. DDS will also attempt to include persons in the sample who are not identified as having special service needs, e.g., psychotropic medications, therapies, etc. Although the survey sample is selected prior to the survey, it is not shared with the agency until the time of the survey. (Please note that the selection of the sample for all programs prior to the survey has not always been standard practice, but will be from now on).

The sample may be adjusted during the survey at the discretion of the survey team leader, e.g., to take into consideration information not previously available, the agency would like to have the team review a particular person, persons are not available for interview, etc.

Program Administration

1. **Clarify the difference between restrictive procedures and suspension of rights. Also, how can agencies tell the difference? What technical assistance is available?** *The most significant distinction between a suspension of rights and a restrictive procedure is the purpose of the intended action. The technical assistance paper developed to outline the differences between a suspension of rights and a restrictive procedure is included in Attachment A.*

Please refer to Rule 16.312, 16.120. 16.520.

2. **Some clarification is needed on how to review rights suspensions when it is not reasonably expected that the right will be returned.** *At times, rights suspensions may exist due to what are viewed as lifelong conditions. For example, a suspension may be in place related to free access to food for an individual with a diagnosis of Prader-Willi. In this case, the suspension may exist for a long period of time, perhaps indefinitely. It is still expected that the IDT reviews the suspension at least every 6 months and have a plan to reinstate the right and/or work toward less restrictive options. The Team should continue to look at environmental supports and adaptations necessary to move toward less restrictive actions, what progress the individual has made in the last 6 months, any recommendations from the Human Rights Committee or other professionals, and other relevant information.*

Please refer to Rule 16.312.

3. **Are there times when an individual may have both a suspension of rights and a restrictive procedure in place? If so, please give an example.** *There may be occasions where a suspension of rights and restrictive procedure are in place due to special behavioral circumstances. For example, an individual with sex offense specific behaviors may have a right or rights suspended to protect others from harm. This same individual may also have a restrictive procedure in place that addresses and seeks to decrease the sex offense specific behaviors. Another example may be interventions used to address an individual's pica behaviors. A suspension of rights may be necessary to protect the individual from harming him or herself by ingesting inedible objects. An ISSP with restrictive procedures may also be used to decrease the frequency of pica behavior. In these cases, both the rights suspension and the restrictive procedure may be warranted and prove effective in protecting individuals and decreasing challenging behaviors.*

Please refer to Rules 16.120, 16.312, 16.520.

4. **How does one complete an informed consent and notice properly?** *An informed consent should be detailed enough to clearly outline the procedure being proposed as well as use language that is understandable to the person from whom consent is sought. Some common problems with the completion of informed consents include: the description of the proposed procedure may lack detail, the benefits of the procedure are sometimes not outlined in layman's terms, the discomforts and risks areas of the informed consent at times do not include key information such as dangerous side effects (e.g. Tardive Dyskinesia, Extrapyramidal Symptoms, etc.) for some psychotropic medications, and the alternative procedures section sometimes*

lacks the benefits and risks of that proposed alternative procedure. The informed consent should explain the proposed procedure in terms that are easy to understand, should outline the pros and cons to the use of the procedure, and should offer viable alternatives for the individual to choose from, in the event the proposed procedure is rejected.

Regarding the provision of notice, the following information must be included in the written notice:

- *The proposed action,*
- *The reason(s) for the action,*
- *The effective date of the action,*
- *The specific law, regulation, or policy,*
- *The responsible agency with which a protest of the action may be filed, including the name and address of the director of the agency.*

Because rights suspensions are enacted to protect from harm and keep the individual or others safe, the suspension itself is not disputable. However, there are a few cases where a rights suspension may be disputable. Any time that a rights suspension results in services set forth in the IP being changed, reduced, or denied, notice is required and dispute resolution procedures may apply.

Please refer to Rule 16.120 16.312 16.322.

5. **For an individual who is on probation and therefore has court ordered suspensions, does notice still need to be provided or does the probation documentation suffice? Do these cases still need to be reviewed by HRC?** *In this case, the court ordered suspensions supercede the requirements of rules and regulations regarding provision of notice for a suspension of rights. The agency must be careful, however, to recognize which specific suspensions are court ordered and if there are any additional agency or Team driven suspensions that are warranted. It is advised that the Human Rights Committee review the court ordered suspensions so that the HRC is aware of the case. Once the terms of probation are satisfied, the IDT will need to reassess the need for additional or continued rights suspensions.*

Please refer to C.R.S. 27-10.5-110, C.R.S. 27-10.5-112, Rule 16.312.

6. **Is posting pictures of consumers at a Day Program or in staff offices considered public viewing? If so, can we do this if we have a consent to release information?** *Generally, posting pictures for inner agency use is not considered public viewing. If the photographs were to be shared with outside agencies or are in places that are accessible to the public (e.g. the lobby of the site), then releases of information that meet the requirements of rules would need to be completed.*

Please refer to Rule 16.331.

7. **Clarification for notice of action usage for any program. Specific questions are: If the person is moving from one GRSS setting into another or from one IRSS setting to another within the same service agency (or if CCB is the provider of service) is notice of action required? A person is deceased, is notice of action required as they are technically terminated from service? Upon transition from Part C to Part B services, through a transition plan? Being moved from extended support to request support in FSP services?**

- ✓ *Movement within GRSS (Group Residential Services and Supports) or IRSS (Individual Residential Services and Supports): Any time there is a proposed change in a residential placement, the notification requirements of 16.622 B 8 apply. This includes changes between GRSS settings, between IRSS settings, or movement from GRSS to IRSS or vice versa. It is expected that the individual, guardian, and authorized representatives, as appropriate, are involved in planning residential placement changes and that if a proposed move is contested, the grievance policy of the agency is followed. If there is still dissatisfaction with the decision, the CCB may be asked to review the decision. Note: If the move constitutes or involves changes in services outlined in the IP, then 15 day notice is required, as with any change in services.*
- ✓ *An individual who is deceased: Notice of action is not required for an individual who is deceased. The expectation is that the program approved service agency will appropriately close the case and record of the individual who passed away, including conducting an investigation as warranted or cooperating with a CCB or other agency investigation in the event this is necessary due to the circumstances of the death.*
- ✓ *Upon transition from Part C to Part B services: Even though the service will automatically terminate due to age, notice must be sent to families. This notification process is part of the transition planning process but it is a separate step, much like when an adult in services has an IDT meeting to discuss the change and then receives formal notice when it is decided the change will formally take place. This also applies to children who age out of CES.*

Please refer to Rule 16.622 B 8 16.322.

8. **Is it expected that a monitoring plan for an agency be written out?** *It is expected that an agency has a written plan that outlines how monitoring of a program will occur, including who monitors, frequency of monitoring, announced versus unannounced visits, what to monitor, and what mechanism will be used to correct any concerns/problems identified during monitoring.*

Please refer to Rule 16.622 B 4.

9. **In terms of notification of residential placement changes in comprehensive services, if the individual in services initiates the change, does the service agency still need to provide notification? Would interdisciplinary team minutes suffice as notification?** *Regardless of who initiates the change in a residential placement setting, the service agency needs to ensure that notification has been provided and is documented. Interdisciplinary team minutes may be one way to document this, a letter of notification may be another. The intent of notification is to ensure that the individual/guardian have been notified of the impending move, been given the opportunity to provide input in the decision process, and had adequate opportunity to*

express concerns and have them addressed prior to the move. ***Note:*** *If the change in a residential setting is from one agency to another—regardless of who initiates the change—notice of termination must be provided per requirements.*

Please refer to Rule 16.622 B 8, 16.322 A 3.

