Welcome!

The Department of Health, Department of Health Improvement, Quality Management Bureau and the Parties involved in Jackson are working together to develop an individual review process and tool that will replace the Community Practice Review. In order to have this individual review result in a positive process and one that improves supports and services for individuals we need your thinking and suggestions to make it better.

Here is how to give us input and how we will let you know what we've done with your input.

To review the current DRAFT Individual Quality Review protocol go to the Jackson website at: Jacksoncommunityreview.org

1. Identify which section you are making comments on as well as the specific number of the question or item. Examples follow in the table below.
2. If you think we should rewrite a question, please rewrite that question the way you think makes it better and send it to us as part of your comments.
3. If you think we should delete a question, identify it, tell us why and send that to us.
4. If you have other suggestions for additions, changes or deletions … send your suggestions to:

    Lyn Rucker at: rpaltd@aol.com
    And copy: Paula Bigham at: paulathebigham1@yahoo.com; Sally Karingada at Karingada@state.nm.us; and Crystal Lopez-beck at Crystal.Lopez-beck@state.nm.us

Thank you in advance for working with us to improve the content and the process of the Individual Quality Review!

We will review your comments regularly and respond so that you know how we have incorporated your suggested changes. We will use the following format to provide you with feedback regarding what we have done with your suggestions. What follows is a summary of the feedback we have received as of 4.20.17.
Green = changes we've made based on your feedback.
White = Clarification on our part with respect to the language or what we are looking for.
Yellow = Questions

Section and Number	Current Language	Comment/Suggestion	Response
Section #1:			
1B.	Diagnosis Table	What and where is this?	Clarification: The reviewer is expected to identify diagnosis attributed to the person in documents found in the record including eChat. They enter this information in the table under 1B. called Diagnosis Table. Page. 2
1F. 7.	Health & Safety: check to assure that all relevant diagnoses and summary information about health concerns are discussed. ==Note whether an Assistive Technology Inventory exists. Cross reference with the Equipment Table.==	Are these two things *(AT Inventory and Equipment Table)* the same thing with 2 different names?	Clarification: The "equipment table" (1X) in Section #1. Is different than the Assistive Technology Inventory that DDSD requires. Reviewers are asked to identify anything that has been recommended for the person whether it is "adaptive equipment", "assistive technology", "environmental modifications", etc. and list those recommended items in the equipment table in Section 1. We are not expecting that anyone other than reviewers will use the term "equipment table" unless they are speaking specifically to this table in Section #1. Guidance with 1X includes: *Equipment is defined as: any item needed to enable a person to be successful in his/her environment. Examples of equipment include: durable medical equipment such as wheelchairs of any type, walkers, shower chairs, shower trolleys, hospital beds, eating and drinking equipment; also personal items such as glasses, dentures, hearing aids. Adaptive equipment should be included e.g.; communication systems, switches, electronic devices (anything with an on/off switch) and/or simple non-electric items such as picture devices communication systems including communications rings. Equipment identified as being needed must be available and used by the person in all relevant environments; it works as intended; and continues to be appropriate to the person. If the person refuses to use the equipment identified, there is evidence that the appropriate specialist has been consulted and alternative devices/interventions assessed, sought and tried. Devices designed specifically for use to support work tasks only, need not be used at home and vice versa.*
1F. A5; B5; C5; D5	Integration therapies: Are recommendations and/or objectives/strategies of ancillary providers integrated into the outcomes, action plans and T&SS of the ISP?	You realize that you are asking lay persons to write strategies from a therapy plan written by a licensed professional.	Clarification: Reviewers are not instructed to identify exactly "who" provided the (T&SS) strategies from the therapy plans but having said that, the 2012 DD Waiver Standards seem to make it clear that the responsibility for T&SS, overall, is the Team. Specifically, Chapter 4. 1G. (Case managers are to) Ensure the

