LA PLUS: Guide to Routine Supports for Medical/Physical and Behavioral Health Needs Checklist

The medical/physical and behavioral health supports which are to be scored on the *Routine Supports Checklist* are generally defined as the following:

- Medical/Physical Support Needs: Moderate or intensive supports that are routinely provided (possibly every day, but at least every week) to maintain required medical/allied health treatment, support the prevention/treatment of medical conditions (including medication administration), or provide physical/nutritional support.

- Behavioral Health Support Needs: Moderate or intensive supports that are routinely provided (possibly every day, but at least every week) to prevent and/or intervene with regard to occurrences of challenging behavior and/or illegal behavior, and/or maintain prescribed mental health treatments.

There are two key aspects of these support needs:

1) The support is provided by non-professionals who provide the support at home or in the community. This includes paid or unpaid support, such as support provided by parents, family members, friends, or direct service workers. This does not include the support or services provided by those who are licensed and provide professional services such as skilled nursing services, physician services, occupational/physical therapy services, or behavioral and mental health services.

2) The support needs are current and necessary, and will continue to be so. This means: It is support that the person is receiving now (and needs now), has been receiving, and will continue to need for the foreseeable future in order to prevent and/or manage symptoms, maintain treatment, etc. This applies to medical/physical issues or behavioral health issues/challenging behaviors that would occur if caregivers/supporters did not provide certain supports on an ongoing basis to prevent it. This does not apply to supports that are needed temporarily to address an acute or temporary situation. For example: A person is injured and has a sprained ankle or is recuperating from surgery. The related support needs are only expected to last for perhaps 6-8 weeks, thus scoring those support needs here based on that temporary condition is not going to be reflective of the person's true support needs once they are better, and scoring that here would not be appropriate.
   Note: If necessary, for temporary changes in support needs, a support plan revision to temporarily request more support hours over allocation can be submitted along with documentation explaining the need for the temporary increase in support hours. This *does not* require re-assessment or adjusting the ratings on the Routine Supports Checklist.

   This also means that a 'history' of a condition, diagnosis, or challenging behavior is not scored on these checklists, unless support needs continue to be required in order to keep the symptoms from reoccurring, or to keep the challenging behavior from re-emerging.

The support needs scored here: **a)** Are typically more complex and/or intensive compared to support needs for basic daily living tasks, **b)** Likely required prior training by a professional to equip the caregiver/supporter to provide the proper support, and **c)** If the support is absent, it would likely pose a health/safety risk, either immediately or over time, for the person (or others).

There are some support needs that are not scored here, *if* these are the only supports provided for a medical/physical or behavioral health support need. These include:

- ≠ *Support with daily medications*: Even though medications as part of a daily routine may be prescribed to assist with managing a medical or behavioral health condition, they are not scored here. Providing medication administration assistance is considered a common and typical daily living support need (i.e., nearly everyone takes daily medications in some form), and is not considered a more complex/intensive support provided. Also, the reason for taking certain medications does not factor into the ratings on the Routine Supports Checklist. For documentation purposes, all daily medications must be included on Attachment E to the EPOC.

- ≠ *Support with diet*: Similar to daily medications, providing support with meal preparation and/or eating of prescribed diets (i.e., low-fat diet, low-salt diet, texture-modified diets such as chopped or pureed) is *not considered* a more complex/intensive support need, as everyone eats and a significant number of people require assistance to prepare their meals. These are common and typical daily living support needs. However, meals received via enteral feeding (i.e., tube feeding) *is scored* here if support is needed from a caregiver/supporter. Information about prescribed diets and/or enteral feeding must be included on Attachment C and D to the EPOC.

Also, these things are not scored on the checklists:

- ≠ *Self-Management of conditions* If a person can independently complete the medical/physical support activities or can self-manage the behavioral health concerns listed here in these checklists, then it is not scored because they do not receive support from others.

- ≠ *Diagnoses, medical conditions, behavioral health conditions*: The focus of these checklists is to score the support provided by others to assist with medical/physical and/or behavioral health needs, not to score the actual diagnosis or condition that the person has. In other words, for medical conditions, you are not scoring how "severe" a condition is. For behavioral health challenges, you are not scoring how "bad" or "disruptive" a behavior is. Rather, you are scoring the support that the caregiver/supporter must provide to prevent or manage it.

- ≠ *Support needs related to vision or hearing impairments:* Although support provided with regard to one's vision or hearing impairment is likely to occur on a routine basis, the support needs resulting from the impairments are not considered more complex/intensive. This is because the impairments are more likely to impact basic daily living activities and related supports needs which is consistent with disability-related services provided for many participants.

Tips in Decision-Making: Is it a "1" or a "2"?