10. **If an individual in services/customer has concerns with a provider, does the provider need to be notified by the agency that someone will be checking on/monitoring them and the situation?** *It is not expected that the provider be notified each time a monitoring visit is to occur, in fact, the expectation is that unannounced monitoring be included in the agency monitoring plan. If an individual has concerns with a provider, the agency also needs to address and actively seek to resolve these issues—ensuring that the individual/guardian is aware of the agency's grievance and dispute resolution processes.*

Please refer to Rule 16.622 B 4, 16.322, 16.326.

11. **What agency takes responsibility to conduct the consumer satisfaction survey?** *The program approved service agency must conduct an evaluation of consumer satisfaction with the services and supports no less than once every three years. The purpose of this survey is to assess the satisfaction of individuals/guardians with the services and supports provided by the agency.*

Please refer to Rule 16.622 B 9.

12. **Please clarify the use of checkbooks and double signature accounts in terms of suspension of rights, restrictive procedure, or skill issues.** *There are a number of considerations when addressing the issue of money management. First, it is necessary to accurately assess individuals' skills in the area of managing their funds. In doing so, the IDT can determine what, if any, assistance, teaching or additional support the individual needs in this area. If the individual or the guardian requests assistance in managing their funds, the program approved service agency can provide this support (e.g. keeping the individual's checkbook secured, using a double signature for security purposes, assisting in purchases, etc.). Suspensions of rights can occur if, for example, the individual has the basic skills for money management but is making poor choices that are directly putting the individual at risk, e.g. identified risk of exploitation by others. In this case, a double signature account may be one way to implement the rights suspension to ensure protection for the individual. Regarding a restrictive procedure related to money, there are times when it may be appropriate for an individual with significant property destructive behaviors—who clearly understands the concept of money and payment for items—to purchase replacement items for those destroyed during a behavioral episode. This process of replacement is viewed as a restrictive procedure as the replacement of items (other than the individual's possessions) is a direct contingency in place to decrease the occurrence of property destruction. This process would not be appropriate to use with an individual who had been assessed to not have the skills or understanding of money concepts or the fact that money is used to purchase property and possessions.*

Please refer to Rules 16.120, 16.440 C, 16.622 B.

13. **What information should be written in the "alternative procedures" section of the informed consent form?** *The intent of the "alternative procedures" section of the informed consent form is to provide the individual/guardian viable options to the intervention proposed by the informed consent. Some examples of alternative procedures for proposed use of a psychotropic medication may include counseling support or increased supports and/or supervision. It is essential that when this information is presented, the benefits and risks of <u>each</u> alternative procedure are also explained so that the individual/guardian can make an informed choice, considering all options.*

Please refer to Rule 16.120.

14. **For an individual served who is diabetic and is dependent on the provider to prepare meals, is an informed consent required since the diet is being monitored by the provider/agency?** *Completion of an informed consent is required prior to use of a psychotropic medication and prior to the implementation of a restrictive procedure. In this case, an informed consent is not required, but the agency should determine the individual's understanding of the diabetic diet and what needs to occur to maintain the person's health and safety with regard to diabetes. If the individual needs the provider to prepare the appropriate meals, then the preparation of diabetic specific menus is seen as a support required to maintain the person's health and well being. There is an expectation that the agency will educate the individual/guardian on the supports being provided around diabetic issues and provide training or support as the Team identifies it is needed.*

Please refer to Rule 16.624 D.

15. **For an individual who is capable of making decisions but is making dangerous choices, is a rights suspension needed?** *This is an issue that needs to be examined in detail by the Team. Since the intent of a rights suspension is to keep an individual and/or others safe, it may be that a rights suspension is warranted. Certainly, the Team must consider what can be done to provide support and training to the individual through identification of what is motivating the person to make dangerous choices and then address this on an individual basis. This may include rights suspensions and other programming means, depending on the situation and the Team's assessments.*

Please refer to Rule 16.312, 16.622 A.

16. **For an individual who is obese and the Team is encouraging lower calorie, lower fat food choices, would this be a rights suspension?** *If the Interdisciplinary Team is simply encouraging, educating, and teaching the individual to make more appropriate food and lifestyle choices to address obesity, this would not be considered a suspension of rights. If, however, food is being withheld, secured, or taken away, then this would generally be seen as a rights suspension. It is expected in either case that the Team gain information and assessments from appropriate professionals, as well as work with the individual through education, support, training, and other means to address the issue of obesity. There may be occasions when an individual's health or safety is at risk when rights suspensions may be warranted and appropriate—the Team needs to make decisions based on all information available.*

Please refer to Rule 16.312, 16.624 D.

Service and Support Planning

1. **What are the elements that make an ISSP acceptable or unacceptable?** *Individual service or support plans must be developed based on the prioritized needs identified in the person's Individualized Plan. ISSPs are developed by service agencies to address the prioritized needs for training, habilitation, and/or supports in such areas as personal, physical, mental, and social development, and to promote self-sufficiency and community inclusion. Written ISSPs must include:*
    - *Objectives,*
    - *A methodology for instruction, intervention or the provision of support,*
    - *Criteria against which the effectiveness of the ISSP should be measured, data to be collected, and*
    - *Timelines for review.*

   It is essential that the objective, the criteria, and the data being taken all correspond and relate to the identified goal. ISSPs should be clearly written, contain enough information to adequately address and carry out the intent of the plan (i.e. teaching or support), and have a clearly defined way to measure progress on developing new skills or receiving appropriate support. Some key indicators of an effective ISSP include that the plan is comprehensive, makes sense, staff are able to easily implement it, that the individual served is making progress toward his or her IP goal, and that the ISSP is relevant and beneficial to the person served.

   Please refer to Rules 16.510 A, 16.510 B.

2. **What constitutes a "person with behavioral expertise" regarding qualifications to complete a functional analysis?** *A person with behavioral expertise may be someone who has formal educational training in applied behavior analysis or it may be someone who has had field experience that includes the use/application of positive teaching strategies, effective ISSP development to address challenging behaviors, skills in identification of the function of behaviors, and experience in the application of basic behavioral principles.*

   Please refer to Rule 16.520 A 16.120.

3. **Is a functional analysis required for someone on a psychotropic medication, does that constitute a restrictive procedure?** *Psychotropic medication use no longer falls under the definition of a restrictive procedure, as it used to in old rules. A functional analysis is only required to be completed prior to the use of a restrictive procedure, which is defined as a procedure "when the intent or plan is to bring the person's behavior into compliance." This may include "limitations of an individual's movement or activity against his or her wishes; or, interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences." It may be advantageous to conduct a functional analysis if an individual demonstrates persistent challenging behaviors to develop more effective strategies and supports to assist the individual. However, completion of a functional analysis for the use of psychotropic medication is not required.*

   Please refer to Rules 16.120, 16.520 A 1-4, 16.623 D 7-8.

4. **We would like clarification regarding conditions under which ISSPs with restrictive procedures need to be developed. In past surveys, we understood that these plans needed to be in place for persons on psychotropic medications and that these plans need to include how the individual will be supported when displaying symptoms of their psychiatric diagnosis.** *Psychotropic medication use does not fall under the definition of a restrictive procedure and has not since the rule re-write that occurred in 1995. An ISSP that addresses psychiatric symptoms and related target behaviors is required for any individual who takes psychotropic medications but this medication use is not seen as a restrictive procedure.*

Please refer to Rules 16.120, 16.520 A 1-4, 16.623 D 7-8.

