HEALTH AND WELLNESS GUIDELINES

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STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Disabilities, Aging, and Independent Living
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Health and Wellness Guidelines
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Introduction

Standards:
Standards are requirements for some or all individuals receiving supports. Standards will be listed in the boxes and a detailed description will be listed below the boxes.

Applies to:
The individuals to whom the standard applies will be noted in the boxes.

Suggestions:
Suggestions or helpful hints will appear below the boxes.

The Developmental Disabilities Services Division is responsible to ensure the health and safety of people who receive Home and Community Based Services (HCBS)-funded developmental services.

One of the key purposes of the *Health and Wellness Guidelines* is to provide the tools necessary to advocate for the best possible medical care for people with developmental disabilities. The Guidelines will not address all possible health conditions and individual circumstances vary. Therefore, the role of the individual and those that support him/her to advocate for good health care is important. It is also important that those who help the individual be knowledgeable about health issues and receive the necessary training to gain this knowledge.

Each designated agency (DA), specialized service agency (SSA) and person or family who manages their supports has the responsibility to ensure that health services are provided and documented as appropriate. These responsibilities apply to all individuals who receive home supports in group living (3-6 people), shared living or developmental homes (1-2 people); staffed living (1-2 people), and any other Division-funded (DDS-funded) residential living situation. The applicability of these Guidelines to individuals who live in their own home or with their families is dependent upon the degree of support a person receives to do so. ***For most individuals receiving a small amount of support to live in their own home or to be employed, the person and his or her support team will determine the appropriate roles for members of the team. Most standards do not apply to individuals receiving only Flexible Family Funding and/or Transition grant funded employment services.***

Health and wellness services and the roles of various individuals must be specifically noted within the person's Individual Support Agreement (ISA).

For the purposes of this document medical professional is defined as MD (Medical Doctor), DO (Doctor of Osteopathic Medicine), PA (Physician's Assistant) or NP (Nurse Practitioner).

Variances

Variances:
Variances to the Health and Wellness Guidelines can be made with the documented approval of an involved medical professional.

Applies to:
All individuals receiving DDS-funded services.

Circumstances may occur for which application of a standard may not be indicated or may not be in the best interest of an individual. When this situation occurs, there should be discussion(s) between the individual, the health care provider, support team and guardian (if there is one) as to whether a variance is possible. Variances cannot be for the convenience of the support team or physician.

Documentation of any decisions concerning variances to these guidelines must be documented in the person's record. If a variance occurs secondary to difficulties, such as fear of blood drawing, Pap test, etc., then there must be information in the file that indicates attempts have been made to desensitize the individual, as well as the effectiveness and plans for review.

The right of an individual to refuse treatment is respected. However, the DA/SSA is responsible to ensure the individual's decision is based on an informed choice.

Examples of situations where a variance might occur:

- A healthy person may need less frequent physical exams than on an annual basis
- Contractures or other physical difficulties may prevent certain testing.

Standard 1: Emergency Fact Sheet

Emergency Fact Sheet:
A current emergency fact sheet, following the standardized State format, is accessible and available in all files (e.g., home, agency, etc.) and to all individuals involved in a person's supports.

Applies to:
All individuals receiving DDS-funded services, except Flexible Family Funding and Family Manage Respite (see note). While not required, they are highly recommended.

Note: For this, and all other references, "individual or person" includes people who are self- or family-managing their services.

All relevant individuals, including "on-call" people and respite workers, need to have access to emergency information. The information required on an Emergency Fact Sheet includes:

1. Individual's name, address, phone number, date of birth and marital status.

2. Guardian's name (if there is one) and court-appointed powers, address and phone number; when there isn't a guardian, the next-of-kin's name, address and phone number. Parents are considered the next-of-kin/guardian for minor children, unless otherwise determined by a court.

3. Health insurance information.

4. Health care providers' names (e.g., physician, nurse practitioner, therapist, dentist, etc.), phone numbers, and the specialty (e.g., primary care provider, cardiologist, neurologist, etc.).

5. Medical problems list, any known allergies and a list of current medications with dosages, purpose and times of administration.
   - The medical problems list is complete when all current and past medical problems, surgeries, treatments, etc., are included and up-to-date. The information should be specific (e.g., history of seizures, status post, etc.) and include relevant dates.
   - The list should also include any significant family history such as diabetes or heart condition.
   - Food, drug or environmental allergies and any adverse reactions are also listed. Any specific emergency treatment that may be required because of an allergy should be indicated. If there is no allergy, no allergy should be listed as well.
   - Medication information for people receiving home supports is obtained from prescriptions in the file. For people receiving other types of supports, the information is obtained from the person himself/herself, parent or other knowledgeable individuals.

- The diagnosis and/or symptoms for which a medication is prescribed must be documented (i.e., each medication must have a corresponding medical problem identified on the Medical Problem List). Some medications have multiple uses (e.g., Valproic Acid and Tegretol could be given for seizures and/or as a mood stabilizer); therefore, it is important that this information is accurate.
- PRN over-the-counter medications DO need to be listed.

6. Protocols for any emergency treatment and advance directives.
   - Prior consent for emergency treatment on the fact sheet is optional; therefore, if an individual or guardian (if there is one) does not wish to sign, ensure that proper emergency contact information is available.

7. Date of last annual physical exam, dental exam and tetanus immunization.
   - Listing immunization information on the emergency fact sheet does not replace the need for an immunization record in the file for people receiving 24-hour home supports.

8. Other interested individuals (friends, relatives, providers, etc.)
   - The service coordinator and shared living/ developmental home provider need to be listed; the individual may wish to include the names of people whom she/he wants contacted in an emergency.

9. Communication Method.
   - The preferred communication method should be listed along with any supports needed.

10. Other individual pertinent information (e.g., ambulating needs, special dietary needs, special care procedures, etc.)
    - This information could include behavioral information; directions to a person's home; physical description of the person, etc. Remember to ask the individual what he/she would like included.