LA PLUS:
Routine Supports for Medical/Physical and Behavioral Health Needs

Scoring Chart

Not Scored = Not an issue / Needed support in the past but not anymore / person manages support needs by themselves

1 = Moderate Support Needed

- Vigilant monitoring/supervision (remaining constantly alert and aware of/looking out for)
- Verbal prompting/redirection/coaching/reminders
- Individualized prevention strategies which prevent/lessen symptoms of a condition or risk (for behavioral health support needs) (i.e., making changes to the environment, adhering to specific daily routine, alarms on windows/doors, hazardous items locked out of reach, etc.)
- Partial physical assistance or periodic hands-on assistance *(for medical/physical support needs)*

2 = Intensive Support Needed

- Time-consuming or rigorous assistance
- Maintain close proximity/observation at all times (for immediate intervention, if necessary)
- Full physical assistance (completing something on behalf of the person)
- Physical guidance or physical blocking strategies *(for behavioral health support needs)*
- Strategies based on professional recommendations/plan, that includes more than supervision or verbal reminders *(for behavioral health support needs)*

❖ Remember: If "medication" and/or "diet" are the *only* supports provided, then it is **Not Scored**

Sometimes, it can be difficult to decide whether a score of "1" or "2" is more appropriate. It may appear that a person's support needs rides the fence between a "1" and a "2". It is completely appropriate for assessors to further probe an issue and ask questions for clarification when they are not sure of the appropriateness of a score. Assessors may ask the respondent to describe what the support strategies "look like" (i.e., what they do, when they do it, and why) in order to better determine the more accurate score.

When trying to determine which is more appropriate, assessors may want to ask the following questions of the respondents:

1. *On a typical day (not their best day, not their worst day), what type of support do you typically have to provide?* If the respondent describes support that falls more in the "moderate" category, then score the support needs as "1". If the respondent describes supports that fall more in the "intensive" category, then score the support needs as "2".

2. *Think about the environments or places that the person is most frequently in (home, school, work, specific communication locations, etc). What type of support do they typically need in all of these?* If the respondent describes support that falls more in the "moderate" category, then score the support needs as "1". If the respondent describes supports that fall more in the "intensive" category, then score the support needs as "2".

With regard to scoring behavioral health support needs in particular, the support strategies endorsed in behavioral health items should be consistent with recommendations provided by professionals, clinicians, committees, and/or required by the court, *if these are present.* The assessor should review professional recommendations and/or evaluations, including those of the NSB/LOT committee, as well as other clinical evaluations that may have previously occurred. The assessor should also look for any information from legal documents and/or court orders which identify a history of law enforcement/court involvement and related supervision needs because of the behavior.

- For current participants, if they are followed/monitored by the NSB/LOT committee, there will, minimally, be information and recommendations available in order to complete items #6 and/or #7. The assessor should use this information, in addition to other available documentation discussed above, to determine appropriate scoring on these items.
- For new participants for whom very little may be known, the needs-based assessment is where we may first identify behavioral concerns. For some participants, there is little to no external documentation of the needs or risks related to behavioral concerns. In these cases, the assessor should endorse either 'moderate' or 'intensive' (and the specific strategies) based on what staff/family are using currently to prevent/manage the behavioral issues. If these support strategies do not appear to be effective, then it may warrant a consultation with the LGE and/or Resource Center clinician for appropriate identification of support needs and risks, as well as scoring of the item(s).
    - If the presence of non-consensual sexual behavior (items #6 or #7) is first identified via this assessment, it is required that these participants are referred to the NSB/LOT committee for further review.
- If there is <u>no</u> documentation available but it appears that there is risk for CSV-specific criminal behavior, the assessor may need to consult with the LGE and/or Resource Center clinician for appropriate identification of supervision needs and risks, and thus, scoring of the CSV item on the LA PLUS.

Documentation Tip:

❖ If the overall type of support provided is "intensive" and a score of "2" is given, but there are also support strategies in the "moderate" category which are routinely provided, then it is recommended to also check those support strategies in the checklist so that this information is recorded for the sake of documentation, and can be transferred to the EPOC or other attachments as needed.

Routine Supports for Medical/Physical Needs (NOT Requiring Skilled Nursing):

1. **Repositioning:**

   Support to move or shift a person into a different position to redistribute pressure from a particular part of the body. May involve changing a person's position in their chair or bed, and/or may involve use of positioning equipment such as pillows, wedges, rolls, etc. This is usually done according to a set schedule to help prevent pressure sores (i.e., bedsores) or skin breakdown.

   - *No Support:* Person previously required assistance with repositioning in order to prevent sores, but can now move by himself (without physical assistance from others).
   - *Moderate Support:* Person needs partial physical assistance to reposition. Partial physical assistance = intermittent hands-on assistance, assistance for balance to steady/guide OR person can participate in and complete part of the task but supporter must complete some parts of the task for the person.
   - *Intensive Support:* Person needs full physical assistance to reposition. Full physical assistance = person does not participate in any aspect of the task; supporter must complete all aspects of the task on the person's behalf.

2. **Lifting or Transferring:**

   Support to lift (pick a person up from their sitting/lying position who is unable to bear weight on at least one leg) and support to transfer (move a person from one surface (bed, chair, toilet, etc.) to another surface. Lifts and transfers typically include use of certain techniques to ensure safety for both the caregiver and the person being lifted/transferred, which are taught by allied health or nursing professionals. Lifts and transfers may also involve the use of certain equipment such as a gait/transfer belt, sliding board, pivot disc, bed transfer rails, motorized lift, etc. to limit physical strain for caregiver and make movement safer or easier for the person.

   - *No Support*: A person who can use grab bars and/or their walker and pull themselves up to a standing position and then move from their chair or bed to another location without any physical assistance.
   - *Moderate Support:* Person needs partial physical assistance for transfers. Partial physical assistance = intermittent hands-on assistance or assistance for balance to steady/guide *OR* person can participate in and complete part of the task but caregiver must complete some parts of the task for the person.
   - *Intensive Support:* Person needs full physical assistance for transfers of one or more staff OR uses lift/equipment with one or more staff. Full physical assistance = person does not participate in any aspect of the task; caregiver must complete all aspects of the task on the person's behalf.