5. **Clarification is needed regarding mechanical restraint vs. environmental controls/protective devices. More detail is needed system wide regarding the mechanical restraint statutes—what is okay and what is prohibited by law.** *In determining whether a device meets the definition of a mechanical restraint, the intent of application and use of the device must be closely examined. One example to illustrate this difference may be with an individual who uses a helmet. A person may wear a helmet due to severe grand mal seizures that have caused the individual significant injury in the past. In this case, the helmet may be worn the majority of waking hours to protect the person from injury in the event of a drop seizure. The individual exhibits no behaviors associated with the use of the helmet, i.e. self-injurious behaviors. In this case, the helmet would not meet the definition of a mechanical restraint. This differs greatly from a person who exhibits severe self-injurious behaviors such as striking his/her head on objects or the floor. In this case, a safety control procedure may exist in which the helmet is applied for a specific period of time during a severe behavioral incident to ensure protection from harm. The helmet serves as a mechanical restraint because the intent is to ensure safety due to immediate, demonstrated behaviors placing the individual at risk.*

In terms of the DDS mechanical restraint statutes and clarification on what is prohibited, CRS 27-10.5-115 "Right to humane care and treatment" outlines the use of mechanical restraints and lists "posey vests, straight jackets, ankle and wrist restraints, and other devices defined in rules and regulations" as prohibited. The statute is clear that posey vests, straight jackets, and ankle and wrist restraints can not be used, however, some agencies remain unclear on the "other devices defined in rules and regulations" reference—there are not currently further devices formally defined in rules and regulations. DDS is specifically excluded from restraint legislation passed several years ago because DDS requirements are equivalent to or exceed those specified in the restraint legislation. DDS has, however, incorporated requirements of the statutes, as appropriate, for use of mechanical restraints into its rules effective 2/01.

Please refer to Rule 16.120, 16.530 and C.R.S. 27-10.5-115.

6. **Further clarification is needed on how to monitor for breathing and circulation during restraint, i.e. acceptable practices which ensure client safety and do not interfere with the intervention process and effective behavioral modification.** *Program approved service agencies must determine what program will be used by the agency in training staff to perform safe and appropriate restraint techniques. These programs (i.e. Mandt, Therapeutic Crisis Intervention, CPI, etc.) must define*

how monitoring for breathing and circulation should and will occur. The agency, with assistance and input from medical personnel, must develop policies and procedures to ensure that the individual's breathing and/or circulation are not compromised at any time during the restraint procedure.

Some ways an agency may choose a training program using restraint include researching the training program's mortality data related to restraint, talking with other agencies who utilize the program—both locally and nationally, or having a staff person "sample" different training programs and compare to determine which best meets agency needs. It is important that an agency chooses and utilizes a training program that appropriately addresses the needs of the individuals they serve.

Please refer to Rule 16.530 A 1-5.

7. **When must staff monitor for breathing/circulation during physical restraint—all the time or only after 15 minutes have passed?** *Breathing and circulation of the individual must be monitored AT ALL TIMES during the use of physical restraint techniques. Staff should receive training through the approved course and agency medical personnel on what to look for if/when breathing and/or circulation becomes compromised and how to respond immediately if this is noted. For physical restraint of more than 15 minutes, the agency must have a policy and procedure that provides for appropriate back up from professional or other agency staff.*

Please refer to Rule 16.530 A 3-5.

8. **How often does a wheelchair need to be reviewed and what "professional" is appropriate?** *Reviews of wheelchairs and other assistive technology devices should occur as recommended by professionals (i.e. physical or occupational therapists as relevant) and/or after significant changes occur in the person (medical condition, growth, changes in weight, functioning, etc.) Likewise, if an individual experiences skin breakdown, redness, discomfort, or any other sign or symptom to suggest there may be a problem, the use of the wheelchair/assistive device should be reviewed by the professional as soon as possible to determine what intervention steps to take. Additionally, the agency should have a system to evaluate the cleanliness and mechanics of the chair (i.e. wheels, brake system, upholstery, etc.). This process should define who is responsible (staff, professional, etc.) and how often checks should occur.*

Please refer to Rule 16.623 C 1-3.

9. **Please provide a list of all the areas DDS would expect to see an individualized protocol.** *It is expected that written protocols exist to address individualized needs in which there are specific, consistent steps required for staff to complete to ensure the health and safety of an individual. Examples may include the following: a protocol for eating for individuals at risk of aspiration, a positioning protocol/schedule for individuals with positioning needs, a seizure protocol for individuals who experience frequent or lengthy seizures or those that require specific individualized intervention from staff, a gastrostomy tube protocol for individuals who use a G-tube, therapy programs/protocols as determined by the*

therapist and the IDT, a bathing/showering protocol for those with specific needs in this area, a suctioning protocol, a protocol for monitoring a diet, as well as other issues determined by the individual's professional staff and interdisciplinary team members. Protocols are one way to ensure that specific steps to maintain the health and safety of an individual are provided to staff, along with agency training and monitoring. Written ISSPs or therapy programs may also serve the purpose of maintaining health and safety. Protocols typically differ from basic staff instructional information in that protocols provide person specific information and specific staff intervention strategies to address health and safety issues of concern that have been identified for the individual.

Please refer to Rules 16.623 A and C, 16.624 C and C 4.

10. **How should an agency handle it when a therapist says to come back for further or continued evaluation and the primary physician says there is no need for further assessment?** *In such a case, the agency should talk with the therapist and the primary physician to determine the basis for their differing recommendations. Certainly, in terms of therapy needs and evaluation, a physical or occupational therapist has expertise in determining what should occur for assessment and ongoing treatment. Oftentimes, talking individually with the professionals involved, explaining rules and regulations the agency must adhere to, and encouraging professionals (e.g. physician, therapist) to discuss with each other the individual's case will serve to resolve these situations. If these steps are still ineffective, the Team may need to meet to determine how best to ensure the individual's needs are being consistently met across all disciplines. This may include obtaining a second opinion or changing professionals.*

Please refer to Rule 16.623C.

Transportation

1. **Do emergency instructions need to be in all vehicles used to transport individuals receiving services—agency and staff's own?** *Any agency vehicles used to transport individuals receiving services must have written instructions in the vehicle for how staff is to handle accidents and other emergencies. For non-agency owned vehicles, written instructions as to how to handle accidents and road emergencies are also needed but may not be as extensive as for agency owned vehicles. Oftentimes, the personal insurance card of the individual driver contains some of this information. The agency needs to establish, by policy, minimum requirements for what written emergency information needs to be in each vehicle.*

Please refer to Rules 16.641D and 16.642.

2. **For clients who are ambulatory without behaviors, is there anything besides a first aid kit required to be in a provider's car to fit the "necessary safety equipment" requirement?** *All vehicles must have "passenger securement devices"- seat belts or other equipment appropriate to the individual being transported. There may be other safety equipment present in the vehicle, based on the individual needs of the person. The agency could also require additional equipment by policy, e.g., flashlight, fire extinguisher, snow chains and shovel for winter driving, emergency signaling devices/reflectors, etc. A first aid kit is not specifically required by DDS but certainly reasonable safety equipment to be included as part of an agency's requirements.*

Please refer to Rules 16.641 B and 16.642.

3. **How often and by whom should safety inspections be done?**
Transportation standards issued in January 1991 required written documentation of pre-trip inspections of all vehicles owned and operated by a CCB or PASA and that any problems identified be clearly listed. Furthermore, they outline what pre-trip inspections should include: vehicle systems such as service brakes, parking brakes, steering, lights and reflectors, tires, horn, windshield wipers, mirrors, signaling devices, emergency equipment and wheels. For agency owned and operated multi-passenger vehicles (e.g., vans, buses), the frequency of and type of inspection outlined above appears reasonable. In order to determine the frequency and type of inspections necessary for a vehicle, the agency should consider factors such as conditions under which vehicle is driven, miles driven, frequency of use, etc. Even if the driver conducts pre-trip inspections, it would be expected that the agency establish a schedule of more extensive inspections by a person with some training/expertise in this area and that the manufacturer's recommended maintenance schedule be followed.