11. Date the Emergency Fact Sheet was completed or updated. Emergency Fact Sheets need to be updated as changes occur or at least annually.

Standard 2: Medical Consent

Medical Consent:
Consent from the individual or his/her medical guardian (if there is one) is required prior to medical treatment, proposed changes in medical treatment or proposed changes/additions to medication regimens, unless other arrangements have been made with the guardian. The medical guardian (if there is one) is also informed of any changes in health status.

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Applies to:
Individuals receiving home supports and when the DA/SSA is identified in the ISA as overseeing health services.

Some people have medical guardians appointed by a court. If a person has a medical guardian, he/she is an important part of an individual's team. Except in emergency cases, the guardian is notified of appointments with the primary physician and other health care providers (e.g., psychiatrist, neurologist, etc.) prior to the visit. Consent from the individual or his/her guardian (if there is one) to administer prescribed psychotropic medications must be obtained prior to starting the medications. When any other medication is added, or changed the individual and/or his guardian will be notified, unless other arrangements have been made with the guardian. The following information is shared or explained to the person or his/her medical guardian (if there is one):

- When medications may have significant side effects or are new or controversial, a plan to track or monitor the medication and its effects needs to be implemented.
- Information regarding the dangers of psychiatric medications should come from the prescribing medical professional. The person or guardian needs to know how the medical professional will monitor for side effects. The service coordinator may need to facilitate communication between the person/guardian and the medical professional.
- The service coordinator needs to inform the guardian when tests (other than routine) are ordered, especially if a problem is suspected. If the individual has no guardian, the reasons for the tests need to be explained.

Standard 3: Incident Reporting

Incident Reporting:
Critical Incident Reports (CIRs) are sent to the Division of Developmental Services (see guidelines for Critical Incident Reporting.) As they relate to medical issues, Critical Incident Reports are completed for any unusual and/or significant medical event that occurs.

Other medical incident reports are used within a DA/SSA to monitor health practices. These reports are maintained at the DA/SSA.

Applies to:
All individuals served by an Agency who is receiving developmental disability services, including services contracted by the Agency and people who self/family manage their services.

Exceptions:
Bridge Family Managed Respite or Flexible Family Funding recipients, except in the event of death (any cause).

TCM, PASRR/Specialized Services, except in the event of death (any cause).

Critical Incident Reports (CIR) note unusual and/or significant medical events. Specific CIR categories that are considered medical are: death of an individual receiving DDSD funded supports; suicide attempt (or lethal gesture); chemical restraints; and medical emergencies which include all hospitalization, all ER visits, medication errors that result in hospitalization; or other medical treatment and significant injuries (see guidelines for Critical Incident Reporting.)

- The definition of chemical restraint is found in the *Behavior Support Guidelines.*

Other medical incident reports are used in cases where the DA/SSA reviews the circumstances around incidents to establish patterns, identify unsafe practices or environmental problems. Agencies will set up their own system of monitoring medical events and occurrences. This may be in the form of an internal medical incident form or review of all Medication Administration Records (MAR). Examples of these situations are medications that are used for pre-sedation for medical appointments, medication errors not resulting in emergency treatment, medication errors involving a pharmacy incorrectly filling a prescription, PRN medications prescribed as part of behavior support plan, and injuries.

Standard 4: Restraint Procedures for Medical Purposes

Restraint Procedures for Medical Purposes:
Physical, mechanical or chemical restraints may be used for medical purposes on a time-limited basis.

Applies to:
All individuals receiving DDS-funded services, except Flexible Family Funding.

Restraints used for medical purposes must be time-limited in nature. (For a full definition of restraints, refer to the *Behavior Support Guidelines.)* When time-limited restraints are used, a physician's or dentist's order documenting the medical reason for the restraint must be present in the file. Any such order must be renewed at least weekly. Unless there is documentation in the file from the medical professional that a weekly renewal is not necessary and specifically states why and when the renewal would be due.

Physical, mechanical (e.g., mittens, straps, arm splints and restraint chairs, bed rails and bed netting) or chemical restraints may be used for medical purposes for the following reasons:

- To assist an individual during a time-sensitive, necessary medical or dental procedure.
- To promote healing following a medical procedure or injury.

Mechanical *supports* are not mechanical restraints. Some individuals may require the use of mechanical supports for daily life (e.g., devices used for body positioning, seat belts, etc.). For a full description of mechanical supports please refer to the *Behavior Support Guidelines*.

Standard 5: Universal Precautions

Universal Precautions:
Training must be provided in accordance with the requirements of the Occupational, Safety, and Health Administration (OSHA). Designated agencies and specialized service agencies must have a written policy consistent with OSHA rules.

Applies to:
All workers..

All agencies must comply with Occupational, Safety, and Health Administration (OSHA) training requirements related to blood borne pathogens and universal precautions. A record of the training and annual retraining for all workers is required.

In accordance with OSHA regulations, the Hepatitis B vaccine is offered to all DA/SSA employees. Individuals who are not employees of a DA/SSA (e.g., shared living/ developmental home providers, contracted community support workers, respite workers, etc.) must be given information about the Hepatitis B vaccine. Responsibility for payment for non-agency employees is determined by the employer or the individual/organization contracting for services.

Standard 6: Hepatitis B Vaccine

Hepatitis B Vaccine: *Physicians should evaluate a person's risk of contracting Hepatitis B on an individual basis. The vaccine shall be administered to any individual desiring to receive it.*

Applies to:
All individuals receiving DDS-funded services, except Flexible Family Funding.

The medical professional of each individual receiving services should evaluate his/her risk for contracting Hepatitis B. Hepatitis B can have life-long consequences such as cirrhosis of the liver, cancer, etc.

If someone living in a group home is a Hepatitis B carrier, other people who live in group homes are at an increased risk of contracting Hepatitis B. Therefore, all people who live in group homes must be offered the vaccine, without cost to the individual, because the Hepatitis status of other individuals who live in the home may not be known.

