



# Office for People With Developmental Disabilities

DIVISION OF PERSON-CENTERED SUPPORTS

## **REQUEST FOR APPLICATIONS**

**NY START - Region 4 Implementation**

September 24, 2015

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## I. Introduction

By this Request for Applications (“RFA”), the New York State Office for People With Developmental Disabilities (“OPWDD”) is seeking applications from non- profit organizations authorized to do business in New York State to serve as the provider of “NY START” services in OPWDD’s Developmental Disabilities Regional Office 4 (“Region 4”). The RFA process will result in two independent grant contracts between the successful applicants and OPWDD for the performance of the services described in this RFA. This RFA provides information and instructions necessary for the submission of applications seeking award of this contract. Please read this RFA in its entirety and follow the instructions carefully; failure to do so could result in rejection of the application.

## II. Calendar of Events

Event	Date
Release of RFA	Monday, August 17, 2015
Letters of Intent Due	Friday, September 4, 2015
Registration for Mandatory Applicant’s Conference	Friday, September 4, 2015
Last Day for Submission of Written Questions	Friday, September 11, 2015
Mandatory Applicant’s Conference	Friday, September 18, 2015
Posting of Responses to Written Questions and Questions from Applicant’s Conference	Thursday, September 24, 2015
Application Due Date	Monday, October 5, 2015, 3:00 PM
Application Opening	Monday, October 5, 2015, 3:01 PM
Application Evaluations**	
Technical and Cost Evaluations**	Tuesday, October 6, 2015 – Friday, October 16, 2015
Oral Presentations/Interviews**	Monday, October 26, 2015 –Friday, November 6, 2015
Preliminary Contract Award Announcement**	Friday, November 13, 2015
Estimated Control Agency Approvals	Friday, January 1, 2016
Contract Start Date	Friday, January 1, 2016

\*\* **NOTE:** These dates are target dates and are subject to change at OPWDD’s sole discretion.

## III. Background

### A. OPWDD

The New York State Office for People With Developmental Disabilities is a New York State executive agency responsible for the provision, regulation and oversight of services to individuals with developmental disabilities in New York State. OPWDD directly provides services, and also oversees services delivered by an extensive network of over 700 not for profit service providers who employ over 70,000 people. More than 125,000 individuals with developmental disabilities are served by the combined public/private service system. OPWDD has extensive investment in stakeholder groups comprised of self-advocates, families, advocates, state and local human service agencies, state and local government, and the business community. It is overseen by multiple federal and state oversight and control agencies.

Region 4 encompasses Queens, Brooklyn, Manhattan, Bronx and Staten Island. Over 47,000 individuals with developmental disabilities living in Region 4 receive services from OPWDD directly or from voluntary

providers funded and overseen by OPWDD. Services focused on responding to challenging behavioral health presentation include family training and educational programs, behavioral and social skills training, respite, Intensive Behavioral Services, and crisis intervention services.

## **B. Funding**

### **a. Balancing Incentive Program**

New York State has received a federal grant under the Balancing Incentive Program (“BIP”). This program provides financial incentives to stimulate greater access to non-institutional services and supports. The START teams operating in Region 4 may be financed in part through the BIP grant.

### **b. State Funding**

Additional funding required to support the operation of Region 4 START teams and related services in excess of the BIP grant will be funded by the state.

### **c. Pending Funding Steams**

Although initial funding for this initiative will involve funds from the BIP grant and the state, alternate funding streams may be utilized. It is the expectation that the vendor will comply with any regulatory, policy, defined documentation and billing standards relevant to the funding source utilized.

## **C. Background Information on START Program**

This section contains background information on the START program, and is for information purposes only. The Scope of Work section of this RFA contains the requirements that will be in the grant contract awarded pursuant to this RFA.

### 1. Introduction

START (Systematic, Therapeutic, Assessment, Resources and Treatment) is an evidence-informed model for crisis prevention and intervention services. It has been operated by the Center for START Services at the Institute on Disability at the University of New Hampshire since 2009 and has been implemented in Virginia, North Carolina, Ohio, New Hampshire and other states. The START program addresses the need for available community based crisis prevention and intervention services to individuals with intellectual/developmental disabilities (I/DD) and co-occurring behavioral/mental health needs.

START is also a linkage model that promotes a system of care in the provision of community services, natural supports and mental health treatment to individuals with I/DD and mental health needs.