In summary, it is left up to the agency to determine how often and who should do safety inspections. A system, however, must exist to ensure that vehicles are maintained in a safe manner at all times. The agency must ensure that documentation of regular safety and maintenance checks occurs, that problems identified are corrected/repaired, and that legal requirements (e.g. emissions, proof of insurance, etc.) are met for vehicles.

For vehicles that are not agency owned or operated but are used to transport persons receiving services, the agency will need to determine how it will establish that the vehicle is not hazardous and meets legal requirements. DDS does not have specific guidelines for this. The agency will need to establish its own policy taking into consideration such factors as frequency and purpose of use, person(s) to be used for, relationship to the

individual, etc. For example, if an agency expects Host Home providers to provide all or most of the transportation, a periodic review by agency staff along with the provider may be reasonable (e.g., look for condition of tires, cracked windshield, maintenance records, etc.). For an independent contractor occasionally providing transportation to an SLS recipient and selected by that person receiving services, certain questions and signed assurances might be considered sufficient by some agencies and acceptable to DDS.

Please refer to Rules 16.641 C and 16.642.

Day Habilitation Services and Supports

1. **Is it necessary to have ISSPs for each person at vocational (retirement) day program, if all their needs are being met through activities and services?** *For a person served in DHSS, an ISSP(s) must be developed to address prioritized needs as identified in the person's IP. This requirement applies regardless of the setting. The IDT should determine what the specific prioritized needs are and what supports and/or services should be provided to address these needs. An ISSP can teach a skill or it can provide the person with structured supports or it can do both. The IDT should identify what is appropriate at the time of the IP.*

Please refer to Rules 16.440 D 3, 16.612 A and 16.510 A 1.

2. **Can DHSS happen outside of a 9 a.m. to 3 p.m. window?** *There are no requirements that specify the specific time of day DHSS should be provided to an individual. The IP must identify the number of hours to be provided to each person and should determine what supports/services should be provided in that amount of time. Since these services are individualized, it may be appropriate to provide the service outside of regular day hours and/or business days. However, any provision of DHSS integrated activity services must be scrutinized to ensure services at these times do not significantly vary from the pattern and conditions of community life for non-disabled persons. Additionally, to meet the requirement for DHSS, these services and supports must be planned, meet the definition for the service as specified in DDS rules (e.g., non-integrated activities, integrated employment services) and must be provided and documentation maintained separate from residential services.*

Please refer to Rule 16.500 and 16.626.

3. **Community employment may be the #1 choice on paper but what about those clients who have chosen (informed choice) not to work and are resistant to anything they perceive as a program.** *Integrated employment services should be offered as a primary option to all persons receiving services. Individuals who do not desire work in an integrated setting should have paid work in a sheltered work setting or be involved in meaningful community or sheltered activities. Decisions should be based upon the informed choices of persons receiving services and after exposure to the full range of day program service options. If the IDT has identified DHSS as a need for the person and the person is resistant or presents challenges that interfere with these options, the IDT should provide support, counseling, and assistance to the person to address this unmet need.*

Please refer to Rule 16.626 A.

4. **If staff bake cookies, make a cake, food for holiday parties, do we need the health department to approve our day program kitchen facilities?** *DDS requires day program providers to comply with all applicable local health department regulations and licensing requirements. If such facilities are used for the purpose provided in the example, the agency should contact its local health department to determine if such approval is needed.*

Please refer to Rule 16.622 B 1 and 16.631.

5. **What if individuals served choose to go to Breckenridge to view ice sculptures? These are activities people without disabilities access that are on your "questionable" list. Would documenting a whole list of choices discussed fulfill the requirements?** *It is the intent of integrated activity services to provide opportunities for typical activities and functions of community life, which utilize the community as a learning environment. These activities should assist the person with developing relationships and natural supports within their community. Recreational activities can be used within this context, but unless those activities serve the purposes of the integrated activities program, the activities cannot be part of that program. Programs that provide such activities as volunteer work, community education or training, and retirement activities generally meet the requirements of this program. The question also raises a second issue in regard to what do we mean by 'community'. It is expected that agencies schedule activities that are in the person's community and the activities promote the person's interaction with people that are not part of the developmental disabilities services system. The agency should evaluate each activity to determine what opportunities are provided for persons to have such interaction and to ensure that the activity is not provided simply to allow persons receiving services to "be seen" in the larger community. Additionally, agencies that only offer activities outside of the person's community are not in compliance with this requirement (some exceptions apply in rural areas).*

Please refer to Rule 16.626 A. 3 b.

6. **If a person wants to bowl to learn to be on a team, is that reason enough to be in community access activities to bowl?** *When a person is receiving integrated activity services (e.g., community access), the agency and IDT must review what activities will be functional and meaningful for the person. Since this is an individualized process, the agency and IDT must carefully consider activities based on the person's choices and needs. If the IDT has determined that the activity to be provided will meet a specific purpose, it will usually be acceptable in an integrated activity program. The IDT might also consider if this need could be met more efficiently and effectively through the person's residential services program, in which community activities are a requirement of the residential services provider.*

With regard to the example given in the question, if one of the person's goals is to join a bowling team (presumably in an integrated bowling league), it would very likely be acceptable for the person to go bowling as part of his/her integrated activities program. The rationale would be that belonging to a bowling team would facilitate relationships and natural supports, a defining feature of the integrated activities program. DDS would expect that the agency develop specific plans to provide training and/or support to the person to learn the necessary skills to bowl with sufficient proficiency to make membership on a team probable. Additionally, it would be expected that the agency take specific steps to assist the person with making personal connections with other people not associated with the developmental disabilities service system to facilitate the person's inclusion on the team.

Please refer to Rule 16.626.

7. **Do day program settings need original doctor's orders or can they use copies to administer medications?** *Original physician's orders do not need to be maintained by the DHSS agency and can be duplicates of the orders provided to the residential program. The orders maintained in the file must be current and reflect the current medication regime.*

Please refer to Rule 16.623 D.

8. **What is a retirement activity and how old does a person need to be to participate in that activity?** *DDS has no requirements specifically for retirement programs or activities. As with all services that DDS funds, activities targeted to the aging and older persons need to be provided to meet the prioritized needs specified in the person's IP and take into account the preferences and abilities of the person. Where needed, the person's IP should also specify what services and supports are to be provided per a written ISSP, as required for any person receiving day habilitation services and supports. Additionally, all retirement activities should make available to each person the patterns and conditions of everyday life consistent with those of persons without disabilities.*

Please refer to Rule 16.500 and 16.626.

9. **What responsibility does the residential provider have in the following scenario: an individual served administers their own medications at home but brings medications to day program—what procedures need to be in place for monitoring day program medications?** *DDS requires agencies providing day habilitation services to meet the same requirements as residential programs and would expect the residential provider to work cooperatively with the day program provider to ensure medications are used safely and according to the law. With regard to the scenario presented in this question, DDS would expect that the residential provider provide a copy of this assessment information to the day program provider and work cooperatively with the day provider to monitor the person's safe self-administration of his/her medication. If the medications are taken from the person's home to the day program, the residential provider would need to ensure that requirements for labeling and storage of the medications are met. DDS would also expect the residential provider to communicate and work cooperatively with the day program provider to address problems with medication errors or medication refusals. Additionally, the residential and day program providers would need to work together to develop and implement a written individualized monitoring plan. The individualized monitoring should specify who is responsible for monitoring, how often, and plans to address any errors made by the person. The residential and day program provider should maintain documentation that the medication is taken as prescribed through self recording and monitoring.*

Please refer to Rule 16.623 D.