Standard 7: Annual Physical Exam

Annual Physical Exam:
An annual physical and associated documentation is required for all individuals. Documentation varies depending on the type of supports received.

Applies to:
All individuals receiving Home and Community Based Services (HCBS).

An annual physical exam is **required** for all individuals receiving home supports, unless otherwise documented in writing, by the primary medical professional. A copy of the exam results is required for the DA/SSA file and the home file that should include the following:

1. Medical professional's name and signature;
2. Complete medical problems list;
3. Body systems review with blood pressure and weight;
4. Complete list of prescribed medications, including over-the-counter medication and any other alternative therapy used by the individual;
5. A list of lab, diagnostic or cancer screening tests ordered; and
6. Any recommendations made by the medical professional.

For individuals receiving home supports, monitoring and follow-up to the medical professional's recommendations is the responsibility of the service coordinator.

For all other individuals receiving Home and Community Based Services (HCBS), only a notation of the date of the annual physical exam is required. If the person's primary medical professional determines an annual physical is unnecessary, it must be documented in writing in the person's record.

Suggestions to Prepare for the Annual Physical Exam

1. Let the medical professional's office know that the appointment is for an annual exam so that sufficient time is allowed.

2. Make a list of all known medical problems on the annual exam form before going to the appointment. The information is obtained from the Emergency Fact Sheet.

3. List all current medications. This includes over-the-counter medications and any other alternative therapy used by the person.

4. All testing that has been completed in the last year should be available to the primary medical professional. For example, anticonvulsant or psychiatric medication levels, complete blood count, liver function tests, etc., that may have been ordered.
5. Review the immunization information and discuss the need for updates with the primary medical professional. (see Standard 10).

6. Discuss the need for any cancer screening tests and indicate the need on the examination form (see Standard 17).

7. Discuss the need for vision or hearing screening (see Standards 12 and 16).

8. Ask the medical professional for an oral examination if the individual is edentulous.

9. Copies of all reports from other medical professionals such as specialists, emergency room episodes, etc., should be sent to the primary medial professional.

10. Medicaid reimbursement is available for vitamins or nutritional supplements prescribed by a medical professional. A medical justification form completed by the medical professional is required for payment.

Standard 8: Dental Exam

Dental Exam:
Semi-annual dental examinations and cleanings (or as specified by the dentist) are performed as recommended by the American Dental Association.

Applies to:
Individuals receiving home supports.

The American Dental Association recommends semi-annual dental cleanings and exams. In certain situations, an individual's dentist may specify a different frequency (i.e., either more *or* less frequently). The date of the exam is obtained and documented on the Emergency Fact Sheet. The service coordinator is responsible to ensure that all follow-ups and recommendations are completed.

- For individuals with diagnosed cardiac conditions (e.g., congenital cardiac malformations, rheumatic and other valve dysfunction, mitral valve prolapse, etc.) the person's medical professional may prescribe a prophylactic antibiotic to prevent infections of the heart tissues (endocarditis) (see Standard 9 regarding medications).
- The person's primary medical professional may prescribe an anti-anxiety medication to be administered prior to exams. This needs to be documented on the Medication Administration Record (MAR) and reviewed as part of the regular monthly MAR review.

Standard 9: Medication Prescription & Administration

Medication Prescription & Administration:
A primary medical professional, or other authorized medical professional, must prescribe and annually review all medications. For individuals taking prescription medications, over-the-counter medications must also be approved by the appropriate medical professional. Each DA/SSA must have written procedures that address medication administration and training as defined in the Regulations Implementing the DD Act of 1996. There are different requirements for DA/SSA staff and shared living/ developmental home providers.

Applies to:
Individuals receiving home supports and DA/SSA employees who administer medications.

For individuals with developmental disabilities to receive medication safely in home and community settings, a variety of procedural protections and trainings are necessary.

Medication Prescription

1. All prescription medications are reviewed and renewed annually at the time of the annual physical exam or as indicated by the physician or other authorized medical professional. A change in medication dosage requires a new prescription. A written order by the physician or other authorized medical professional, or a copy from the pharmacist indicating the medication prescribed, is required for the person's file.
2. For individuals taking prescription medications, all other medications, including over-the-counter medication, must also be approved by the appropriate medical professional. The pharmacist should be informed of any over-the-counter medications because they may interact with prescription medications. The actual medication and dosages should be checked for accuracy at the time of purchase.
3. The diagnosis and/or symptoms for which medications are prescribed must be documented.
4. PRN medications (medications which are given as the circumstance arises) are specifically prescribed by a physician or other authorized medical professional. The prescription must include specific parameters and reason for use.

Written Procedures

The DA/SSA must have written procedures that address all components of medication administration. Procedures include the following subjects:

- Medication refusal
- Recording medications
- Reporting medication errors
- Disposal of medications (outdated, unused or contaminated)
- Administering PRN medications
- Administering medications during different times of the day and week (e.g., during community supports, work, respite, etc.)
- Proper storage of medications

- Telephone orders
- Self-medication

Medication Administration

1. All medications must be administered as defined. Medication administration sheets are required for all people who are not self-medicating. Sheets include a clear record of medication name, dosage, time of administration and signature of person(s) who administered the medication.
2. If medication errors occur, the nature of the error or reason for the omission is documented with a medical or critical incident report (see Standard 3).
3. PRN medications must be documented on the medication administration sheets, and include the name and dosage, the time administered, the reason for use and effectiveness of the medication.
4. Prescription PRN medications require medical assessment. For example, medication given to address symptoms of a psychiatric condition will need assessment by a nurse or the prescribing medical professional prior to its administration by an agency employee, unless the order is clearly written and states, when and under what circumstances the medication is to be given and no assessment is required.
5. The name and dosages of PRN medications given for addressing a psychiatric illness that meets the definition of a chemical restraint as defined in a behavior support plan must be documented with a critical incident report (see Standards 3 and 11). The incident report shall include a description of the person's behaviors as well as documentation of less intrusive interventions tried prior to medication administration. Follow-up by supervisory staff must occur.