3. **Support from Staff/Family to Participate in Speech/OT/PT Activities:**

   Support to implement recommendations (homework) given by professionals in physical therapy, occupational therapy, speech-language therapy, or other allied health services. Reminder: This does not include supports to complete therapy homework from mental health professionals – this is scored in the other checklist under Support to Access and Participate in Behavioral Health Treatment.

- *No Support*: Person has "homework" from therapist (exercise/strength-training reps that require completion between sessions). They complete the work on their own without assistance or support from others.
- *Moderate Support*: Needs reminders and verbal prompts to participate and/or instructions/demonstration; Practice of simple skills outside sessions.
- *Intensive Support*: Practice outside of session requires full physical support; Needs full physical guidance to do routine range of motion, exercises, or other therapy related activities. Full physical assistance = person does not participate in any aspect of the task; caregiver must complete all aspects of the task on the person's behalf.

4. Supports Before/During/After Seizure Activity:

Support with seizure precautions (for safety) and management, and support with post-seizure care.

Many people with developmental disabilities also have a seizure disorder diagnosis or a history of seizures. It is important to differentiate between those who are actively having seizures (within the last two-four years) and those who simply have a history of seizures and are continuing to take seizure meds as a possible preventative or because the person's physician hasn't adjusted the medication regimen within recent years.

In addition, there are different types of seizures, not all of which result in a person having total body convulsions and falling to the floor. The type of seizures a person has will impact the type and intensity of support that a caregiver might provide, so it's important that assessors ask respondents, "What type of seizures do they have? What do their seizures look like? What are some symptoms?"

Here are the general types of seizures:

- Generalized Onset Seizures:
  - Absence seizures: "petit mal seizures". Causes a short loss of consciousness (just a few seconds) with few or no symptoms. The person typically interrupts an activity and stares blankly. These seizures begin and end abruptly and may occur several times a day. People are usually not aware that they are having a seizure, except that they may be aware of "losing time."
  - Myoclonic seizures: Consists of sudden body or limb jerks that can involve the arms, head and neck. The spasms occur on both sides of the body in clusters, especially in the morning. People sometimes describe the jerks as brief electrical shocks. When violent, these seizures may result in dropping or involuntarily throwing objects.
  - Tonic and Atonic seizures: "drop attacks". Some people, usually those with multiple brain injuries along with intellectual disability, have tonic seizures consisting of sudden stiffness in the arms and body, which can cause falls and injuries. Many persons with tonic seizures have a syndrome called Lennox Gastaut syndrome. Persons with diffuse brain disorders also may have atonic seizures, characterized by a sudden loss of body tone that results in collapsing, often with injuries.
  - Tonic, Clonic, and Tonic-clonic seizures: Previously "grand-mal seizures". Tonic-Clonic seizures can evolve from any of the focal or generalized seizure types. The person loses consciousness and usually collapses. Loss of consciousness is followed by generalized body stiffening for 30 to 60 seconds, then by violent jerking for 30 to 60 seconds, after which the

person goes into a deep sleep. Injuries and accidents may occur, such as tongue biting and urinary incontinence.

- Focal seizures**:** Also called "partial" seizures. These begin in one part of the brain and may spread to other parts. Focal seizures can evolve into major events that spread to the entire brain and cause tonic-clonic seizures.
  - Focal aware seizures: Also called "simple partial seizures". People maintain awareness during the seizure but they may experience some muscle spasms or jerking or experience unusual sensory sensations involving their hearing, sight, etc.
  - Focal unaware seizures: Also called "complex partial seizures". Causes altered awareness. People engage in repetitive, involuntary, but coordinated movements such as lip-smacking, chewing, fidgeting.

Examples of support that may be provided:

- Prevention (before): Some people must avoid certain elements in their environment that are likely to trigger a seizure such as extreme heat or cold, or flashing lights. Some people must be closely observed at all times for early signs of an impending seizure, so that they can be reminded to sit/lay down to avoid falls, if necessary. Some people must have their caregivers within close proximity at all times to closely observe and act at a moment's notice to prevent or reduce injuries when the seizures begin. They may have daily monitoring logs in place that staff/family must document in in order to assist in identifying patterns (frequency, intensity, duration) or triggers of the seizures.
- Interventions (during): For those who have tonic-clonic seizures and are likely to injure themselves during the seizure, there is a typical "seizure first aid" protocol that is followed: It is advised to ease the person to the floor and to roll the person gently onto their side to help them breathe. Caregivers may need to place a pillow under their head and clear the immediate area of hard or sharp items which could cause injury. No items should ever be put in the person's mouth during a seizure! Do not hold the person down or try to stop their movements. Caregivers will need to time the seizure, and if it extends beyond 5 minutes or if a person has 3 seizures in a row without coming to between them (status epilepticus), they will usually need to call 911. Some people may be prescribed medications that will be administered by an RN or a family member during a seizure in order to stop the seizure.
- Post-seizure care (after): Depending on the type of seizure, the type and amount of support that a person needs may vary, and the amount of recuperation time that a person needs may vary. People who experience absence seizures may have very little support needs with regard to post-seizure care. However, people who experience grand-mal seizures will have more support needs. With regard to physical needs, of course, any potential injuries they sustained during the seizure will need to be treated. In addition, they may have bitten their lip or their tongue, and may need to rinse their mouth out with water, as well as use ointments to help with discomfort and speed up healing. They may have a headache or migraine. They may have sore muscles. They may have experienced loss of bladder or bowel control. It is common to feel physically weak and very tired after a seizure, and the person may have trouble jumping right back into school, work, or their usual activities, so they may need a break from their usual schedule for the rest of the day. With regard to mental and emotional needs, a person may experience forgetfulness, confusion and trouble concentrating for a time after the seizure, so they may need extra support with reminders and patience. They may feel agitated or frustrated, and may become aggressive. Those with chronic seizures may see a decline in functioning memory over time. There may also be changes in mood, and feelings of anxiousness or sadness. Over time, with chronic seizures,

