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Number: APD-AR-16-070

Issue date: 9/30/2016

Topic: Developmental Disabilities

Due date:

Subject: Tier Review Practices

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Aging and People with Disabilities | <input checked="" type="checkbox"/> Office of Developmental Disabilities Services(ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs | <input type="checkbox"/> ODDS Children's Intensive In Home Services |
| <input checked="" type="checkbox"/> County DD Program Managers | <input type="checkbox"/> Stabilization and Crisis Unit (SACU) |
| <input type="checkbox"/> ODDS Children's Residential Services | <input checked="" type="checkbox"/> Other (please specify): Provider Agencies |
| <input type="checkbox"/> Child Welfare Programs | |

Action required: The Office of Developmental Disabilities Services (ODDS) Tier Review Committee reviews the level of supports needed for individuals with exceptional or unique support needs which may not be fully reflected in their Supports Intensity Scale (SIS) Tier assignment and determines a rate which reflects those supports.

This transmittal introduces a document, the ODDS Tier Review Form, DHS 0383, which is to be completed under the oversight of CDDP staff and by provider staff, CDDP staff or in team collaboration.

The DHS 0383 is to be completed for all initial tier reviews, updated for tier re-reviews, tier rate appeals, tier rate desk reviews and used when a exceptional or unique transition or interim tier rate is requested. It is intended the form become a living document which can be completed initially, saved electronically, updated, and used for tier re-reviews or other tier reviews in the future.

Reason for action: The DHS 0383 will guide the provider and CDDP to gather and submit the necessary documentation, information and data so the ODDS Tier Review Committee can make an appropriate tier level determination. The committee will then

authorize a service rate reflective of the actual needs of the individual for whom the tier review is being conducted.

Field/stakeholder review: Yes No

If yes, reviewed by: Piloted over several months via re-reviews and interim rate review processes

If you have any questions about this action request, contact:

Contact(s):	Dan Boyd		
Phone:	503-602-8548	Fax:	503-945-6219
Email:	daniel.k.boyd@state.or.us		

ODDS Tier Review Information



Instructions:

Please include a response to each request for information. If information requested does not apply to the individual please indicate "NA" for not applicable. Check boxes may be left blank if the information requested does not apply to the individual.

Type of review: Choose one Individual's prime: _____

Individual's name: *(first, last)*: _____ Date of Birth: mm/dd/yyyy

Provider organization: _____ Most recent SIS assessed tier: _____

Licensed capacity: _____ Current number of individuals residing in this home: _____

Staffing:

Current staffing pattern for the site (*day/swing/nocturnal*). Please attach staffing schedules with this packet. Please do not include more than 3 months staffing schedules. Please be sure documentation is readable and legible:

Other individuals in the home have exclusive focus staff: Yes No

Briefly describe the reasons why this individual's needs exceed the currently assessed tier:

Diagnoses:

Protocol:

<input type="checkbox"/>	There is a current constipation protocol	<input type="checkbox"/>	There is a current dehydration protocol
<input type="checkbox"/>	There is a current seizure protocol	<input type="checkbox"/>	There is a current aspiration protocol
<input type="checkbox"/>	Other protocols:		

1:1 and 2:1 Exclusive Focus Staffing*:

Describe, in detail, what the assigned 1:1 or 2:1 exclusive focus* staff does during the time they are supporting the individual (*e.g.; Kari acts out aggressively, including flailing her arms at passersby and using foul language toward other women when in the community, requiring additional supervision and physical interventions to mitigate the risk to the community*). In this example, a narrative or bullet-pointed description of the actual tasks completed by the 1:1 or 2:1 staff while this behavior is occurring is helpful. Also include data for the past three months identifying the number of community outings, including the length of the community outing and the frequency, intensity and duration of the challenging behaviors during those community outings. (*In addition, please attach data summary sheets to this packet*):

* Exclusive focus staffing means the individual has one or more assigned staff who provides a constant level of supervision, generally within arm's reach and visual range so that intervention can be immediate. In some situations, such as toileting, exclusive focus staff might be positioned outside a closed door, but would be actively engaged in listening for indicators that the intervention is required. The exclusive focus staff must be unable to perform other duties that remove their attention from the individual they support such as driving, household functions, covering breaks for other direct care staff or charting.

Sleep:

Clearly describe the individual's typical sleep pattern. If up at night describe the type, frequency and duration of staff support required. Be sure to include any 1:1 or 2:1 exclusive focus supports required:

Transportation:

Describe, in detail, special supports or considerations for transportation including 1:1 or 2:1 (*Note: 2:1 does not include the driver*) exclusive focus supports and why necessary:

Community:

Describe, in detail, special supports or considerations for time in the community including 1:1 or 2:1 exclusive focus supports and why necessary:

LPN/RN support:

Describe, in detail, what a LPN/RN does during the time they are supporting the individual and the number of hours per day/week/month they provide the supports:

Describe, in detail, including number of hours and frequency per day/week/month the delegated tasks staff perform to support the individual:

- Nursing Care Plan Included in this packet
- Nursing support add to the staffing pattern **OR**;
- Nursing support are a replacement to the staffing pattern
- The setting has nurses for full shifts. If so, describe the nature of the general support provided: (*ADLs, behavior support, etc.*):

Behavior support:

- FBA Included in this packet
- Functional Behavior Assessment (FBA)
Most recent date: _____ Behavior consultant: _____
- BSP included in this packet
- Interaction guidelines are attached How often are interaction guidelines updated: _____
Most recent date: _____ Behavior consultant: _____
- Behavior Support Plan (BSP) How often are interaction guidelines updated: _____
Most recent date: _____ Behavior consultant: _____

Behavior tracking summary: Please do not include more than 6 months of data.

Behavior description and support needed (e.g. <i>physical aggression, property destruction, self-injurious behavior, etc.</i>)	Behavior frequency per day, week, month, 3 months, 6 months, or year (e.g. <i>11 times per month</i>)	Intensity on a scale of 1-10 with 1 indicating low intensity and 10 indicating high intensity

Please indicate individual specific environmental adaptations which are in place: e.g. “hardened walls”. Please explain why the individual requires these environmental adaptations or if the adaptations are the model of the home:

Please, describe in detail, how staff utilize the BSP to attempt to de-escalate a typical situation:

Have the individual’s behaviors have resulted in serious injury to self or others requiring medical attention beyond general first aid. Please describe:

Legal:

List active court orders:

End of jurisdiction:

Psychiatric Security Review Board: Yes No

End of jurisdiction:

Incident reports and general event records:

How many IRs/GERs are generated on average each month?

Summarize the general nature of the IRs/GERs:

Please share additional information which is pertinent to the individual and the Tier 7 Review:

Signature of person completing the form (*date is automatic*):

Note: Signature indicates individual(s) completing form have done so as thoroughly and accurately as possible and to the best of their knowledge. X

Signature of CDDP staff reviewing form (*date is automatic*):

Note: Signature indicates CDDP staff have reviewed form for completeness and feel the information contained within is thorough and accurate to the best of their knowledge. X