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			development of targeted, realistic desired outcomes and action plans with measurable action steps and relevant useful Teaching and Support Strategies (TSS) by the IDT… they go on to say…, "The Case Manager and the IDT then need to develop Desired Outcomes, Actions Plans and Teaching and Support Strategies…"
			The reviewers are looking to ensure that strategies of ancillary providers are integrated into the ISP; who helps with that, it is agreed, should be the therapists and/or licensed professionals.
1M.	Provider Annual/Semi Annual/ Quarterly Reports	QMB just requested we call them both Semi-annual reports.	Change: I checked with QMB. They suggest we use the terminology "Quarterly Reports" until JCM officially roll into the new waiver standards so we will use that terminology.
1R.	RORI's for this person.	You should add, "RORI should be filed by the provider agency anytime a Case Manager is untimely in providing needed information, reports, the ISP, budget and accompanying documents.	Change: Will add this language.
1Y.7.	Describe progress since the last report, especially progress on outcomes and action steps.	The auditor needs to be mindful that there are times when all Therapies are working on preventing decline and/or maintaining skill sets when there are multiple comorbidities.	Change: A note will be added which reads, "Note: In some cases, preventing decline and/or maintaining identified skills can be "progress" for an individual. Please indicate if this is applicable to the individual you are reviewing".
1X.	Equipment table	Call it "Assistive Technology (AT) Inventory.	Clarification: As mentioned above, this terminology is only for the reviewer and only makes reference to the table in 1X.
Section #2			
2C1.16; PT 2C2.16; OT 2C3.16; SLP	How long have you worked with (name)	This seems redundant with first question in #7 above. (When did you start with (name).	Change: Will delete Question #16
Section #3			
3B.5.	… (check the list against the adaptive equipment list for the person).	Better term for adaptive may be assistive technology.	Change: Will add "assistive" so it references both.
3C.4.	What does (name) do each day? (Ask to see the daily schedule and review it with staff. Choose an activity or two and ask the staff to explain the purpose of the activity.)	There is nothing in the DDW Standards that reflects a requirement for a "Daily Schedule". Furthermore, if the individual is offered choices throughout the day on preferred activity choices,	Change: The Note will be changed to read, "Choose an activity or two mentioned by the staff and ask the staff to explain the purpose of the activity."

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		there is no way to create a written daily schedule prior to implementation.	
3C.8.	What kinds of medical issues does s/he have? (If you are given a list of diagnoses, ask what each one means for (insert name). How do they impact on daily life?)	*You do realize that some of the direct care staff may not be able to explain the list of diagnosis to the reviewer. They will surly know and understand 'seizure disorder', but may not be able to discourse on* Spastic Choreoathetoid Quadriparesis.	Change: The note will be changed to read, "Staff can bring information with them regarding the individual's diagnosis (this is not a memory test). When staff provide you with a diagnosis or description of one, you are looking to see if they understand the implications of that diagnosis to the person's day-to-day care."
3C.9.	What medications does s/he take while here and what are they for? What side effects do you look for?	*Most staff will not be able to commit to memory these medications and list off the side effects on demand….*	Change: A Note will be added which reads, "Staff can either describe and/or get a list of the side effects and show you. Some may do both." This is consistent with the question asked of home/residential staff.
3C.10.	How do you assist with these medical issues? What do the MERPs and/or HCP's say should be done? (Compare what they say to the actual plan.)	*Most staff will not be able to commit to memory these plans and respond to them verbally.*	Change: We will add a note: "Staff can reference HCPs and MERPs but not read them back without further questions from the reviewer in terms of what they would actually do under specific circumstances".
3C.19	How long has (insert name) been working on this? What progress has been made? (Guidance: it is not enough to say that the person is doing "good" or "has made progress. The staff needs to be able to describe what skills have been learned. If the person has been working for 3 months or longer, progress is expected.)	**Secondary to many individuals having multiple comorbidities, a timeline of 3 months for expected progress is not reasonable.**	Change: The following will be added to the note. "If there has been no progress, ask the staff why they think that is and if the outcome should continue and why."
3C.33.	Does (insert name) have any advanced medical directives, or any end-of-life directions? If so, what are the instructions? Do you know how these were chosen? If not, do you know why none have been prepared?	**A direct care staff would not likely be the appropriate person to ask this.**	Question: This is a question for Day/Community staff. If something happens during the day who would be the right person to know and have this information?
3D.4.	How many different jobs or types of work was (insert name) able to experience before s/he began working here?	**A direct care staff would not likely be the appropriate person to ask this.**	Question: This is a question for Employment staff (job coach). Wouldn't the ISP have this information and if the person is on the team, wouldn't they know this?
3D.7.	How much does (insert name) get paid? How does this impact on his finances and benefits?	**A direct care staff would not likely be the appropriate person to ask this.**	Change: The question regarding how much the person is paid will be deleted.