personality changes may occur and a person may experience depression. Symptoms of psychosis have been reported in about 6-10%, including paranoid thoughts, delusions, and hallucinations. Symptoms usually emerge about 1-3 days after a seizure, and insomnia is often the first sign. While the postictal phase (after the seizure ends to when the person returns to normal state) usually lasts for a few minutes to a few hours, for some people it can last for a few days.

- *No Support* : Medication only
- *Moderate support*: Observance of early signs and reminder to sit/lay down to avoid falls; Timing and observation during seizure; Observation for brief period post seizure. (Typical seizure first-aid protocol).
- *Intensive Support*: Close proximity during most occasions to assure no injuries when seizure starts; Timing and observation during seizure to alert RN/MD; Observation for lengthy period post seizure or remainder of day requires altering due to impacts of seizure. (Beyond typical seizure first-aid protocol).

    * Documentation Tip: If scored as "Intensive Support", a detailed seizure protocol specific to the person must be attached to the EPOC *OR* written in Attachment D, outlining prevention strategies (if any), intervention strategies, and post-seizure care which must occur. This protocol must have strategies beyond what is expected in the typical seizure first-aid protocol.

5. Oral Stimulation or Specific Jaw Positioning for Meals:

Sometimes, a person may have too high or too low muscle tone and is unable to control their jaw positioning independently, so caregivers have to assist by externally providing support to a person's head or closing their jaw for them after they take a bite.

Exercises/techniques (usually taught by a speech-language pathologist or occupational therapist) are used by caregivers to help support a person with achieving better oral motor skills: awareness of the mouth and tongue, lip closure, chewing, improving coordination and helping with issues like hypersensitive gag reflex and tongue protrusion.

- *No support*: person does not require oral stimulation or jaw positioning.
- *Moderate support*: Intermittent physical positioning/stimulation and/or verbal prompts prior to or during all meals
- *Intensive support*: Continuous oral stimulation, repositioning of jaw, head support or postural alignment and/or physical engagement throughout the meals

6. Administration of Enteral Meals by Staff/Family:

A tube feeding, in which nutrition is delivered through a tube into the GI tract (called enteral nutrition), is used for people who have a functioning gastrointestinal (GI) tract but cannot ingest enough nutrients orally to meet their current needs. Tube feedings can be used as the sole source of nutrition or in combination with oral intake. In certain situations, tube feeding is indicated, such as for people who tend to aspirate (food/liquids get into lungs) significantly if they eat by mouth or those with severe dysphagia (difficulty swallowing).

Nasogastric tube: runs from nose to stomach. Placed non-surgically; caregivers can be taught how to place them at home; need to be changed every 1-3 weeks. Generally used for short-term tube feedings.

Gastric tube (g-tubes) – surgically placed directly into the stomach. Different types of g-tubes including PEG tubes, Bard g – tubes, etc. These don't have to be changed as often (can go a month to several weeks), but they have to be flushed out to prevent clogging. Side-effects include development of scar tissue or granulation tissue (blisters, redness) to area around stoma/ostomy (surgical opening).

- *No Support*: Person does not need enteral meals.
- *Moderate Support*: Person requires caregiver to administer enteral meals; Person is able to position themselves following instructions. RN-delegated tasks are documented in Attachment D of the EPOC.
- *Intensive Support*: Person requires caregiver to administer meals, position/reposition and monitor throughout meals. RN-delegated tasks are documented in Attachment D of the EPOC.

7. Completion of Wound Care/Skin Integrity Care

Support with cleaning and dressing wounds or chronic open sores. This includes typical temporary 'first aid' care such as cleaning, applying ointment, and gauze/bandages to simple wounds such as cuts and scrapes, and this *also* refers to more intensive, long-term support for monitoring those who are *at risk for skin breakdown* and require regular skin checks and monitoring of existing wounds and decubitus ulcers.

Skin breakdown is damage to the skin from lack of blood flow most often caused by prolonged pressure, friction, or shear forces, chemical exposure (including urine, stool, or other secretions, or exposure to excessive perspiration.)

The following issues/conditions put people at risk for skin breakdown: immobility; incontinence; decreased sensation; impaired circulation; poor nutritional status; dehydration; self-inflicted injuries; degenerative neurologic diseases; central nervous system injuries; cerebrovascular accident/stroke; depression; fractures; diabetes mellitus; drugs that impair wound healing (i.e., steroids); placement of orthotic device; previous history of pressure-related skin problems/infectious skin disease; barriers to implementation of positioning programs (i.e. medical issues, enteral meal schedule, etc.). Generally, the more issues/conditions that are present, the more at risk a person is for developing skin breakdown.