Residential Services and Supports

1. **What are the guidelines for dosage ranges for psychotropic medications?** *The assumption is that this question relates to dosage ranges listed on informed consents for psychotropic medications. The expectation is that the informed consent should outline the specific dosage of the psychotropic medication and be completed according to the actual dosage to be administered. Some psychotropic medications have different actions and side effects at different dosages so it is important to complete the informed consent based on a specific dosage. There are times when psychotropic medications may be added to a medication regime or adjusted by the psychiatrist to increase effectiveness. In these cases, it is very common and often considered best practice for a psychiatrist to adjust the range of a new medication over a period of time in order to establish a minimum effective dose as well as determine side effects. In addition, medications are frequently reduced gradually over a period of time before they are completely discontinued. At these times, it would be very appropriate and best practice to have a dosage range on the informed consent. The program approved service agency should also check with CCBs and the reviewing Human Rights Committee and follow the expectations or guidelines from those entities regarding dosage ranges.*

Please refer to Rules 16.120, 16.623 D 7.

2. **How does DDS view the use of several medications to address the same psychiatric symptom(s)?** *There are certainly cases where more than one medication is prescribed by the psychiatrist to effectively treat psychiatric symptoms. It is expected that the psychiatrist and Team have looked closely at the benefits and risks that are present in using more than one medication and have informed the individual/guardian of these. The agency and Team must ensure that the psychiatrist is receiving accurate information regarding target behaviors and psychiatric symptoms for which the medications are prescribed to determine the best medication intervention for the individual.*

Polypharmacy, which is the use of more than one medication that have the same mechanism of action and are used for the same purpose, should be avoided. This issue was more prevalent in past years within the population of individuals with developmental disabilities but if polypharmacy is occurring, the agency should discuss this situation with the prescribing psychiatrist immediately. It should be noted that with some anti-convulsant medications, use of more than one of the same medication class may be warranted and more than one anti-convulsant, when administered for seizures, may be necessary to effectively control seizure activity.

Please refer to Rule 16.623 D 8.

3. **Are quarterly reviews for psychotropic medications required to be done by a psychiatrist?** *A psychiatrist must review the administration of psychotropic medication at least annually. More frequent reviews may be warranted for new medications, when the medication is not working as intended, the person is not on a maintenance dose, or there are significant changes in the person's life. Quarterly reviews can be completed by other physicians.*

Please refer to Rule 16.623 D 8.

4. **Do psychotropic medication requirements apply to medications given prior to medical procedures?** *There are occasions when a medication such as Valium or Ativan is administered prior to a specific medical procedure. In this case, the order to administer the medication is written as one-time order and is only administered prior to that specific procedure. In this case, the requirements for psychotropic medications do not apply. Because it is presumed that the medications are to treat the anxiety associated with medical procedures, the Team may wish to explore other options to help reduce anxiety, especially if it is excessive. It is not appropriate to have a doctor's order for administration of medications like Ativan or Valium for all (e.g. medical, dental, hygiene, daily cares) procedures or in any case that would depend on direct care staff making a judgment to administer the medication. The order should be very specific to the time of administration, the reason for use of the medication, the dosage, and the procedure for which the medication is being given.*

Please refer to Rule 16.623 D 7, D 8.

5. **If someone begins taking an antidepressant that does not have side effects of Tardive Dyskinesia, for example, what kind of tracking of side effects needs to occur?** *It is expected that side effects and possible adverse effects of a medication be reviewed with staff/providers each time a new medication is started. Even if a medication does not have the adverse effect of Tardive Dyskinesia, it is still expected that the agency have ways to monitor for all side effects to ensure the individual's well being and that medical personnel, including the individual's psychiatrist, are kept apprised of any side or adverse effects. It should be noted that many medications without the side effect of Tardive Dyskinesia may have adverse effects, e.g. the potential for liver damage from long-term use of Depakote, and an agency should have a means to monitor for this potential.*

Please refer to Rule 16.623 D8.

6. **What procedures need to be followed when antidepressants are used to address chronic pain?** *Generally, if an antidepressant is prescribed, it is presumed that the medication is being given for a diagnosis of Depression. In this case, all requirements for use of a psychotropic medication apply. Depression and chronic pain often occur simultaneously due to the constant physical and emotional stress on the individual. If a physician indicates that an antidepressant is being used to treat the chronic pain symptoms only, the agency should clarify the reason for using an antidepressant versus or in addition to a traditional pain medication. If the medication is used to address depressive signs and/or symptoms, even if related to chronic pain, requirements for use of a psychotropic medication must be followed. It is, of course, expected that the agency and medical personnel continue to explore what is causing chronic pain and treatment options to address it.*

Please refer to Rules 16.623 D7, 16.623 D 8.

7. **If a psychotropic medication is prescribed but the only symptom being addressed is hallucinations, are a Comprehensive Life Review and psychotropic ISSP still required? (The premise being that the hallucinations may not be significantly reduced by programming.)** *At times, there are symptoms of a mental illness diagnosis that may initially seem difficult to positively impact with programming. If an individual is experiencing hallucinations, the assumption may be that little can be done, aside from medication, to decrease the hallucinations. However, often individuals experience more hallucinations at times of higher stress, discomfort in their surroundings, or times of life change. At these times, staff support may include reassurance, reorientation of reality, teaching coping strategies and effective communications skills to address hallucinations, and arranging consultation with the individual's therapist and/or psychiatrist. A comprehensive life review and ISSP are required in this situation to help identify what life circumstances may increase or help reduce hallucinations, as well as establishing a consistent staff intervention strategy to assist the individual.*

Please refer to Rule 16.623 D 7.

8. **How is the medication reduction plan developed, by the IDT or the psychiatrist?** *Generally, a medication reduction plan recommendation comes from the psychiatrist. However, the IDT is key to providing the psychiatrist relevant and appropriate information regarding target behaviors, signs and symptoms of the diagnosis for which the medication is prescribed, and noted side effects of the medication. Without this crucial information, the psychiatrist may be unable to provide a reasonable medication reduction plan for the individual. The goal should be for reducing and ultimately discontinuing a psychotropic medication unless contraindicated or the need for a maintenance dose is clearly documented.*

Please refer to Rule 16.623 D 8 c.

9. **How does the agency address a situation in which the psychiatrist is recommending a medication that may be effective to address psychiatric issues but the parent or guardian opposes the use?** *The Team is crucial in this situation to assist in outlining the risks, benefits, and outcomes desired for the individual. Education and open communication are essential to ensure that all IDT members are involved in working through this issue. Oftentimes, requesting the parent/guardian to be present at an appointment to discuss medication use with the psychiatrist can resolve this issue. Ultimately, informed consent must be granted for the use of psychotropic medications. If the individual or guardian will not grant informed consent, the agency and Team must identify viable alternatives to provide the individual with the services and supports they need.*

Please refer to Rule 16.623 D 7.

Individual Residential Services and Supports

1. **Standards say that homes must have two exits from floors used for sleeping. Is it acceptable for a person to have a bedroom on a second floor if the person cannot use a ladder to get down from the window? In this case, the person can wait for help by their bedroom window, or open the window and yell for help, but cannot climb down a ladder outside the window. The window is big enough for firefighters to retrieve the person through the window.** *It is imperative that the individual's safety plan provide detailed information as to what steps the person and support staff will take to ensure the individual's safety in the event of a fire. For some individuals, it is not reasonable and may be very dangerous for them to attempt to use a ladder to exit. The agency should evaluate the location of the home relative to the fire department, the approximate response time of the fire department, and, given this information, determine what is the quickest and safest way for an individual to evacuate. If, after evaluation of the circumstances, the agency determines that the individual could not evacuate or be assisted to evacuate quickly, the agency must make changes to the safety plan, staffing situation, or environment to ensure the individual's safety. It is also recommended that the agency has notified the local fire department so that the department is alerted to the need for specialized rescue circumstances. The agency is also encouraged to consult with the fire department regarding evacuation timelines as well as have a department representative review the plan.*

Please refer to Rules 16.624 B 2 a-c.