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3D.8.	Has (insert name) ever had a benefits analysis of the potential impact of employment on (his/her) finances, benefits and services? (Get A COPY!)	A direct care staff (job coach or program manager) would not likely be the appropriate person to ask this. *This would be something that is available to clients as needed and it is done by a person in the agency in the financial division.*	Change: This question has been deleted. We will ask for it as a part of the document requests.
3D.9.	How many hours per week does this person work? How much money do they make?	A direct care staff would not likely be the appropriate person to ask this. This would be personal information that direct care staff would not have access to.	Change: The last question will be deleted.
3D.10.	Is there a chance of more hours or responsibilities? A raise?	A direct care staff would not likely be the appropriate person to ask this.	Question: Since this is the employment staff who works with and knows the person best, would they not know this?
3D.16.	What kinds of medical issues does s/he have? (If you are given a list of diagnoses, ask what each one means for (insert name). How do they impact on daily life?)	*You do realize that some of the direct care staff may not be able to explain the list of diagnosis to the reviewer. They will surly know and understand 'seizure disorder', but may not be able to discourse on* Spastic Choreoathetoid Quadriparesis.	Change: The note will be changed to read, "Staff can bring information with them regarding the individual's diagnosis (this is not a memory test). When staff provide you with a diagnosis or description of one, you are looking to see if they understand the implications of that diagnosis to the person's day-to-day care. "
3D.17.	What medications does s/he take while here and what are they for? What side effects do you look for? *Note: Staff can either describe and/or get a list of the side effects and show you. Some may do both.*	This is good.	Thank you.
Section 4.			
4A.8.	Ask to review the person's daily schedule. Make notes as to what is to occur.	There is nothing in the DDW Standards that reflects a requirement for a "Daily Schedule". Furthermore, if the individual is offered choices throughout the day on preferred activity choices, there is no way to create a written daily schedule prior to implementation. In the home, time for bathing,	Change: This request will be deleted.

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		medication delivery and meals would be consistent.	
4A.10.	Review shift/progress notes. Indicate how they compare to the daily schedule. Note any evidence of varying the daily routine, making choices, being involved in activities beyond the regular program, access to money, transportation and staff, purpose of activities, relationships, activities of personal preference,/cultural activities, contact with neighbors and other community members, staff assistance to encourage social interaction.	There is nothing in the DDW Standards that reflects a requirement for a "Daily Schedule". Furthermore, if the individual is offered choices throughout the day on preferred activity choices, there is no way to create a written daily schedule prior to implementation. In the home, time for bathing, medication delivery and meals would be consistent.	Change: The statement, "indicate how they compare to the daily schedule" will be deleted.
4D.4.	What does (insert name) do each day? (Ask to see the daily schedule and review it with staff. Choose an activity or two and ask the staff to explain the purpose of the activity.)	There is nothing in the DDW Standards that reflects a requirement for a "Daily Schedule". Furthermore, if the individual is offered choices throughout the day on preferred activity choices, there is no way to create a written daily schedule prior to implementation. In the home, time for bathing, medication delivery and meals would be consistent.	Change: The Note will be changed to read, "After the staff describe the person's daily activities, ask the staff to explain the purpose of a couple of those activities."
Section 5			
		No comments	