- *No Support*: Person is not at significant risk for skin breakdown and can typically apply ointment and bandages independently.
- *Moderate Support*: Person may or may not be at significant risk for skin breakdown, but if gets injured and/or requires first aid, caregiver must provide the necessary support for cleaning and bandaging wounds.
- *Intensive Support*: Person is at risk for skin breakdown and requires frequent (possibly head-to-toe) skin checks for new wounds, regular monitoring of existing wounds for signs/symptoms that wounds are worsening or not healing, and maintaining a log of skin checks and monitoring, as per RN instructions. Staff/family may also provide additional supplemental supports to ensure best possible skin health such as applying moisturizer or topical skin protectant regularly (in addition to encouraging good diet, hydration, exercise, and repositioning as needed.) RN-delegated tasks are documented in Attachment D of the EPOC.

8. **Cleaning and observing or other delegated care for ostomy site**:

Support with ostomy (colostomy, tracheostomy, or other stoma) care. "Ostomy" means a surgically-created opening in the body. There are several different types of ostomy sites including colostomy, ileostomy, urostomy, and tracheostomy, as well as ostomy sites created for g-tube feedings.

- Colostomy: opening from the large intestine (colon). Part of the colon protrudes through the abdomen to the outside and it is stitched down to secure it. People must wear a bag over the colostomy to collect stool as there is no way to control when the stool will be released. The bag will be will need to be changed after each bowel motion, usually 1-3 times per day.
- Ileostomy: opening from the small intestine. The number of times people empty their ileostomy bags varies greatly and may be anywhere between 4-12 times per day.
- Urostomy: opening for urine drainage. A part of small intestine is used to create a channel for urine to pass through, and one end protrudes through the abdomen to the outside to create a urostomy. People must wear a urostomy bag over the ostomy site to collect urine.
- Tracheostomy: opening made into the trachea to allow a person to breathe normally. Tracheostomy has to be cleaned and suctioned periodically.

All ostomy sites require a certain amount of care: they must be cleaned regularly to prevent or minimize skin irritation of the surrounding area. In addition, people with certain ostomy sites may need to change out their bag several times per day (i.e., colostomy, ileostomy). People with ostomy sites are at greater risk for infection because bacteria can enter their body through these openings. Ostomy sites for g-tube placements may leak. Some ostomy sites are prone to closing up very quickly if tubing comes out.

- *No Support*: Person has an ostomy site and addresses their own care. They do not require assistance.
- *Moderate support*: Not applicable
- *Intensive Support*: Has an ostomy and requires ostomy site checks (includes assessing for redness, inflammation, and oozing) and cleaning (via saline, wound cleanser, etc., as determined by RN) around ostomy site. RN-delegated tasks are documented in Attachment D of the EPOC.

9. **Suctioning Around Tracheostomy as Delegated by RN:**

Support with suctioning of secretions around tracheostomy. This involves suctioning mucus out of the mouth and/or tracheostomy tube that the person is unable to cough up/spit out. In Louisiana, there are policies in place about what direct service workers can/cannot do with regard to suctioning. Any deep suctioning involving tracheostomy tube or newly placed tracheostomy tube (non-healed) must be completed by a nurse, or completed by family members who have been trained by a nurse.

- *No Support:* Person does not have a tracheostomy
- *Moderate Support:* Not applicable
- *Intensive Support:* Person requires frequent/daily suctioning using a yankauer (suctioning tool) around the tracheostomy. RN-delegated tasks are documented in Attachment D of the EPOC.

10. Other Supports for Medical Needs as Delegated by RN

Support for medical needs not covered under previous items

- *No Support*: Person has no other medical/physical support needs/ Person has physical support needs and/or a medical condition which requires at-home treatments, but all supports needs are addressed by home health/nursing services
- *Moderate support*: Not applicable
- *Intensive Support*: Any medical care/needs that can be delegated by an RN not addressed in other items. RN-delegated tasks are documented in Attachment D of the EPOC

Routine Supports for Behavioral Health Needs:

1. **Physical Aggression That May Cause Injury to Others:**
   Support to prevent hitting, slapping, kicking, punching, shoving, biting, choking, or throwing things at another person. This does *not* include threats of physical violence, or yelling, screaming, or cursing at people

   - *No Support*: Person does not engage in this behavior/Person has a history of physical aggression but no longer needs ongoing support to prevent/intervene with regard to this behavior
   - *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
   - *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

2. **Destruction of Property That has Monetary and/or Significant Emotional Value**
   Support to prevent intentionally damaging/destroying items such as knocking over or throwing furniture, punching holes in walls, throwing breakable items to the ground, breaking electronic items, throwing items at vehicles, etc. This would also include behaviors such as pulling threads of clothing and unraveling socks, shirts, etc. since this results in the need to replace the clothing. This would not include slamming doors, throwing or pushing unbreakable items to the ground (this would be scored under Emotional/Verbal Outbursts Directed Toward Others*)*

   - *No Support*: Person does not engage in this behavior/Person has a history of property destruction but no longer needs ongoing support to prevent/intervene with regard to this behavior
   - *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
   - *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

3. **Self-Injurious Behavior (not including suicidal threats/attempts)**
   Supports to prevent/intervene with a person's attempt to injure oneself, such as head-banging, eye gouging, skin picking, biting oneself, cutting, etc. This does not include Pica (consuming or ingesting things that are not food).