2. **Standards say that a secondary entrance must be ramped if the safety plan provides for the person to exit a home in a wheelchair through this secondary entrance. Does this apply if the person is never left alone, the provider is responsible for evacuating the person when necessary, and the secondary entrance has only one to two small steps that the provider can easily guide the wheelchair over? (The main entrance, of course, is ramped.)** *The standard states that the secondary exit must be "accessible for purposes of safety." The intent here is to ensure that, using a wheelchair or mobility aid, the individual can independently or with assistance evacuate quickly and safely in an emergency situation. The safest way for anyone using a wheelchair or mobility aid to exit is almost always using a ramp and not steps. Although a provider can navigate a wheelchair over a step or two, a ramp is still generally considered safer. And if the emergency occurs when the individual is not in a wheelchair, the person would need to be lifted over the steps, which is not always safe or possible. Agencies should look carefully at the safest and most efficient means for individuals to exit and respond accordingly.*

Please refer to Rules 16.624 A 10, 16.624 B 2.

3. **Is a guardrail on a portable ramp sufficient to meet 16.624 A-10 if the wheelchair is safe on it?** *A ramp should contain a guardrail or handrail and should be adequate to keep the wheelchair on the ramp to ensure the individual's safety by preventing the wheelchair from falling off the ramp. If the guardrail on the portable ramp in this situation was strong enough to keep the wheelchair on the ramp in the event the wheelchair hit it, then it should be sufficient. Each situation must be considered individually, based on the size of the wheelchair and the sturdiness of the guardrail to ensure the individual's safety.*

Please refer to Rule 16.624 A 10.

4. **Does the safety plan have to address the actions of another individual served in the home, even if their evacuation does not pose a barrier to the evacuation of the other individual served?** *This guideline emphasizes the need to address the provider's ability to evacuate all individuals in the household. If there is more than one person to be evacuated, the plan must specify how evacuation of all individuals will take place. One plan should not mutually exclude the other plan. For example, if two individuals require total assistance out of the home and there is a single provider who has two small children, how will evacuation, in the event of a fire, occur from the provider's perspective? Or, if one person requires minimal to no assistance in evacuation, this should be stated in the plan so that it is clear that the provider will respond to this individual's and others' needs according to the assistance needed. The specification should be as basic or detailed as necessary to adequately address the evacuation needs of each individual and how all will evacuate safely and quickly.*

Please refer to Rule 16.624 B 2.

5. **Must there be an exit route out of the front of the home and the back of the home, or does there just need to be two exits, wherever their location?** *Rules and regulations do not specify that there must be an exit route out the front and back of the home. Homes must, however, have two exits on floors used for sleeping. If the individual's bedroom is above the first floor level the stairway can serve as one route of exit and a window or balcony from which the person can exit the other route. If the person's bedroom is in the basement, again, the stairs can serve as one route to safety and a window or door to the outside a second, functional evacuation route. An important point here is that the secondary exit must be functional, e.g. if there is a window but it is not large enough for the individual to exit from, then the requirements of a secondary exit from the floor used for sleeping are not met. Clearly, the two exits should be located in such a way for the person to exit in different directions—based on the location of the fire (e.g. two exits should not be a door and a window next to each other.)*

Please refer to Rule 16.624 A 6.

6. **If a doctor feels an annual physical is only needed every two years and the doctor writes a letter stating this, are we in compliance?** *Yes. Each person must receive an annual medical evaluation, unless the physician indicates a greater or lesser frequency. When a physician indicates an annual evaluation is not needed, the agency should ensure that this is documented and then a physical is completed no less than every two years.*

Please refer to Rule 16.624 C 2.

7. **Annual physical exams are no longer being paid for by Medicaid. Does DDS have suggestions on how to meet the requirements for annual physicals?** *As stated above, each person must receive an annual medical evaluation, unless the physician indicates a greater or lesser frequency. If Medicaid does not pay, then the service agency is responsible for payment of that examination as part of their Medicaid funding dollars.*

Please refer to Rule 16.624 C 2.

8. **What are DDS' expectations of the Team and agency if a person refuses proper medical/nutritional intervention or services due to religious reasons?** *The expectation with any situation that involves refusal of intervention or services is that the Team and agency have educated the individual on the intervention/services proposed, as well as the benefits and risks of accepting or refusing the services. C.R.S.27-10.5-116 outline that "No person receiving services shall be required to perform any act or be subject to any procedure whatsoever which is contrary to the person's religious belief, and each such person shall have the right to practice such religious belief and be accorded the opportunity for religious worship." It is essential that the individual's Team be sensitive to and respectful of the religious beliefs of the individual, while ensuring that the individual is also well educated on health concerns/issues that may arise from the refusal of medical/nutritional intervention or services. Ultimately, in the comprehensive services program, the service agency must take appropriate steps to ensure that the individual receives proper medical and nutritional intervention. Depending on the person's ability to understand the scope of this situation and make informed decisions, guardianship may need to be considered to assist the individual with making decisions in this area.*

Please refer to C.R.S. 27-10.5-116, Rule 16.311 A and 16.624 C.

9. **What are the requirements for documentation when the person independently administers medications?** *For an individual who is independent in administration of medications, a current assessment of these abilities should be available. The individualized monitoring for the person should be outlined in a written plan to include who is responsible for the monitoring, how often, and plans to address any errors made by the person. Some ways the agency can ensure and maintain documentation that the medication is taken as prescribed may be through self-recording, pill counts, announced and unannounced monitoring of medication use, etc. No one way of monitoring should ever be relied upon as a means of oversight. For example, self-recording is never sufficient by itself to adequately monitor an individual's independence and skill in medication administration.*

Please refer to Rule 16.623 D 6.

10. **Two individuals live in a host home, for example, is it acceptable for them to share a bottle of aspirin, if they each have individual physician's orders for the medication?** *There needs to be an individual, labeled supply of over the counter medication for each person in the home—it is not acceptable for individuals to share over the counter medications out of the same bottle.*

Please refer to Rule 16.623 D 1, Medication Administration Manual.

11. **Are pharmacy labels required for over the counter medications?** *Each prescription medication needs to have a pharmacy label. Each over the counter medication must have, at a minimum, the person's name on it. The person's name is to be taped to or written on the original container as not to obscure the original label.*

Please refer to Rule 16.623 D 1, Medication Administration Manual.

12. **A physician's order states to "encourage low fat diet" for an individual—does that constitute a therapeutic diet?** *The agency should clarify with the physician the rationales for the order, i.e. is the individual at risk of heart disease or above or close to being over their ideal body weight? It may be that the doctor makes a general recommendation for all patients to encourage a low fat diet as part of general wellness. After further discussion with the physician about why the order was written for this individual, the agency may need to follow up with a dietary assessment or evaluation in order to ensure that the doctor prescribed diet is followed and monitored accordingly.*

Please refer to Rule 16.624 D.

13. **Is a dietician required to review a therapeutic diet?** *A therapeutic diet must be prescribed by a licensed physician and implemented. The therapeutic diet should be based on assessment/plan by a professional staff such as a Registered Dietician as deemed necessary.*

Please refer to Rule 16.624 D 2.