Training and Monitoring

The provider shall have a training plan as required in the *Regulations Implementing the DD Act of 1996* that insures verification that all workers paid with DDS funds (including contractors, subcontractors, employees of contractors and consumer-directed workers) have necessary training.

1. Shared living/developmental home providers who administer medications must be provided with initial training and information regarding safe and correct administration of medications, as well as handling and storage of medications. This training includes the following:
   - Correct recording of medication on the medication administration records
   - Notifying the medical professional of a change in the person's condition
   - Medication side effect information
   - The five rights of administering medications
   - Safe storage of medications in original containers as labeled by the pharmacist
   - Medication refusal
   - Abbreviations and measurements
   - Reason for the medication

2. All DA/SSA employees who are paid with DS funds and who administer medications during their employment must receive delegation as determined by an appropriate medical professional. Only a registered nurse, a licensed practical nurse working under the supervision of a registered nurse, or a physician may determine if workers have the skills and knowledge to administer medications. Documentation of this delegation is required.

3. Ongoing monitoring of all people who administer medications is required to ensure safe medication administration practices. Documentation of this monitoring is required. Monitoring includes:
   - Tracking of medication errors
   - Review of medical professional's orders
   - Regular (monthly is recommended) check of medication administration sheets

Self-medication

Individuals, who indicate the desire and possess the capabilities, may administer their own medications. An assessment based on recognized standards for self-medication should be used, with any accommodations needed by the individual specifically noted. A nurse or medical professional must assess knowledge and skills and determine the frequency of review/reassessment. Documentation of this assessment is required if the agency has a role in health services. Review of the person's knowledge and skill by the nurse or medical professional should occur periodically.

Standard 10: Immunizations

Immunizations:
Immunization records are maintained in the person's file; childhood immunization records are maintained for children ages two months to sixteen years.

Applies to:
Full standard applies to individuals receiving 24-hour home supports; tetanus information applies to all individuals receiving HCBS.

Immunizations are maintained in the individual's file with current dates of relevant immunizations:

- Tetanus - every ten years
- Measles/mumps/rubella - for anyone born after 1957
- Influenza vaccine - annually for recommended individuals and as early in the summer/fall as possible
- Pneumococcal - for recommended individuals, usually once, but sometimes repeated at six-year intervals

If available, information about hepatitis immunizations should be included in the record.

Childhood immunization records are maintained for children aged two months through sixteen years. The childhood immunization schedule is based on the Vermont standard set by the Department of Health. Any parental approved variances to the standard must be documented in the child's file.

Standard 11: Psychiatric Services

Psychiatric Services: *Psychiatric assessment and treatment will be available for individuals with known or suspected psychiatric disorders. Licensed psychiatrists or psychiatric NPs will provide assessment, diagnosis and treatment of psychiatric disorders.*

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services when psychiatric services or psychiatric medications are provided or overseen by the DA/SSA.

General Considerations for Treatment

The principles of psychiatric assessment and treatment are the same for both people with developmental disabilities and those without developmental disabilities. People with developmental disabilities may experience all types of mental illness.

Many health conditions can result in changes in a person's behavior. Examples of these include untreated thyroid condition, pain, and brain lesions. Medication can have unintended side effects such as akathisia, disinhibition, aggression and self-injurious behavior. Other changes in a person's life can also trigger changes in behavior (e.g., home provider changes, death of someone close, post-surgery depression or a traumatic incident, etc.) It is likely that an individual may need active assistance and psychiatric intervention to cope with these changes.

All behavior is a form of communication; understanding what is being communicated is important when developing a support plan. The medical professional and the person's team should use a comprehensive biological-psychological-social approach to assessment and treatment. Often a comprehensive approach is required to effectively support a person with complex needs. This may include psychiatric medications, counseling or therapy, environmental considerations, social supports and teaching improved emotional regulation and communication skills. The goal of these supports is not only a reduction of symptoms, but improvement in the person's quality of life.

Psychopharmacologic Medications

Psychopharmacologic medications can be valuable tools in the treatment of psychiatric disorders and emotional distress. Psychopharmacologic medications are drugs prescribed to stabilize or improve mood, mental status, or behavior. These medications are sometimes called "psychiatric medications" or "psychoactive medications". The following protocols must be applied when treating both short-term and long-term symptoms of a person's mental illness that affect his/her life.

1. A working diagnosis for a prescribed medication is needed. The diagnosis needs to be clearly supported by findings outlined in a comprehensive assessment.
   - Physical health reasons for changes in behavior must be ruled out. Psychosocial reasons for acute behavior changes likewise need to be investigated. However, some persistent and significant behaviors may lead to a nonspecific diagnosis (e.g., aggression, self-injurious behavior).

2. Medical guardians and individuals who have no guardian are informed of any proposed psychiatric medication or changes to existing prescriptions prior to administration of the medication(s), unless other arrangements have been made. Medical guardians and individuals who have no guardian must give consent to any psychotropic medications or medication changes.
   - The prescribing medical professional should inform the individual or guardian (if there is one) of the medication's expected effects and side effects.

3. Active monitoring of medication effectiveness and side effects is required.
   - Critical incident reports, medical incident reports, medication administration records, as well as other relevant data need to be reviewed.
   - Risks/benefits of medications and side effects (e.g., adverse effects on cognition, sedation, weight changes, etc.) should be continuously assessed during treatment.

4. Medication checks require direct contact with the prescribing medical professional at least quarterly.
   - A medical professional may indicate that an individual's circumstances are stable and less frequent checks are appropriate.