   - *No Support*: Person does not engage in this behavior/Person has a history of self-injury but no longer needs ongoing support to prevent/intervene with regard to this behavior
   - *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
   - *Intensive Support*: Physically blocking the behavior/Removal of means used for self-injury; Physically guiding the person away from environment and/or means used for self-injury; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

4. <u>Suicidal Statements (Talks About Suicide/Death) and/or Suicidal Intent/Attempts:</u>

The focus of this item is on support needed to appropriately address talking about suicide/death (suicidal ideation) or to prevent attempts to hurt oneself with the intention of suicide (suicidal action). The focus of this item is *not* about engaging in more typical observed forms of self-injury without the intention of suicide (i.e., banging head on wall, biting oneself).

Only licensed mental health professionals are qualified to assess whether a person is truly actively suicidal, therefore, if it is determined that a score of "1" or "2" is appropriate, then assessors must notify their supervisors immediately after completing this assessment to find out how to get this person access to a mental health professional for an evaluation if they do not currently have one. If the person already has a mental health professional, but a professional evaluation has not been conducted to specifically assess the suicidal ideation or behavior or the support strategies needed, then assessors must ensure that an appointment is scheduled with this professional immediately to conduct an evaluation. If support strategies are already in place to address suicidal ideation and/or suicidal attempts (i.e., Safety Plan, person knows to contact 988, person has a crisis counselor, etc.), then this is not needed. Detailed documentation of support strategies, a copy of the Safety Plan, or other relevant documents must be included/attached to the person's EPOC.

With regard to scoring support needs for prevention/intervention:

- At-home caregivers/supporters and direct service workers may not be equipped to provide the appropriate support and care to persons who are truly imminently suicidal. Thus, a score of "1" would most likely involve ongoing support to address the more chronic nature of suicidal ideation. Support strategies may include monitoring a person for signs/symptoms of significant changes in mood, closer monitoring during certain times of the year (particular holidays or anniversaries of a loved one's death, etc.), and/or ongoing support to use strategies in their Wellness Guide (coping skills, engaging in positive "feel good" activities, etc.).
- A score of" 2" should be uncommon, as this pertains more to support that is provided when a person is in crisis, has suicidal intent, and/or is planning to attempt suicide. More than likely, in situations where this score is appropriate, there is a protocol in place that caregivers/supporters can recite (as developed with assistance of a mental health professional), and have had to put into action on a regular basis, such as locking up certain items in the home or monitoring the person when they are in the bathroom at times (i.e., blocking certain behaviors and/or removing the means by which people plan to use to end their life). They are keenly aware of the triggers or the person's unique warning signs and must be vigilant during the crisis window to intervene.

    - *No Support*: Person does not have suicidal ideation and/or demonstrated suicidal intent or attempts/Person has a history of suicidal ideation but no longer needs ongoing support to prevent/intervene with regard to these thought patterns or behavior
    - *Moderate support*: Suicidal ideation is present, supervision/verbal guidance is needed to participate in positive activities, or other wellness strategies in Wellness Guide; Monitoring of intensity and nature of thoughts needed with instructions to report to mental health professional; Requires active listening and validation support to reduce feelings of isolation/hopelessness
    - *Intensive Support*: Suicidal intent present, requires physically blocking the behavior/removal of means; Requires support to implement/use individualized Safety Plan; Maintenance of close proximity during "Crisis Window" to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

5. **Ingesting or Inserting (in any part of the body) Objects That are Harmful:**

Support to prevent/intervene with ingesting or attempting to ingest and swallow inedible and/or harmful items. This does not include occasional accidents involving ingestion of food-related items or situations in which the person confuses an item for food (for example, accidental consumption of a wrapper on snack food item; consuming liquid that looks like something to drink).

This also includes support to prevent/intervene with inserting harmful objects into any part of the body, including into directly into the skin, eyes, ears, nose, or others orifices.

- *No Support*: Person does not engage in this behavior/Person has a history of ingesting harmful items but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

6. **Sexual Aggression or Assault:**

Supports to prevent behavior involving physically touching others (in a sexual way) without their consent. This includes attempted rape (all forms) through threats, coercion, or physical force, or rape of someone unable to give consent, sexual battery or other forms of sexual assault, including sexual behavior involving or toward children. This also includes fondling of genitalia, breasts, and buttocks, over or under clothing, with a sexual intent (i.e., sexual battery).

- People who engage in nonconsensual sexual behavior (including pedophiles, and others who pose a perpetual risk to others) often require continuous supervision in certain environments, and sometimes certain forms of intervention in order to prevent reoffending. They may not require any hands-on assistance to prevent or interrupt the behavior, but if the supervision were absent, the outcome of the behavior could be very dangerous. The supervision may or may not be court-ordered.
- In addition to supervision, caregivers may also be required to *intervene* by performing searches of the person and/or his belongings, and when necessary, confiscating certain additional items which lead to reoffending opportunities or increase the chances that the person will reoffend. As with any restrictive strategies, the person's legal rights must be respected and due process procedures must be followed prior to implementation of any such interventions.