This model, first developed in 1988, and cited by the Surgeon General’s Report (U.S. Public Health Service, 2002), has been used as a basis for the development of services throughout the United States. The goal of START is to enhance the existing system of care, provide technical support and assistance, and fill in service gaps. Emergency and planned therapeutic resource centers and supports are included in the services provided to meet this important goal.

Fidelity to the model is essential for success. While START promotes the development of services in the context of the local system of care, essential mechanisms must be in place for effective service delivery.

### 2. Mission

The Mission of START is to enhance local capacity and provide collaborative cost-effective support to individuals and their families through exemplary clinical services, education and training, with close attention to service outcomes. In meeting this mission, START aims to:

- a. Promote the development of least-restrictive, life-enhancing services and supports to the people referred.
- b. Provide 24-hour-a-day, 7-days-a-week timely response to the system of care in support of individuals with I/DD and behavioral health care needs. In times of crisis this means immediate telephonic access and in-person assessments within two hours of the request whenever possible.
- c. Provide clinical treatment, assessment, and stabilization services in the context of short-term therapeutic respite – both emergency (hospital prevention, transition to community, and acute assessment and treatment) and planned (ongoing support for the individual and care provider for individuals who primarily live with family members or other natural/unpaid supports).
- d. Facilitate the development and implementation of individual, Cross-Systems Crisis Prevention and Intervention Plans.
- e. Provide support and technical assistance to partners in the community including but not limited to: Individuals and their families, mobile mental health crisis teams, residential and day providers, and outpatient and inpatient mental health providers.
- f. Provide state-of-the-art assistance through Certified START Coordinators along with a highly trained work force, access to experts in the field, linkages with local and national resources, and the commitment to ongoing consultation and training for both the START programs and their partners.
- g. Create and maintain affiliation and linkage agreements with community partners in order to clarify roles and responsibilities, overcome existing barriers in the system, and enhance the capacity of the system as a whole.
- h. Provide systemic consultation to work with teams to improve: opportunities for mutual engagement; understanding and a team approach that fosters clarity of roles and responsibilities; and cooperation and collaboration in the context of a comprehensive understanding of the people we serve.
- i. Assess the needs of the population locally, statewide, nationally, and internationally, and work with stakeholders to insure that effective service delivery takes place.
- j. Collect data, measure outcomes, and modify strategies to meet the aforementioned goals.

### 3. Service Effectiveness

A primary goal of all START programs is to promote effective supports and services for persons with I/DD and behavioral health needs. Service elements aim to accomplish goals to improve access, appropriateness and accountability – the three cornerstones of the START model.

*Access to Care and Supports:* Care must be inclusive, timely, and community-based. START provides a systemic approach to link systems and improve access to all services including those of affiliates and partners.

*Appropriateness of Care:* Appropriateness of care is reflected in the ability of service providers to meet the specific needs of an individual. This requires linkages to a number of services and service providers, as individual service needs range and change over time. It also requires expertise to serve the population.

*Accountability:* The third essential element for effective service provision is accountability. There must be specified outcome measures to care. Service systems must be accountable to everyone involved in the provision of care and this includes funding sources. Outcome measures must be clearly defined, and review of data must be frequent and ongoing. The service delivery system must be accountable first and foremost to the persons receiving care. Therefore, outcome measures need to account for whether an individual's service/treatment plan is effective over time. Service recipient satisfaction with services is an important outcome measure as well. Accountability measures should also pay attention to cost. Services must be cost effective, and when insuring access and appropriateness, they can also be treatment effective. The three only conflict with each other when attention to appropriateness of care and the need for access are lacking.

Finally, accountability is a measure of the ability of a system to adapt to changes in individual service needs. Systems must have a structure that can readily adapt to changes in the demands which are placed upon them. In order to provide an effective service delivery system and continue to assess progress in meeting our goals, the Center for START Services, the University of New Hampshire, and participating projects developed a START Information Reporting System (SIRS). Utilizing unique ID numbers, the SIRS database captures de-identified health information about individuals receiving START services and has the ability to provide reporting by case load, by region, and by state. Analysis of service outcomes will provide valuable information on service effectiveness over time and be used as a management tool for decision-makers. Analysis of data must be used as a barometer to determine where a service delivery system has succeeded and where it must now go. Data is multi-dimensional and includes both qualitative as well as quantitative measures.