5. Tardive dyskinesia checks are needed for individuals who are prescribed medications that have the potential for this side effect. Checks are performed and documented at regular intervals, preferably at medication reviews, by the prescribing medical professional or a nurse. Ensuring that the checks are done and the date documented may require service coordinator intervention.
   - Tardive dyskinesia symptoms may not be apparent until the medication is decreased.
   - There are medications other than psychiatric medications that may cause tardive dyskinesia symptoms (e.g., Reglan).

6. A Psychiatric Medication Support Plan is no longer required when psychopharmacologic medications are prescribed to treat psychiatric disorders, emotional distress, etc. It is expected that this plan will be folded in the behavior support plan of an individual. Please see the *Behavior Support Guidelines* for further information on Behavior Support Plans.

   A medical professional may order medication to be administered as part of a support plan. The plan must include a medication order that specifically states when and under what conditions it is to be used. The need for the medication must not require an assessment of the individual's behavior by a nurse or medical professional prior to agency employees administering the medication.

Record the giving of medication on the medication administration record. The effectiveness of the medication must be documented. Medication used in a dosage that causes disorientation, confusion or an impairment of mobility is considered a chemical restraint (see *Behavior Support Guidelines).*

7. A medical professional may order medication to be administered on a PRN basis. If this medication is not specific as to when and under what conditions the medication is to be given the psychiatrist or other medical professional is requiring a nurse's or physician's assessment of the individual prior to the medication being administered. A critical incident report is needed if the PRN medication meets the definition of a chemical restraint. (Additional information is found in the *Behavior Support Guidelines,* see also Standard 9 and Standard 13.)
   - The team should evaluate the circumstances to determine if the situation is a one-time incident or if a behavior support plan is needed.

   Medications used for pre-sedation for medical or dental appointments are not included in the requirements above, and do not require a critical incident report (see Standard 3).

   The decision to use psychiatric medication must take into consideration the anticipated benefits of the medication considering potential risks and side effects of the medication.
   - The potentially observable benefits of the medication should clearly outweigh the risks.
   - Medication dosages must be reasonable and within acceptable dosage parameters.
   - Duration of treatment must be long enough to assess effectiveness.

Standard 12: Vision/Eye Health Care

Vision/Eye Health Care:
An initial comprehensive eye examination is obtained as recommended by the American Academy of Ophthalmology. Eye/vision examinations must be conducted by an ophthalmologist or by an optometrist.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family Funding.

At the initiation of home support services an initial comprehensive eye examination must be obtained. Documentation of the date of the exam and any prescription(s) are kept in the person's file. Eyeglasses are provided as prescribed. The service coordinator is responsible for monitoring and ensuring that follow-ups and recommendations are completed as required.

- Children need to have an initial exam as noted above, and only need to be reexamined if ocular symptoms, visual changes, or injury occur.
- Individuals from the age of puberty to age 40 only need to be reexamined if ocular symptoms, visual changes, or injury occur. The exception to this is for those individuals who are at risk of developing significant eye disease because of other risk factors (e.g., chronic disease such as diabetes, family history, race, etc.).
- Eye/vision exams are required for individuals from ages 40-64; the optometrist or ophthalmologist determines the frequency of follow-up.
- Individuals with diabetes should be examined annually.

Individuals may need assistance or support to use eyeglasses as prescribed. They may also need assistance to keep their eyeglasses in good repair.

Standard 13: Neurological Services & Seizures

Neurological Services & Seizures:
An evaluation by a neurologist is required for individuals who are initially prescribed seizure medications. Seizure records are kept.

Applies to:
Evaluation by a neurologist applies to individuals receiving home supports; seizure records apply to all individuals receiving DDS-funded supports, except Flexible Family Funding.

A diagnostic evaluation by a neurologist is obtained for individuals who are initially prescribed medications for seizures. Documentation of the date of the evaluation is kept in the person's file. If an individual has a seizure for the first time, a neurology exam is required.

- The neurologist may prescribe an electroencephalogram (EEG) to identify the type of seizure, a computed tomography (CT) scan or a magnetic resonance image (MRI) to rule out lesion, tumor or structural problems, and lab work to rule out errors of metabolism, poisoning, infection, etc. It is recommended documentation of these diagnostic tests be in the person's file.
- An individual whose anti-epileptic medication has been stopped and who resumes having seizures should be seen by a neurologist as soon as possible and treated as if a new seizure disorder has developed.
- A primary medical professional may decide to follow a person with a stable seizure disorder.
- If an individual has been seizure free for five years, the medical professional may consider a medication reduction or discontinuance. The usual timeline is five years, but this may be a consideration anywhere from three to seven years. An EEG should be obtained prior to the attempt to withdraw medications. Medications should be gradually tapered.
- The discontinuance or tapering of seizure medication requires the consent of the individual or the guardian (if there is one). The medical professional should explain the possible risks associated with a change in seizure medication. Documentation of the effort and the results is needed in the person's file.
- Blood levels are required for specific medications at least annually and as determined by the physician. Most medications are metabolized in the liver. Liver function testing is indicated for most seizure medications, as well as complete blood count.

It is recommended that documentation of lab results be maintained in the person's file

For all individuals receiving 24-hour DDS-funded home supports, a seizure record must be maintained for individuals with seizure disorders. Seizure records are kept assisting the medical professional to more accurately treat seizures and to note trends of increased or decreased seizure activity. The services coordinator should review seizure frequency monthly. All individuals involved in providing support, including respite workers, must be informed about how and to whom seizures should be reported.

A complete seizure record consists of the following information:

- Date of seizure
- Time of seizure
- Antecedent to the seizure
- Description of the seizure
- Duration of the seizure
- Post seizure status

For individuals receiving community supports or employment supports, the team needs to determine how the seizure information is communicated to others on the team. If a person lives with his or her family, where are copies of the seizure reports filed? What information does the medical professional need? These questions are worth discussing at the annual ISA meeting.

Standard 14: Orthopedic Services

Orthopedic Services:
An orthopedic evaluation is required for individuals with musculo-skeletal disorders, neurological dysfunctions and other related types of disease, injury or illness.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family Funding.