Support Services

1. **In SLS, should the IP list all the person's needs, even if SLS can't address them all?**
   Yes. Federal requirements stipulate that the IP contain information about 'all' needed services related to the person's developmental disability, including non-Medicaid funded. The IP should identify the needs of the person, prioritize those needs and then explore the specific services and supports, as appropriate, to meet the prioritized needs. Some needs specified in the IP may be met by community and natural supports.

   Please refer to Rule 16.440 D.

2. **Should the ISP be a part of the IP?**
   If an individual support plan (ISP) is used, then yes. However, the IP is the overall coordinating service plan for the individual. In some circumstances when a more detailed support plan, such as an ISP, is used to specify details such as who, what, when, where, how, how often, etc., then the ISP becomes part of the IP.

   Please refer to SLS Manual Chapter 3, page 43.

3. **In SLS, if the ISP *is* an attachment to the IP, and if the CCB is going to change the ISP, does that require an IDT meeting and 15 day notice?**
   Yes. If the services set forth in the IP which are to be provided, or are to be changed, reduced, denied or terminated, the person must receive written notice 15 days prior to the action and have the opportunity to dispute the actions. Such notice may be provided at the time of the IDT meeting.

   Please refer to Rule 16.322.

4. **In SLS, for emergency temporary host home placement, does the CCB have to "contract" with that provider if they are already a provider for another agency?**
   Yes. Under the SLS program only, the SCA/CCB is authorized to sub-contract for services and payment must be made only to the actual provider of the service. The SCA/CCB cannot pay an agency that in turn pays a provider/ independent contractor for SLS services.

   Please refer to SLS Manual Chapter 7, page 111-112 and Social Security Act [1902 (a) 32].

5. **If, in SLS, the person wants to change a provider agency, does termination notice still need to be given?**
   Yes, if the agency is a program approved service agency (PASA). The individual or guardian (if applicable) can notify the agency/CM/SCA verbally or in writing that they want to change provider agency. The program approved service agency must provide proper notice that services will be terminated. DDS rules do not require generic service agencies (e.g., Molly Maids, home health agencies, etc.) to provide notice of service termination.

   Please refer to Rule 16.322.

6. **What is the function of mentorship and how does that apply to the SLC role?**
Mentorship: On-going emotional and decision making guidance that may include areas such as parenting education and support, safety in the home and community, citizenship, best practices. May include physical assistance, verbal prompting, or training in these areas.
SLC: One time or intermittent assistance with decision making, assessing the need for and planning daily activities, direct assistance to access community resources and/or service providers.
Each is a different service an individual may choose.

Please refer to SLS Manual Chapter 5, pages 54 and 59.

7. **What is the difference between gathering information versus service agency contact notes review? Since review of contact notes serves the purpose of gathering information, is it acceptable to bill under SLC for this?**
The role of the SLC is to provide one time or intermittent assistance with decision making, assessing the need for and planning daily activities, and direct assistance to access community resources and/or service providers. Information gathering activities used to meet these needs are generally billable under SLC services. Review of contact notes may be billable as an SLC activity when it is done with the person, to review the services completed and options available for the person to choose new providers, change the services provided, etc. Review of notes for billing purposes, monitoring of services, or other functions that are a need of the service system would fall under administrative activities and are not billed to persons' plans.

Please refer to SLS Manual Chapter 5 and DDS memo 'Proper Accounting of SLS Expenditures' dated February 1, 2001.

8. **Can writing or reviewing health and safety plans be seen as an SLC function?**
Writing and reviewing health and safety plans do not fall within the needs to be met with SLC services. In most cases, cost incurred with completing assessments and plans to meet the requirements of rule 16.613 cannot be billed to the person's SLS plan. However, if completing the assessments and developing the plans are done with the person receiving services, the costs may be billed under Mentorship. Additionally, reviewing and/or practicing the safety plan with the person could be billed under Mentorship.

Please refer to SLS Manual Chapter 5, page 59.

9. **If a service provider for community access is completing the health and safety assessment, how is that billed?**
If the provider were to assess the individual's community safety skills while in the community with the individual participating in community access activities, it would fall under the regular community access billing. Otherwise, completion of the health and safety plans may fit best under mentorship.

Please refer to SLS Manual Chapter 5.

CCB/Case Management

1. **We have recently had a large number of children diagnosed with autism. As we read the current rules, it appears that a general intellectual impairment is not required for eligibility, rather the presence of significant limitations in 2 or more skill areas would also qualify someone for services. Most of these children will have significant limitations in 2 or more skill areas, and autism is one of the related conditions. Their IQ scores might range from 70 on up. In the interpretive guidelines we just received, it appears that all of the criteria must be evident, not just one or the other. Can you clarify the intent around people such as I have identified, and how the Developmental Disabilities Services intent is going to be clearer in rules?** *The intent of DDS rule 16.120 is to define a developmental disability in conformance with the definition specified in 27-10.5-102 (11) (a) CRS, which defines a developmental disability as:*

- ✓ *A disability that is manifested before the person reaches twenty-two years of age, which constitutes a substantial disability to the affected individual; and,*
- ✓ *Is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions **when** such conditions result in impairment of*
    - o *general intellectual functioning or,*
    - o *adaptive behavior similar to that of a person with mental retardation.*

Rule 16.120 specifies that 'adaptive behavior similar to that of a person with mental retardation' means that a person's adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial cognitive deficits and may not be attributable to only a physical or sensory impairment or mental illness. Therefore if the person has a diagnosis of autism and has limitations in adaptive behavior, such limitations must be due to substantial cognitive deficits for the person to be eligible for services. Please note that with regard to children under the age of five (5), the definition of developmental delay applies to determinations of eligibility and utilizes different criteria. Technical assistance materials addressing the determination of eligibility are in the process of development and DDS anticipates distribution of these materials within the next several months.

Please refer to Rule 16.120.

2. **Please provide clarification on DDS review of eligibility determinations when formal local disputes have been unsuccessful, timeframes within which determination must be made when appealed to the state.** *DDS does not review decisions regarding the determination of eligibility. If a party chooses to appeal an eligibility decision to the Department, he/she must submit a written request to the Executive Director of the Department of Human Services to review the outcome of the dispute resolution process within fifteen (15) working days from which the written decision by the impartial decision maker was postmarked. DDS staff are available to provide technical assistance and guidance regarding resolution of disputes, including those related to eligibility determination.*

Please refer to Rule 16.322 I 1.

3. **What constitutes an eligibility committee?** *There are no requirements in DDS rules for an eligibility committee. Rules do require the CCB to establish procedures for determining eligibility that must identify the qualifications of person(s) making such determinations. Technical assistance materials addressing the determination of eligibility are in the process of development and DDS anticipates distribution of these materials within the next several months.*

Please refer to Rule 16.420 B.

4. **If someone leaves the area completely and you don't know where he/she has gone, what do you do to provide him or her with notice of termination?** *The case management agency must make reasonable attempts to locate the person and provide notice of termination, as specified in Rules, and must document such efforts. If these attempts are unsuccessful, the case management agency must send notice of termination to the last known address of the person.*

Please refer to Rule 16.322.

5. **Is an IDT required when a change in the ISSP occurs?** *A meeting of members of the person's interdisciplinary team (IDT) would be needed if the changes in the ISSP result in the following:*

   ✓ *The ISSP is terminated and a there is not a new ISSP to be implemented; or,*

   ✓ *A new ISSP is to be implemented that was not originally specified in the person's IP.*

   Such a meeting would be needed to amend the IP to document a change in the prioritized needs to be addressed by the PASA(s) implementing the ISSP. In those situations in which the ISSP has been terminated and the identified need specified in the person's IP has been met, the case manager may consult by telephone with IDT members to determine if a face-to-face meeting is needed.