The START model emphasizes that appropriate services are to be both readily accessible and provided in a timely fashion. Data collection and review determines the need for modification of resources to comply with this requirement. The program is designed to evolve over time to meet the needs of the population and the system of care.

See START's website for additional background information on START, <http://www.centerforstartservices.com/default.aspx>

#### **D. NY START Program**

This section contains background information on the NY START program and is for information purposes only. The Scope of Work section of this RFA contains the requirements that will be in the grant contract awarded pursuant to this RFA.

The NY START program is a statewide initiative that is currently being piloted in OPWDD Regions 1 and 3 prior to full state implementation. The primary goals of the NY START program are to develop linkage agreements between agencies and/or providers serving individuals with intellectual and developmental disabilities (I/DD) and agencies and/or providers serving individuals with mental health needs for the provision of crisis prevention and response services; and to develop site-based and in-home therapeutic resource centers for planned and emergency use.

The Mission of NY START is to increase the community capacity to provide an integrated response to people with intellectual/developmental disabilities and behavioral health needs, as well as their families and those who provide support. This will occur through cross systems relationships, training, education, and crisis prevention and response in order to enhance opportunities for healthy, successful and richer lives.

The NY START Program will enhance relationships and partnerships with I/DD and mental health support and treatment settings and programs, such that individuals with I/DD and co-morbid psychiatric problems receive appropriate and timely clinical support to meet their needs in the least restrictive setting possible. The START program will consist of regionally-based START Clinical Teams, in-home supports, and free-standing therapeutic resource centers. The program will be supported by multi-level linkage agreements between agencies and providers (local, statewide, national); ongoing clinical education and consultation; technical assistance; and data-driven, evidence-informed practices and analyses. The START model requires adherence to a strict level of fidelity to the national START model and its requirements and protocols for training, clinical excellence, data collection and analysis.

#### **IV. SCOPE OF WORK**

In the performance of the work under the contract to be awarded, the successful applicant must plan for, provide and participate in the NY START services as stated in this section and the requirements in section VII B 5, Technical Proposal, Description of Services.

Due to the population density and geography of the Developmental Disabilities Regional Office 4, the boroughs will be divided into two distinct teams. Team 1 will be NY START – Brooklyn/Staten Island. Team 2 will be NY START – Bronx/Manhattan/Queens. *While providers may submit applications for both teams, successful applicants will only be awarded a contract to operate one team; either Brooklyn/Staten Island or Bronx/Manhattan/Queens.*

The applicant will demonstrate that it employs or has access to staff sufficient to form the START team they are bidding for, and will outline an initial staffing plan as well as a plan for phased in staffing which corresponds to the regional sub teams as described in sections IV D 1 and IV D 2. While the delivery of START services would begin upon the establishment of the initial START teams, it is recognized that the full staffing pattern would be achieved in collaboration with OPWDD within 6-12 months from contract start date. Staff must meet the qualifications in section IV D 2, and must be capable of providing NY START Services during the term of the contract. All professional clinical staff persons must have the appropriate credentials as stipulated by the NYS Department of Education.

OPWDD has an arrangement with the University of New Hampshire whereby the University provides OPWDD its expertise in crisis services, technical assistance, and training for the NY START program. If at any time during the term of the contract awarded pursuant to this RFA, such arrangement is terminated, the successful applicant will not be entitled to use any intellectual property of the University of New Hampshire related to the START program, will not be permitted to hold itself out as a provider of START services, and will not be entitled to the support services described in section IV A. Notwithstanding the foregoing, in the event of such termination of the arrangement between OPWDD and the University of New Hampshire, the successful applicant will work with OPWDD to continue to provide services of the same character, quality and quantity during the remainder of the term of the contract, and OPWDD will continue to fund such services at the amounts stated in the contract.

The successful applicant will be required to sign a Business Associate Agreement with START-University of New Hampshire in order to participate in the START Information Reporting System (SIRS) database.

