HEALTH STANDARD #16-1

HEALTHCARE/NURSING SERVICES FOR INDIVIDUALS RECEIVING DDS INDIVIDUALIZED HOME SUPPORTS (IHS)

Issue Date: October 1, 2016

Purpose:
This health standard clarifies expectations and practices for supporting the health and well-being of individuals receiving DDS individualized home supports (IHS).

Applicability:
This health standard applies to all individuals receiving DDS individualized home supports, who have a Level-of-Need (LON) of 1 through 8 and who contract with a qualified provider who receives the safety net for administration of the individuals services

Definitions and Roles:

Individual: A person receiving DDS funding or services through individualized home supports.

Provider: A DDS qualified provider that assists an individual to address healthcare needs and ensures appropriate medical follow-up on the health and safety needs identified in the Individual Plan (IP). Support shall be provided by a registered nurse (employed or contracted) or a community-based healthcare provider.

Planning and Support Team (PST)*: The team, including the individual's case manager, is responsible for ensuring that the individual's medical needs are clearly identified in his or her Individual Plan (IP). The PST supports the individual to live his or her life with the highest degree of independence possible by providing appropriate information for informed choice. All individuals, including those with a LON score of 1-3, require medical supports, which consist of, but are not limited to, the medical oversight responsibilities outlined below. These oversight responsibilities are minimum requirements for basic standard of care.

Nursing Delegation: Nursing delegation is the assignment of specific responsibilities to non-licensed medication-certified staff or a Licensed Practical Nurse (LPN) by a Registered Nurse. The RN maintains accountability for the delegated task. In order for certain individuals to live independently, interventions such as RN delegation for medication administration may be necessary and may be implemented by the provider agency RN.

*Additional definitions and descriptions of the DDS team process can be found at: http://www.ct.gov/dds/lib/dds/forms/ip/ip_guide.pdf

***Technology supports, such as adaptive devices (i.e., medication boxes or other forms of assistive technology) that allow for independence, must be explored as a possibility and should be funded through state or private insurance plans.*

Introduction:
The DDS Commissioner is responsible to ensure that individuals receive prompt, sufficient, and appropriate medical and dental treatment. The goal of this health standard is to detail how adequate health support is to be provided to individuals with IHS.

Standard:
An individual receiving IHS funding and services should have access to quality healthcare and have the opportunity for informed decision-making regarding the health and safety needs identified in his or her Individual Plan. The individual's Planning and Support Team shall ensure that the individual's health and safety needs are adequately identified in the individual plan and addressed appropriately through:

(1) Registered Nurse/Community-Based Healthcare Provider Supports
(2) Healthcare Coordination (HCC)
(3) Home Care or Visiting Nurse

Implementation:

1. **Registered Nurse/Community-Based Healthcare Provider Supports in IHS:** Any individual receiving IHS funding and services is required to have his or her health and safety needs identified and reviewed in the individual's IP according to Health Standard #08-1: DDS Minimum/Routine Preventative Care Guidelines for Persons with Intellectual/Developmental Disabilities. Healthcare may be deferred in accordance with Health Standard #9-2: Guideline for Deferred, Limited or Declined Healthcare. The individual's Planning and Support Team, in conjunction with the RN or Community-Based Healthcare Provider shall be notified if recommended healthcare has been deferred, limited, or declined. The amount and type of medical supports required is based on the individual's health needs and are part of the rate. These services may be provided by the agency Registered Nurse (employed or contracted) and/or by the Community-Based Healthcare Provider. DDS required medical oversight and documentation includes, but is not limited to:

    a. Adherence to **DDS Minimum/Routine Preventative Care Guidelines for Persons with Intellectual/Developmental Disabilities**
    b. **Community Health and Safety Assessment** (Initial and returning from hospital or Skilled Nursing Facility (SNF) admissions)
    c. **Self- Administration of Medication Assessment** (Initial and annual)
    d. **Quarterly Health Reviews** (For those receiving Healthcare Coordination (HCC) waiver service);
    e. **Semiannual or Annual Health Reviews** (For those not receiving HCC, an annual review may be sufficient for those with minimum medical issues)
    f. **Fall Risk Assessment** for anyone who meets criteria (Fall Risk Assessment is required to be reviewed annually by the PST. Screening may be adequate based upon the assessment's findings.)
    g. **DDS Coordination of Care Agreement** (Completed when a home care or visiting nurse and an agency nurse are involved.)