Please refer to Rule 16.440 D.

OTHER QUESTIONS AND ANSWERS

1. **Who regulates J-tube (jejunostomy) services?**
Developmental Disabilities statutes only allow for the Department to develop rules and set standards for administering fluids and nutrients through Gastrostomy tubes (27-10.5-103(2)(k) C.R.S.). The Colorado Medical Act and the Nurse Practice Act regulate other medical or nursing services, including the administration of nutrients and fluids through jejunostomy tubes.

2. **Will DDS staff now begin using the revised standards on surveys?**
DDS began using the new standards for all surveys beginning 3/1/02.

*Note: A number of questions related to medications used for sleep have been posed to DDS. A technical assistance paper is forthcoming within the new few months to address these issues in more detail. DDS has answered the following questions for **general** cases only; specific cases should be directed to Program Quality staff for discussion.*

3. **If a person is prescribed a routine sleep aid for medical, non-behavioral reasons, do we still follow the same process as with a psychotropic medication?** *If a medication is used where the intended effect is to aid the person in sleeping, that medication is considered a psychotropic medication. Any medication that is prescribed to assist with sleep disturbances falls within the requirements and rules of psychotropic medications. If an individual is prescribed a medication to aid in sleep, then it is presumed the doctor ordering the medication has assessed them to have a sleep disturbance.*

Please refer to Rules 16.623 D 7, 16.623 D 8.

4. **What are the requirements for medications used to treat insomnia?** *A medication is considered a psychotropic medication when the intended effect is to aid the person in sleeping. Insomnia is a DSM-IV diagnosis and medications used to treat it fall within the definition of psychotropic. All requirements for psychotropic medications apply to medications used to treat insomnia.*

Please refer to Rules 16.623 D 7, 16.623 D 8.

5. **If a medication for sleep is given for a medical diagnosis like Alzheimer's, do the requirements of use of a psychotropic medication apply?** *Alzheimer's Disease is a recognized psychiatric diagnosis. Any medications given to enhance sleep and, in this case, related to a psychiatric diagnosis like Alzheimer's are considered psychotropic medications. In these cases, all requirements for psychotropic medication use apply.*

Please refer to Rules 16.623 D 7, 16.623 D 8.

ATTACHMENT A

PROCESS COMPARISON

SUSPENSIONS OF RIGHTS – AND – RESTRICTIVE PROCEUDRES

SUSPENSION OF RIGHTS	ISSPs WITH RESTRICTIVE PROCEDURES
Purpose: To utilize the least restrictive approach to protect the individual from endangering themselves, others or property. (16.312 A)	Purpose: To bring a person's behavior into compliance *(16.120)*
Agency Requirements: Service agencies must complete the following requirements prior to suspending a right: • The suspension must be specifically explained to the person; *(16.312 A 1)* • Notice, as described in *Rule 16.120* must be provided to the person. (This includes adherence to the requirements of *Rule 16.320, as applicable.)* • Parents of a minor must approve the suspension. *(16.312 A)* • Ensure that the person's IP includes a statement of services and support required and plans for implementing them to eliminate the need for the suspension; *(16.312A 2)* After a rights suspension is implemented, the agency must: • Make available to the IDT a written report or data that allows for the review of ongoing need for the suspension and the success of programmatic interventions in eliminating the need for the suspension. *(16.312 A 3 a)* • Refer the rights suspension to the HRC for review and recommendation at the time the restriction is put in place. *(16.312 A 4)*	Agency Requirements: Service agencies must complete the following requirements prior to implementing an ISSP with a restrictive procedure: 1. In conjunction with IDT; • Completion of a comprehensive review of the person's life situation. Such a comprehensive review must meet the requirements of *Rule 16.510 E. (16.520 A 1)* • Complete a functional analysis of the person's challenging behavior. *(16.520 A 2)* • Complete an ISSP describing the use of the restrictive procedure and includes the components and information specified in *Rule 16.520 A 3.* 2. Obtain the informed consent of the person for the use of the ISSP with a restrictive procedure. *(16.520 A 4)* 3. After implementation of the ISSP with a restrictive procedure, the agency must: • Review the effectiveness and continuing needs for the ISSP within the criteria and timelines specified in the ISSP. *(16.520 A 3 i)* • Provide a copy of the ISSP to the HRC as well as any subsequent reviews that the HRC requests. *(16.550 F and I 3)*
IDT Requirements: The following requirements must be met anytime a rights suspension is implemented: • The proposed suspension must be reviewed by the IDT. *(16.312 A 2)* • If the IDT decides to suspend the right, it must be documented in the person's IP. *(16.312 A 2)* • Ensure that the person's IP includes a statement of services and support required and plans for implementing them to eliminate the need for the suspension; *(16.312 A 2)*	IDT Requirements: In conjunction with the service agency, the following requirements must be met anytime an ISSP with a restrictive procedure is considered or implemented: • Complete a comprehensive review of the person's life situation, which meets the requirements of *Rule 16.510 E. (16.520 A 1)* • Complete a functional analysis of the person's challenging behavior. *(16.520 A 2)*

SUSPENSION OF RIGHTS	USE OF RESTRICTIVE PROCEDURES
IDT Requirement continued- • Review the continuing need for the suspension and the success of programmatic interventions in eliminating the need for the suspension at a frequency determined by the IDT, but not less than every six months. *(16.312 A 3)* • Ensure that the affected rights are restored as soon as circumstances justify. *(16.312 A 3)*	IDT Requirements continued- • Complete an ISSP describing the use of the restricti procedure and includes the components and informatio specified in *Rule 16.520 A 3.* • Consider and implement any recommendations made by the HRC.
HRC Requirements: The HRC must ensure that the practices of the CCB and agency: *16.550 I 2)* • Meet the procedural safeguards required in *Rule 16.312.* • Include review by the IDT of the ongoing suspension at least every six months	HRC Requirements: The HRC must ensure that the agency's use of ISSPs with restrictive procedures meets the requirements of rules and regulations and is consistent with the mission, goals and policies of the DHS and the CCB or regional center. *(16.550 I 3))*
Persons Must Be Afforded: • Notice, as described in *Rule 16.120* must be provided to the person; (This includes adherence to the requirements of *Rule 16.320, as applicable.*) • With reasonable notice, the opportunity to present relevant information to the HRC. *(16.312 A 4)*	Persons Must Be Afforded: • Ten days notice that an IP is to be developed and/or modified. *(16.440 B)* • The mechanism of informed consent. *(16.520 A 4)*
Emergency Action: If the suspension is implemented as an emergency action, the agency must: *(16.312 A 5)* • Ensure the action is taken by a DD Professional specifically designated for this purpose by the agency director. • The action may only be taken if there is imminent risk to the health and safety of the person, others or property. • The suspension must be the least intrusive possible. • Case management must be notified of the emergency action within 24 hrs. *(16.312 A 5 a)* • The rights suspension must be specifically explained to the person and notice provided to the appropriate parties within 24 hrs of the suspension. *(16.312 A 5 b)* • Immediately implement the provisions of *Rules 16.312 A 2-4*	Prohibitions: Certain practices are prohibited by law and include: (C.R.S. 27-10.5-115) • Corporal punishment; • Seclusion and use of a 'time-out room'; • The use of posey vests, ankle and wrist restraints, straig' jackets; • The use of aversive or noxious stimuli.
	Safety and Emergency Control Procedures: The use of restraint and restrictive procedures on an unplanned and planned basis are specified in *Rules 16.530 and 16.540.* The requirements listed in this column do not apply to the use of restrictive procedures within their use in safety and emergency control procedures.