

I. PURPOSE

The purpose of this policy is to establish procedures that ensure continuity of care during admission and service initiation of a person to receive services, including the company's admission criteria and processes.

II. POLICY

Services may be initiated for persons of all ages when the specific program can meet the needs of the person and is the best available placement, as determined by the person, the Designated Coordinator and/or Designated Manager and the Expanded Support Team. All Services will be consistent with the person's service-related and protection-related rights identified in MN Statutes, section 245D. 04. These services will be directed by the person to receive services, parent/legal representative, and county case manager. The company may provide services to persons with disabilities, including, but not limited to, developmental or intellectual disabilities, brain injury, mental illness, age-related impairments, or physical and medical conditions.

Documentation from admission/service initiation, assessments, and service-planning processes for each person served, and as stated within this policy, will be maintained in the person's file. When referring to a person's individual plan in policy, the term *Coordinated Service and Support Plan* is used. This plan is formerly known as *Individual Service Plan (ISP)*, *Community Support Plan (CSP)*, or *service plan*.

III. PROCEDURE

Admission criteria

- A. Prior to admission, the program will provide information on the limits to available services, knowledge and skill of program staff and the program's ability to meet the service and support needs of the person.
- B. Opportunity Partners programs which meet the definition of health care facilities according to MN Statutes, chapter 245A, will notify all residents when a registered predatory offender is admitted into the program or to a potential admission when the facility is already serving a registered predatory offender. These programs include adult foster care homes, ICFs/ID, Supervised Living Facilities, and Community Residential Settings. This notification will be done according to the requirements in MN Statutes, section 243.166.
- C. When a person and/or legal representative requests services from the company, a refusal to admit the person will be based upon an evaluation of the person's assessed needs and the company's lack of capacity to meet the needs of the person.
- D. Opportunity Partners will not refuse to admit a person solely upon the basis of:
 1. The type of residential services the person is receiving
 2. Severity of disability
 3. Orthopedic or neurological handicaps
 4. Sight or hearing impairments
 5. Lack of communication skills
 6. Physical disabilities
 7. Toilet habits
 8. Behavioral disorders
 9. Past failures to make progress.
- E. Documentation regarding the basis for the refusal will be completed using the *Admission Refusal Notice* and will be provided to the person and/or legal representative and case manager upon request. This documentation will be completed and maintained by the Designated Coordinator and/or Designated Manager or designee.

Admission process and requirements

- A. In the event of an emergency service initiation, the company will ensure that staff training on individual

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service recipient needs occurs within 72 hours of the direct support staff first having unsupervised contact with the person served. Opportunity partners will document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's file.

- B. Prior to or upon the initiation of services, the Designated Coordinator and/or Designated Manager will develop, document, and implement the *Individual Abuse Prevention Plan*.
- C. The Designated Coordinator and/or Designated Manager will ensure that during the admission process the following will occur:
 - 1. Each person to be served and/or legal representative is provided with the written list of the *Rights of Persons Served* that identifies the service recipient's rights (MN Statutes, section 245D.04, subdivisions 2 and 3).
 - a. An explanation will be provided on the day of service initiation or within five (5) working days of service initiation and annually thereafter.
 - b. Reasonable accommodations will be made, when necessary, to provide this information in other formats or languages to facilitate understanding of the rights by the person and/or legal representative.
 - 2. Orientation to the program's *Program Abuse Prevention Plan* will occur within 24 hours of service initiation. For those people who would benefit more from a later orientation, the orientation will take place within 72 hours.
 - 3. If the person served will be working and receiving a wage, an I-9 and a W4 will be obtained.
 - 4. An explanation will be given of the following policies and copies will be provided within five [5] working days of service initiation to the person served and/or legal representative by the Designated Coordinator and/or Designated Manager:
 - a. *Policy and Procedure on Grievances*
 - b. *Policy and Procedure on Temporary Service Suspension and Termination*
 - c. *Policy and Procedure on Data Privacy*
 - d. *Policy and Procedure on Emergency Use of Manual Restraint*
 - e. *Policy and Procedure on Reporting and Reviewing of Maltreatment of Vulnerable Adults*
 - f. *Policy and Procedure on Reporting and Reviewing of Maltreatment of Minors*
 - 5. Written authorization is obtained (and annually thereafter) by the person and/or legal representative for the following:
 - a. *Authorization for Medication and Treatment Administration*
 - b. *Agreement and Authorization for Injectable Medications* (if applicable)
 - c. *Authorization to Act in an Emergency*
 - d. *Standard Release of Information*
 - e. *Specific Release of Information*
 - f. *Financial Authorization* (if applicable)
 - i. This authorization will be obtained within five (5) working days of the admission meeting and annual thereafter.
 - g. The *Admission Form and Data Sheet* is signed by the person and/or legal representative and includes the date of admission or readmission, identifying information, and contact information for members of the support team or expanded support team and others as identified by the person or case manager.
 - h. If applicable, the Designated Coordinator and/or Designated Manager will ensure that an *Informed Consent for Psychotropic Medications* is signed, documented in the person's file and that psychotropic medication monitoring procedures are initiated and followed.
- D. During the admission meeting, the support team or expanded support team will discuss:
 - 1. The company's responsibilities regarding health service needs and the procedures related to meeting those needs as assigned in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum*.
 - 2. Review of the *Coordinated Service and Support Plan* and/or any other support plan prepared by the person, the parent/legal representative, and county case manager.
 - 3. The desired frequency of progress reports and progress review meetings, at a minimum of annually.
 - 4. The initial financial authorization, if applicable. The Designated Coordinator and/or Designated Manager

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will survey, document, and implement the preferences of the person served and/or legal representative and case manager for the frequency of receiving statements that itemizes receipt and disbursements of funds or other property. Changes will be documented and implemented when requested.