2. Healthcare Coordination (HCC) in IHS: Healthcare Coordination is a waiver service provided to an individual who may benefit from assistance in managing complex and changing medical needs, as identified in his or her nursing care plan or Individual Plan (IP). Healthcare Coordination may include the following:

    a. Coordination and management of an individual's care and services with a community-based healthcare provider or other persons involved in the individual's care.

b. Education of the individual and his or her staff or caregivers regarding appropriate interventions, changes in health conditions, signs and symptoms of illness, medication changes, and potential side effects of medications.
c. Review of lab tests and results, appropriate food consistency, dietary orders or recommendations, and minimum healthcare requirements.

Individuals are eligible for HCC if:

(a) Receives less than 24 hours/day of individualized home supports
(b) Have complex medical needs
(c) Have a combination of the following LON scores:

- Health/medical LON score of **4 or more**
- LON Score of **6 or more** from a combination of health/medical **and** either the behavior (home) or psychiatric (home) domains, **whichever is greater.**

d. Receives PRAT approval

In order for a Healthcare Coordinator to provide healthcare coordination services and bill for them, the community-based healthcare provider or the registered nurse is required to be a DDS-approved qualified provider for HCC. A Healthcare Coordination provider shall not provide direct nursing care. If direct nursing services are needed, a home care or visiting nurse shall provide the individual's care. A home care or visiting nurse may be hired through a referral from the individual's primary care provider (PCP). HCC does not provide the following services: (1) nursing on-call services, (2) DDS nursing delegation, or (3) pre-packaging of medications.

3. Home Care or Visiting Nurse Services in IHS: Home Care or Visiting Nurse Services are state and federally funded nursing services for individuals receiving benefits through Medicaid (Title 19), Medicare (Title 18), or other health insurance. A Home Care or Visiting Nurse provides direct nursing care, nursing assessments, administers injections, pre-packages medications, prepares pill pods for self-medication administration, wound care, hospice services, interprets and follows physician's orders, follow-up on changes in condition, etc. A home care or visiting nurse shall not provide nursing delegation and shall not complete DDS-required reports or assessments; however, the home care or visiting nurse is required by the Centers for Medicare and Medicaid Services (CMS) to complete a Home Health Certification and Plan of Care, Form 485. Form 485 outlines all of the home care services provided to the individual and is signed by the individual's Primary Care Provider. Form 485 shall be included in the individual's DDS Coordination of Care Agreement. In addition, each home care or visiting nurse agency is required to have their own Coordination of Care Agreement.

Basic Care Delivery Requirements for IHS:

Providers of IHS supports to individuals, who live independently, are required to ensure basic medical supports such as:

a. Coordination and management of an individual's care and services with a community-based healthcare provider or other persons involved in the individual's care. (Coordination of Care Agreement when indicated)

b. Education of the individual and his or her staff or caregivers regarding appropriate interventions, changes in health conditions, signs and symptoms of illness, medication changes, potential side effects of medications, review of lab tests and results, appropriate food consistency, dietary orders or recommendations, and minimum/routine healthcare requirements.
c. Scheduling physician consult appointments and annual physicals.
d. Managing an individual's medication changes and any potential side effects with a pharmacy.
e. Hospitalizations/Nursing facility admissions require agency involvement from time of admission through discharge
f. For those with HCC, individuals discharged from a hospital admission or skilled nursing facility should have a nursing assessment within 72 hours of returning home or as soon as the HCC is made aware of the discharge if the 72 hour period has passed. For those with or without HCC, this assessment may be completed by the home care nurse or other licensed professional. Nursing documentation is required when there is a change in condition or an intervention/procedure has occurred; this would include a change in condition that has returned to baseline or the development of new baseline status.
g. Documentation: The forms listed in section 1 (a-f) are the DDS documentation requirements to support the processes outlined above.

Attachments:

DDS Reference for Health Care/Nursing Services

Health Standard #08-1 DDS Minimum/Routine Preventative Care Guidelines for Persons with Intellectual/Developmental Disabilities

Health Standard #9-2 Guideline for Deferred, Limited or Declined Healthcare

Health Care Coordination Guidelines