An initial orthopedic evaluation is required for individuals with musculo-skeletal disorders, neurological dysfunctions and other related types of disease, injury or illness (e.g., cerebral palsy, spinal disorders, spastic paralysis, etc.) Documentation of the date of the orthopedic evaluation and any subsequent examinations is maintained in the person's file. After the initial evaluation, the specialist and/or the primary medical professional determine further exams. The service coordinator is responsible for ensuring any necessary follow-up and monitoring.

Standard 15: Occupational Therapy/Physical Therapy Services

Occupational Therapy/ Physical Therapy Services: *Occupational therapy and physical therapy services are provided as necessary.*

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family.

A medical professional may prescribe occupational or physical therapy or these services may be requested through the medical professional by the individual or any member of the support team. Training for workers by qualified individuals (e.g., physical therapist, occupational therapist, nurse, etc.) must be provided, especially if an individual has health issues such as osteoporosis or has extensive therapy programs. Documentation of the date of the consultation is maintained in the person's file. The service coordinator is responsible for ensuring any necessary follow-up and monitoring. Information regarding the therapy program must be included in the person's ISA.

- Impairments that limit mobility can reduce the opportunities for people to participate in work, school, recreation, communication, and leisure. Maximizing mobility through position, range of motion, exercise, adaptive equipment, etc., may be ways to treat or prevent certain conditions.
- Adaptive equipment requires care and upkeep. Details regarding correct and safe use, cleaning and maintenance, and trouble-shooting problems accompany the owner's manual and need to be available for reference (see Standard 21).
- Routine and regular safety checks of equipment need to be done (see Standard 21).

Standard 16: Hearing & Hearing Aids

Hearing & Hearing Aids:
A professional audiological examination is obtained if indicated by a medical professional's screening or by signs and symptoms of a hearing impairment. Hearing aids are provided as prescribed.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family Funding, when indicated in the ISA.

For children, hearing loss can show up at any age, but is often difficult to detect. An exam is indicated if there are concerns that a child cannot hear normally. This may include not achieving language-related milestones. **For adults,** sudden and profound hearing loss is a medical emergency, and a medical professional must be called immediately. Exams are indicated for older adults if:

- Hearing loss interferes with quality of life.
- If work is done in a high-noise environment and there is difficulty hearing.
- If there is hearing loss accompanied by an earache, a discharge from the ears, or tinnitus (a ringing in the ears, dizziness or balance problems).

Individuals may need support to use hearing aids as prescribed. Hearing aids also require care. Details regarding correct and safe wearing, cleaning and maintenance, and trouble-shooting problems accompany the owner's manual and need to be available for reference. Regular and routine checks of the hearing aids, including battery checks and changes, are needed.

Documentation of the date of any hearing exam must be maintained in the person's file, along with any prescriptions for hearing aids. The service coordinator is responsible for ensuring any follow-up and monitoring.

Standard 17: Lab & Other Diagnostic Tests

Lab & Other Diagnostic Tests:
Blood work and other diagnostic testing are indicated by diagnosis, age, medication(s) received, family history and physician's order. Cancer screening is performed as indicated by the American Cancer Society.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family Funding.

The decision of what tests and how often testing is needed is a dialogue between the medical professional and the individual and/or guardian (if there is one), and/or the person who is responsible for assuring that the health needs are being met. In some cases, the medical professional, with the individual's and/or team's input, may decide that testing is too stressful for an individual and that the trauma outweighs the benefits. The medical professional and the individual and/or the support team may also decide that there may be trauma due to an existing condition (e.g., osteoporosis, contractures, etc.) that precludes testing. In this event, documentation from the medical professional is kept in the person's file.

Lab Testing

1. Baseline lab testing must be obtained, unless otherwise documented by the primary medical professional.
   Documentation from the medical professional is required for any reason for which testing is contraindicated. Discussion within the support team, including the individual, if possible, regarding a desensitization program with the goal of allowing future testing needs to take place as necessary. Documentation of the desensitization program as well as the results of desensitization testing must be kept in the person's file. The service coordinator is responsible for ensuring follow-up, monitoring and completion of recommendations.
   - Baseline testing needs to include a complete blood count (CBC), liver function test(s) (LFT). Other testing may include blood chemistry such as glucose level, cholesterol screening, urinalysis, etc.
   - Testing is often used as part of a routine check-up to identify possible changes in a person's health before any symptoms occur.
     - The results of blood tests are printed in columns headed "In Range" and "Out of Range". Next to that is a column called the "Reference Range", which means the numbers in that column are the normal results. The reference range can vary from lab to lab, so always compare the current results with the reference range on the current report only.
   - When an "Out of Range" result is noted on the blood work, this indicates the need to follow up. Further information is available by calling the medical professional's office, through lab interpretation test books, the DA/SSA nurse or the Internet. Although information may

be researched, the interpretation of the findings must be sought through the prescribing medical professional.

2. Other lab testing as indicated by medication (e.g., various seizure, cardiac, psychiatric medications, etc.), age or risk factors (e.g., family history of heart disease, etc.), and certain diagnoses (e.g., diabetes, etc.) must be obtained as necessary. It is recommended testing be maintained in the person's file. The service coordinator is responsible for ensuring that follow-up and recommendations are completed.
   - Blood work for commonly prescribed medications may include:
     a. Seizure medications (e.g., Dilantin, Neurontin, Depakote, etc.). Blood levels are needed for most seizure medications and should be ordered at prescribed intervals for therapeutic level monitoring when initially ordered and at least annually when the medication level is stable. Blood tests (liver function tests) for side effects of these medications, which may affect the liver, are indicated. Testing should be at least annually, and for certain individuals, this testing may be indicated more frequently.
     b. Psychiatric medications (e.g., Lithium, Clozaril, etc.). Lab studies are indicated for these medications and others due to side effects that can only be detected through blood work, which includes levels of the medication(s). It is necessary to discuss with the prescribing physician when and how often studies are indicated.
     c. Monitoring of the therapeutic blood levels for certain medications such as cardiac antiarrhythmics (e.g., Digoxin); bronchodilators to ease breathing (e.g., Theophylline, Theo Dur); and thyroid replacement therapy (e.g., Synthroid) is required.