  - *No Support*: Person does not engage in this behavior/Person has a history of sexual aggression but no longer needs ongoing support to prevent/intervene with regard to this behavior
  - *Moderate support*: Supervision/verbal guidance for positive interaction*;* Verbal reminders to maintain social boundaries
  - *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

7. **<u>Other Nonconsensual Sexual Behavior (including verbal threats of sexual nature):</u>**
Supports to prevent such behavior as public masturbation, deliberately exposing oneself to others, "peeping tom" behavior, stalking, saying "lewd" things, making "lewd" gestures, etc. Even though this behavior does not include an element of physical aggression, it is still considered non-consensual sexual behavior as there are others who are subjected to this behavior without their consent.

The following are *not* considered non-consensual sexual behaviors:

- Those who masturbate in their own home or in a private space, or those who look at pornography (adult pornography) who are able to make that choice for themselves.
- Consensual sexual activity: Any sexual activity, which is consensual in nature, is not scored here, regardless of how caregivers feel about the activity (i.e., bad decision-making) or other potential risks (real or perceived) which may be present.
- Those who exhibit undeveloped social skills concerning knowledge of appropriate boundaries (i.e., excessive hugging of others), as the intent behind this behavior is typically not sexual.

  - *No Support*: Person does not engage in this behavior/Person has a history of public masturbation but no longer needs ongoing support to prevent/intervene with regard to this behavior
  - *Moderate support*: Supervision/verbal guidance for positive interaction*;* Verbal reminders to maintain social boundaries; Individual prevention strategies
  - *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

<u>Documentation Tip:</u> In conjunction with the LGE's, OCDD has implemented committees in every region of the state to further assess and provide oversight to persons who currently engage in non-consensual sexual behavior (or would engage in this behavior if supports were absent), including the behavior discussed above in Items 6 and 7. Any person who receives an endorsement on either of these items must be referred to the local committee for further review, if they have not been already assessed.

These committees may be referred to as Local Oversight Teams (LOTs) or Non-Consensual Sexual Behavior Committees (NSB Committees) and are comprised of a designee(s) from the LGE (waiver and community services), clinical representation from the Resource Center, the person's support coordinator, and the IFS provider (if any). Composition of the group is driven by individual and/or case-specific needs, which may include incorporation of other internal representation from personnel who are familiar with the case, and/or whose expertise would enhance the review process. The committee will provide some recommendations to the support team and, depending on the severity of the behavior or the risk level, will continue to provide monitoring and oversight for as long as needed. It is the responsibility of the support coordinator to ensure that any recommendations and/or relevant feedback received from the team/committee regarding support needs and/or risk mitigation needs is documented in the support plan. Upon further review by the team/committee, should it be determined that the sexual behavior was incorrectly endorsed on this checklist (i.e., the sexual behavior does not warrant or require "moderate" or "intensive" supports, is not a truly nonconsensual sexual behavior, and/or does not put others at risk), the LA PLUS, *Checklist* and/or support plan should be updated as needed to address the incorrectly scored item and to more accurately represent the person's support needs in the plan documentation.

8. **Taking Items of Value from Another Intentionally, Including Shoplifting:**

Support to prevent/intervene with someone intentionally taking or attempting to take items or money from others, from a public building or store, or someone's home. This item does not include if someone picks up an item they like and may walk away with it but is unaware that it does not belong to them because this type of behavior is not a significant behavioral health issue but simply requires supervision of a routine nature.

- *No Support*: Person does not engage in this behavior/Person has a history of shoplifting but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

9. **Intentionally Running Away or Getting Away From Supervision:**

Support to prevent/intervene in situations in which a person intentionally runs away/attempts to run away from supervision, or seeks to intentionally avoid necessary supervision in some way. This item includes people who do or do not have safety awareness while away from supervision. .

- *No Support*: Person does not engage in this behavior/Person has a history of intentionally running away from supervision but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically blocking the behavior; Physically guiding the person back to area; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

10. **Wandering Away or Leaving Supervision Unintentionally (when the person is not able to assure their own safety):**

Support to prevent/intervene in situations in which a person unintentionally wanders away from supervision at home/school/other locations, and/or wanders away from their caregiver with risk of getting lost or injured. This item is referring to behavior where a person may leave the immediate area without any thought, and cannot find their way back and/or cannot assure their own safety. For example, a person who, when outdoors, will walk into the street without any awareness of oncoming traffic would be considered wandering.

Wandering behavior is *not* the same thing as leaving the immediate area or briefly walking away from one's caregiver to explore one's surroundings. For example, if a person is shopping in Wal-Mart with a caregiver, walks over to the next aisle to briefly look at an item, and then comes back, this is *not* wandering. In this instance, the person intentionally walked to the next aisle, was able to assure their own safety during those brief few minutes, and was able to find their way back to the caregiver.

- *No Support*: Person does not engage in this behavior/Person has a history of unintentionally wandering away from supervision but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically blocking the behavior; Physically guiding the person back to area; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

11. <u>Emotional/Verbal Outbursts Directed Towards Others (not simply cursing):</u>

Support to prevent/intervene with verbal aggression directed at others, such as cursing and/or screaming at others, making verbal threats toward others, etc. This behavior being discussed here is not simply being upset or angry, crying, yelling and/or shouting some curse words (i.e., venting), but this behavior must be directed *at others*. Additionally, what is not being scored here is "emotional support" or "comfort" that would be provided to anyone after they have had a bad day, have just received bad news, or are tired/not feeling well, and are upset. These outbursts may also include such behavior as pounding their fists on walls/tables, stomping their feet, kicking walls/doors/furniture, slamming doors, etc.