5. Documentation of receipt of the above information and retention in the person's file.
- E. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, the company will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

Admission process follow up and timelines

- A. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's other providers, medical and mental health care professionals, and vendors are notified of the change in address and phone number, as applicable.
- B. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's record is created according to Opportunity Partners standards.
- C. The Designated Coordinator and/or Designated Manager will ensure that there is documentation in the person's record including:
 1. A physical examination for licensed residential service locations.
 2. The person served is free of communicable diseases, when available.
 3. The person served may or may not administer his/her own medications.
 4. The person served does not have any medical condition that may contraindicate the use of manual restraint if there is a *Positive Support Transition Plan* or an *Emergency Use of Manual Restraint* has occurred.
 5. Any health related protocols and physician's orders/prescriptions are obtained and coordinated with other providers including the pharmacy.
 6. Other license holders serving the person including
 - a. Contact person and telephone numbers
 - b. Services being provided
 - c. Services that require coordination between two license holders
 - d. Name of staff responsible for coordination
 7. Additional contact information will be available in the person's record.
- D. Within 15 calendar days of service initiation, the Designated Coordinator and/or Designated Manager will complete a preliminary *Coordinated Service and Support Plan Addendum* that is based upon *Coordinated Service and Support Plan*. At this time, the person's name and date of admission will be added to the *Admission and Discharge Register* maintained by the Designated Coordinator and/or Designated Manager.
- E. Before the 45-day meeting, the Designated Coordinator and/or Designated Manager will complete the *Self-Management Assessment* regarding the person's ability to self-manage in health and medical needs, personal safety, and symptoms or behavior. This assessment will be based on the person's status within the last 12 months at the time of service initiation.
- F. When a person served requires a *Positive Support Transition Plan* for the emergency use or planned use of restrictive interventions (formerly Rule 40) prohibited under MN Statutes, chapter 245D, and is admitted after January 1, 2014:
 1. The *Positive Support Transition Plan* must be developed and implemented within 30 calendar days of service initiation.
 2. No later than 11 months after the implementation date, the plan must be phased out.
- G. Within 45 calendar days of service initiation, the support team or expanded support team will meet to assess

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and determine based on information obtained from the assessment, *Coordinated Service and Support Plan*, and person centered planning:

1. The scope of services to be provided to support the person's daily needs and activities.
 2. Outcomes and necessary supports to accomplish the outcomes.
 3. The person's preference for how services and supports are provided.
 4. Whether the current service setting is the most integrated setting available and appropriate for the person.
 5. How services for this person will be coordinated across 245D licensed providers to ensure continuity of care.
 6. The person's ability to, at a minimum and within the scope of services, self-manage health and medical needs, personal safety, symptoms or behaviors by using the *Self-Management Assessment* form.
- H. Within 10 working days of the 45-day meeting, the Designated Coordinator will develop a service plan that documents outcomes and supports for the person based upon the assessments completed at the 45-day meeting.
- I. Within 20 working days of 45-day meeting, the Designated Coordinator will obtain dated signatures from the person and/or legal representative and case manager to document completion and approval of the assessment and *Coordinated Service and Support Plan Addendum*.
1. If, within 10 working days of this submission, the legal representative or case manager has not signed and returned the assessments or has not proposed written modifications, the submission is deemed approved and the documents become effective and remain in effect until the legal representative or case manager submits a written request to revise the documents.

IV. ADDITIONAL PROCEDURES

In addition to the previously described procedures, when applicable, the following additional procedures will be taken for *Intermediate Care Facilities for Persons with Intellectual Disabilities* (ICF/ID):

- A. Any person to be served must be in need of and receiving active treatment services from the time of admission to the facility. An individual evaluation will be completed for each person conducted by the facility or outside source that includes background information and valid assessments. These will be used to determine the person's needs and likely benefit from placement in the ICF/ID facility.
- B. Within 30 days prior to or within three days after admission, each person will have a general medical history and physical examination by a physician and will have a Physician Certification completed. The physician will complete a Physician Recertification 30 days after admission and annually thereafter. The physical examination will include that the person served does not require 24 hour nursing.
- C. Prior to admission, a physician must establish a written plan of care that is completed in conjunction with the Expanded Support Team.
- D. During the admission process (admission to 30 day meeting), an assessment of the person's medical status as identified by the physician is considered and addressed by the Expanded Support team.
- E. Each person served will have an individual program plan that has been developed by their Expanded Support team which describes the professions, disciplines, or service areas relevant to:
 1. The person's needs (additional information found in the *Comprehensive Functional Assessment*)
 2. Programs that are designed to meet the person's needs
- F. Within 30 days after admission, the Expanded Support team must:
 1. Complete accurate assessments or reassessments as needed to supplement the preliminary evaluation that was completed prior to admission for each person. These assessments are intended to identify the functional abilities of the person. A *Comprehensive Functional Assessment* will be completed and will

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assess the following:

- a. Age and implications for treatment of each stage for the person
 - b. Presenting problems and disabilities diagnoses and their causes, if possible
 - c. Specific developmental strengths
 - d. Developmental and behavioral management needs
 - e. Need for services without regard to availability of services needed
 - f. Physical developmental and health and nutritional status
 - g. Development in sensorimotor, affective, speech and language development and auditory functioning
 - h. Cognitive and social development and vocational skills, if applicable
 - i. Adaptive behaviors or independent living skills necessary for the person to function in the community
2. Prepare an individual program plan for each person that states the specific objectives necessary to meet the person's needs and the planned sequence for dealing with the objectives.