Check pharmacy print-outs of medication side effects; consulting with the prescribing physician; requesting information from the pharmacist; and, checking web sites such as *www.labtestsonline.org* are ways of finding out if lab studies for medications are required.

Cancer Screening

The American Cancer Society's (ACS) recommendations regarding baseline and continuing testing are the standards that must be followed for cancer screening. These standards are often changing so please check with their website. www.Cancer.org

Documentation dates of all testing is kept in the person's file. The service coordinator is responsible to ensure that follow-up and recommendations are completed.

Screening for both men and women:
- Colon cancer/colonoscopy
- Skin cancer – regular skin checks

Women:
- Breast cancer/mammogram and clinical physical exam of breast
- Cervical cancer/Pap test

Men:
- Prostate cancer/PSA testing and digital rectal exam

For further information regarding cancer, treatments and support there are several web sites to access. Some of these are:

- www.cancer.org(American Cancer Society)
- www.cancer.gov/contact/contact-center (National Cancer Institute Cancer Information Service
- www.cansearch.org (National Coalition for Cancer Survivorship)

There is also a cancer information and counseling hotline at (800) 525-3777and cancer response system at (800) 227-2345.

Lab & Other Diagnostic Tests

For further information regarding tests and procedures consult www.intelihealth.com (tab "Look it up", then Test and Procedures

Bone Density Testing

Osteoporosis is a silent disease and testing for bone mineral density (BMD) should occur if indicated - often the first sign is a fracture of the wrist, hip or vertebra. One in three women and one in eight men 50 years of age and older will break a bone due to osteoporosis. Some risk factors are: age; heredity; body type; estrogen deficiency; inactivity, etc. Medicare covers BMD testing for beneficiaries who are estrogen-deficient, on long-term steroid therapy, currently taking drugs for osteoporosis, have spinal abnormalities suggesting low bone mass, or have an overactive parathyroid gland.

Standard 18: Prescribed Nutritional Diets

Prescribed Nutritional Diets:
A medical professional or registered dietician must prescribe therapeutic diets.

Applies to:
Individuals receiving home supports and individuals receiving other DDS-funded services, except Flexible Family Funding, when prescribed by a medical professional.

A therapeutic diet to address weight loss, allergies, cholesterol, phenylketonuria (PKU), etc., must be prescribed by a medical professional or registered dietician. All support team members must be aware of the dietary requirements and the effectiveness of the diet should be tracked. A copy of the diet prescription is required for the person's file.

- A referral to a registered dietician may be requested from the primary medical professional if an individual or members of his or her support team think this may be beneficial.
- Monitoring of the individual's condition being treated, especially at the beginning of a diet, may be indicated.

Standard 19: Weight & Menses Charts

Weight & Menses Charts: *Weight and menses records are implemented and maintained when indicated by the medical professional.*

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services, except Flexible Family Funding.

Regular weight records are kept for an individual, if a need is determined (e.g., to track chronic weight maintenance; for medications and/or treatments which may affect weight changes, etc.). Individuals who receive gastric tube feedings with prescribed nutritional input from a medical professional or dietician need weight tracking to ensure maintenance of adequate weight range. For some individuals who have a chronic weight maintenance problem and who are seen daily, weight changes may be subtle and not noticed expeditiously. It is important to keep accurate weight records; the readings should be obtained on a regular basis, in the same setting and under the same circumstances to ensure accuracy.

A record of menses is kept for women, if a need is determined by a medical professional.

Standard 20: Adaptive Equipment

Adaptive Equipment:
The need for adaptive equipment is evaluated; adaptive equipment is obtained as necessary and is properly maintained.

Applies to:
Individuals receiving home supports and individuals receiving other DDS-funded services, except Flexible Family Funding.

The need for adaptive equipment should be evaluated as the circumstances arise. This need may change throughout the course of an individual's life. Adaptive equipment (e.g., wheelchairs, braces, communication devices, etc.) is obtained as needed and is kept clean and in good repair. Regular monitoring of proper fit, usage and safety is also provided.

Individuals and their support workers may need training to use, or assist the individual to use, adaptive equipment. Details regarding correct usage, cleaning and maintenance, and trouble-shooting problems accompany the owner's manual and need to be available for reference.

Standard 21: Special Care Procedures

Special Care Procedures:
Individuals who have specialized health care needs will receive them in accordance with the Regulations Implementing the DD Act.

Applies to:
Individuals receiving home supports and to individuals receiving other DDS-funded services when special care procedures are provided.

The purpose of these regulations is to ensure that people with developmental disabilities who have specialized health care needs will receive safe and competent care while living in home and community settings funded by the Department.

The purpose of classifying a procedure as a "special care procedure" is to provide a system for ensuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for.
Examples: (some examples, but not limited to this list)

- Enteral Care procedures – g or j tubes
- Oxygen therapy
- Suctioning
- Respiratory treatments
- Tracheotomy care
- Catheters
- Colostomy/ileostomy care
- Diabetes care
- Dysphagia protocols
- VNS Vagal Nerve Stimulator

For more detail of these examples please refer to the Regulations Implementing the DD Act

Service Coordinator Role

1. The service coordinator is responsible for notifying the nurse if they believe an individual needs a special care procedure. The nurse, however, is responsible for determining when a procedure is a special care procedure.

2. A copy of the current State of Vermont nursing license must be obtained and kept on record for any nurse whom the DA/SSA uses to do special care procedures. If the DA/SSA uses a professional nursing organization to provide training, then the DA/SSA does not need a copy of the license.

   Information about nurse licensure is available on the Secretary of State's website, www.sec.state.vt.us or by calling the Board of Nursing directly at (802) 828-2453.