It is common to see behavioral episodes begin with emotional/verbal outbursts, and if timely intervention does not occur, the verbal outbursts will escalate into physical aggression, property destruction, or self-injury. In these cases, do not score the support for physical aggression or self-injury under "emotional/verbal outbursts". The support provided for each of these separate behaviors should be scored under their specific category. The emotional outburst behavior should be scored alone, in and of itself (prior to its escalation). For instance, caregivers may provide "intensive" support to prevent emotional outburst behavior, but if they do so and do it successfully, then the support needed to prevent physical aggression is "moderate" because the physical aggression typically is not as severe if caregivers intervene early enough.

- *No Support*: Person does not engage in this behavior/Person has a history of emotional outbursts directed at others but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically guiding the person away from others; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

12. <u>Substance Abuse (diagnosed by clinician) or Substance Use That Impairs/Negatively Impacts Person</u>

Implementation of support strategies to address substance abuse (as identified by the licensed mental health professional) or support to address substance use concerns which have significantly impaired the person's day-to-day functioning or negatively impacted the person in some way.

Substance use disorders occur when a person continues to use things like alcohol, drugs, or tobacco, despite the harmful consequences. The reoccurring use of the substance may cause significant impairment in a person's life, including causing health problems, financial problems, problems at work or school, and/or relationship problems with family members or friends, or it may lead to

engaging in other risky behavior. Examples include excessive consumption of alcohol, misusing prescription medication (e.g. pain medications; stimulants), using illegal substances or toxic substances (e.g., inhalants, marijuana, ecstasy, cocaine).

- *No Support*: Person does not engage in this behavior/Person has a history of substance use but no longer needs ongoing support to prevent/intervene with regard to this behavior
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

13. <u>Support to Access & Participate in Behavioral Health Treatment:</u>

Support to access, receive, and/or participate in necessary behavioral health treatment. This includes support for any aspect of the treatment including scheduling the appointment, transportation, communicating during the appointment/session, working on skills or 'homework' after the appointment or session, and taking medication.

- *No Support*: Person does not require behavioral health treatment/Person previously required support for transportation to appointments and to take medication but no longer needs ongoing support from others
- *Moderate support*: Making appointments/transportation; Help communicating needs; Assistance to take behavioral health medication
- *Intensive Support*: Assistance in therapy session; Assistance to practice skills from therapy session; Prompts/reminders and repetition to take behavioral health medications due to repeated refusals

14. <u>Other Behavioral Health Symptoms or Behavioral Challenges (not covered in other items):</u>

Support for behavioral health needs not covered under previous items

- *No Support*: Person has no other behavioral health support needs/ Person experiences behavioral health symptoms but all support/treatment to address the issue is provided by licensed professionals.
- *Moderate support*: Supervision/verbal guidance for interaction; Verbal reminders; Individual prevention strategies
- *Intensive Support*: Physically blocking the behavior; Physically guiding the person away; Maintenance of close proximity at all times to intervene; Professional recommendations/plan that includes more than supervision/guidance/verbal reminders*

❖ **Scoring Tip**: With regard to those who engage in/would engage in criminal behavior that has resulted in or would result in arrest (including such behaviors as assault, property destruction, shoplifting, sexual assault, etc.), whether or not they require support from others to address the behavior (and require a rating here) may be partially dependent on any previous court involvement they have had. Here are some considerations:

- If the person was not receiving significant support/supervision hours (less than daily or brief daily visits) before the crime and arrest and they were found competent to stand trial, if the person's daily needs continue to be minimal and they continue to have significant amount of unsupported time, and there are no professional or court requirements/recommendations related to disability supports/supervision, then no support is needed (from staff, family) to address the criminal behavior, and no rating is needed here.
  - *Example:* Person receives a small number of hours a week for disability-related needs related to physical support needs. They have a history of offenses/crimes with court consequences/jail time, but supports have not changed or been questioned in conjunction with any of the offenses.

- If the person was receiving significant support/supervision hours (several hours each day) before or after the crime and arrest, then support team and LGE discussions should have occurred (including considerations and concerns about support and waiver assurances), in addition to court proceedings and/or professional evaluations that outline *if* and *what type* of support is needed, and whether the person was deemed competent to stand trial. It is these proceedings, evaluations, and recommended supports that should be taken into account when determining the ratings here, and not simply whether the criminal behavior is present or would be present.
  - Support teams may need to review various documents to determine what the support recommendations are, including legal documents, court orders for supervision or other services, psychological evaluations or other behavioral health assessments.

- If the person has not been receiving any support/supervision before or after the crime and arrest, then clinical evaluations should have been conducted, in addition to court proceedings that determine whether the person was deemed competent to stand trial. It is the issues and support needs identified by these evaluations and in these court proceedings which should be taken into account when determining the ratings here, and not simply the whether the criminal behavior is present or would be present.
  - Support teams may need to review various documents to determine what the support recommendations are, including legal documents, court orders for supervision or other services, psychological evaluations or other behavioral health assessments.

- For any instance where the needed supports are *not* clear and/or ratings are *unsure*, then a referral to the OCDD Resource Center for consultation or a referral to the LOT/NSB Committee for review can be made prior to finishing the ratings.

❖ **Documentation Tip**:

***** Prior to the implementation of any restrictive interventions/strategies, due process procedures must be followed and informed consent of the participant (or authorized representative) must be obtained. This informed consent must be documented in the EPOC.