The service coordinator is responsible for including, with the individual's ISA, a special care procedure plan. In the case of Flexible Family Funding, the plan must be available in the person's file (because no ISA is required for Flexible Family Funding recipients).

3. The special care procedure plan must include:
   - The name(s) of the procedure(s)
   - The nurse providing the training and monitoring
   - The frequency of review

4. The person's file at the DA/SSA and at the home must contain:
   - The training record
   - The procedure which was taught

Nurse's Role

1. The nurse must evaluate the individual and decide if it is safe for a layperson to perform the procedure. The decision to determine something is a special care procedure is the registered nurses based on the criteria outlined below and in the *Regulations Implementing the DD Act of 1996:*
   - The procedure requires specialized nursing skill or training not typically possessed by a layperson;
   - The procedure can be performed safely by a layperson with appropriate training and supervision; and,
   - The individual needing the procedure is stable and outcomes are predictable.

2. If the need for a procedure is determined to be a special care procedure, the nurse must complete the special care procedure plan.

3. The nurse will write the procedure(s) the support person(s) will be trained to perform:
   - Training must conform to best practice taking into consideration individualized accommodations.
   - The plan should include information about when training should occur.

4. The nurse must provide a record of who has been trained and found competent to perform the special care procedure, including:
   - Who did the training;
   - When it occurred;
   - Who was trained; and,
   - When retraining should occur. (At least annually)

For more information on please refer to: The Vermont Board of Nursing-
The Role of the Nurse in Delegating Nursing Interventions to Licensed and Unlicensed Assistive Personnel Position Statement with the attached Decision Tree for RN/LPN Delegation to Licensed and Unlicensed Assistive Personnel.

Other Information

1. In the event of an emergency, the DA/SSA is responsible for ensuring that a trained person or a nurse is performing the procedure.

2. The DA/SSA must notify the nurse of changes in the individual's health or living situation.

3. If a person is discharged from the hospital with a caregiver who has been trained by hospital personnel, that caregiver may continue to perform care until the DA/SSA arranges for special care procedures. This should occur within seven to ten (7-10) days.

4. Medicaid will pay for special care procedures if the community home health nursing agency is providing the services, but not if the nursing overview is paid for by the DA/SSA.

Standard 22: Advance Care Directives & Planning

Advance Care Directives & Planning:
Advance care directives must be written per legal standards. Documentation of the directives must be on the Emergency Fact Sheet, with details in the person's file.

Applies to:
All individuals who receive DDS-funded services.

As an individual's life progresses, or if there is a change in a person's health condition, opportunities for discussions with the person about advance care planning should occur. This enables an open dialogue to assist the person to put in place the documents necessary to assure that their wishes regarding end of life care will be followed.

The recognized format currently in Vermont is the COLST form. It is completed by the medical professional, is black and white, and is honored in an out of hospital emergency.

COLST – Clinical Order for Life-Sustaining Treatment and conveys the person's wishes for CPR, intubation, transfer to the hospital, antibiotics, artificial nutrition, and hydration, as well as overall treatment goals.

Please visit the Vermont Ethics Network website for more information. www.vtethicsnetwork.org

Standard 23: Training for Support Workers

Training for Support Workers:
All support workers, DA/SSA employees and contractors or subcontractors need appropriate training. Training must be provided in accordance with the Regulations Implementing the DD Act of1996, Part 9.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services.

Training for people who are responsible for the special health needs of individuals must be provided in accordance with the *Regulations Implementing the DD Act of 1996, Part9.* This includes shared living/developmental home providers, direct support staff employed by agencies, home providers, individuals or families, temporary and substitute workers, respite providers, etc. A knowledgeable and qualified person must provide specific training, as indicated by the health needs of individuals. The training must be documented as to:

- Person who is trained
- Person who is doing the training
- What they have been trained on or about
- If further training or monitoring is required

Standard 24: Alternative/Complementary Therapies

Alternative/Complementary Therapies:
The primary care medical professional needs to be consulted prior to the initiation of alternative/ complementary therapies.

Applies to:
Individuals receiving home supports and other individuals receiving DDS-funded services.

All alternative and complementary therapies need the input of the primary medical professional prior to implementation. Any medications (e.g., herbal or homeopathic) need a written order by the primary medical professional. Documentation must be kept in the person's file. The services coordinator is responsible to ensure any follow-up or recommendations are completed as needed.

- Alternative and complementary healthcare and medical practices are those that are not currently an integral part of conventional healthcare.
- Alternative and complementary healthcare and practices may include, but are not limited to, chiropractic therapy, homeopathic and herbal medicines, acupuncture, naturopathy, mind/body therapy, etc.

Standard 25: Tobacco Use

Tobacco Use: *Individuals will receive services in a smoke-free environment unless they choose to smoke. If a person uses tobacco (e.g., smokes, chews, etc.), education about the dangers of tobacco use will be provided.*

Applies to:
All individuals receiving DDS-funded services.

There is well-documented information concerning the risks of tobacco use and exposure to second-hand smoke. Given that, the following information applies to the use of tobacco or tobacco products:

1. Individuals will receive services in smoke-free environments. Any exception to this must be documented in writing with the approval of the individual and/or guardian (if there is one) and the team. Input from the primary medical professional needs to be obtained prior to making an exception when individuals have health concerns that may be further exacerbated by smoke.
2. Individuals who choose to use tobacco will receive information regarding the dangers of using tobacco. If an individual needs assistance with stopping the use of tobacco, it will be initiated. Discussion with the primary medical professional regarding products developed to help people quit smoking, such as nicotine patches, gum, or prescription medications should be considered as part of a smoking cessation program.
3. Individuals who smoke will not have their opportunity to smoke restricted, except for the restrictions that are set by State and Federal law and consistent with DA/SSA policies.
4. Each DA/SSA must have a written smoking policy that is implemented and enforced.