NY START services consist of linkage/clinical teams and therapeutic resource centers. Pursuant to the contract, the successful applicant will be required to include the following elements in its program:

- A team approach
- Linkages, outreach, follow-up
- Systemic and clinical consultation and training
- Cross systems crisis prevention and intervention planning
- Cultural competency development
- Crisis assessment and intervention
- Mobile crisis response and services
- Emergency and planned therapeutic resource centers
- Facilitation of interdisciplinary meetings
- Advisory Council
- Ongoing assessment of service outcomes (data, documentation)

#### **A. Support Services from the Center for START Services**

The Center for START Services at the Institute on Disability at the University of New Hampshire offers numerous support services to START providers and states developing START. As long as the Center for START Services continues its arrangement with OPWDD for the NY START program, the successful applicant will be required to use the following support services from University of New Hampshire as part of the contract:

- Customized coaching
- Technical support
- Certification of START Coordinators and START Teams
- National Online Training Series
- National database for collection of required data
  - (START Information Reporting System (SIRS))

The successful applicant will not be required to pay for the above support services.

#### **B. Population to be Served**

The successful applicant will be required to provide NY START services to all individuals eligible for such services. To be eligible for NY START services, an individual must meet each of the following four criteria:

1. The individual must live in Region 4;
2. The individual must have a developmental disability as defined in New York State Mental Hygiene Law section 1.03 (22);
3. The individual must have significant behavioral or mental health needs that have not been adequately addressed with typically available supports; and
4. The individual must be at least six years of age for all services other than therapeutic respite, and at least 21 years of age for admission to therapeutic resource centers.

NY START Services are designed for individuals with intellectual and other developmental disabilities and co-occurring behavioral/mental health needs who are at imminent risk of placement into a more restrictive living environment, are at risk of self-harm, and/or are at risk of harming others. However, there is an exception to criterion 2 above in that confirmed OPWDD eligibility is not required for access to START linkage services during an emergent situation; rather, a reasonable basis to suspect developmental disability will be sufficient in these circumstances. An OPWDD Eligibility Determination (i.e., a determination by OPWDD that an individual has a developmental disability as defined in Mental Hygiene Law) is required in order to receive additional START services.

### **C. Cultural Competency**

Given the level of cultural and linguistic diversity within the NYC area, there is recognition of the need to possess and display effective cultural competency skills in developing NY START Programs in this region. The successful applicant will be required to describe how their teams are trained in such matters in order to best support people with I/DD from diverse cultural backgrounds. By demonstrating a sensitivity to cultural differences and engaging in both inter- and intra-cultural communications, the successful applicant will effectively improve the capacity of the system as a whole in order to provide needed services and supports to children and adults with I/DD and behavioral health needs.

Applications should include:

1. A description of approaches utilized and plans for collaborative relationship building with providers who serve individuals in multicultural provider agencies;
2. A description of the cultural diversity/competency trainings the successful applicant's team will participate in;
3. A description of how the successful applicant's team will provide similar training to local stakeholders who receive NY START services;
4. A description of how the successful applicant's team will ensure that all necessary materials are translated as appropriate;
5. A description of how the successful applicant's team will ensure that interpreters are developed and engaged as appropriate; and
6. As development of cultural competence skills are an ongoing activity, the successful applications should include a description of how cultural diversity and competency trainings will continue to be integrated into daily practice.

### **D. START Services**

The contents of this section of the RFA are approved by the Center for START Services, University of New Hampshire, Institute on Disability (UNH/IOD) for application of the START model. This section intends to provide a detailed description of the elements of the NY START program for Region 4 and guidelines for promoting fidelity to the START model.

#### **1. START Clinical Staff**

The successful applicant will be required to establish one START clinical team within their identified area, with sub-teams as necessary. The START clinical teams offer both the linkage/clinical and resource centers that will be described in greater detail in the pages that follow.

The START clinical team for **Team 1 – Brooklyn/Staten Island (Team 1)** must consist of the following personnel, and such personnel must meet the qualifications set forth in section IV D 2 below:

- 1 FTE Director
- 1 FTE Assistant Director
- 1 FTE Administrative Assistant
- 1 FTE Clinical Director
- .50 FTE Medical Director (may be more than one person)
- 1 FTE Resource Center Director
- 1 FTE In-Home Supports Director

**Brooklyn:** Three sub-teams with locations recommended by the provider

- A. 1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant
- B. 1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant
- C. 1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant

**Staten Island:** One team centrally located and recommended by the provider  
1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant

The NY START Organizational Chart - Team 1 is included as Attachment A1.

The START clinical team for **Team 2 – Bronx/Manhattan/Queens (Team 2)** must consist of the following personnel, and such personnel must meet the qualifications set forth in section IV D 2 below:

- 1 FTE Director
- 1 FTE Assistant Director
- 1 FTE Administrative Assistant
- 1 FTE Clinical Director
- .50 FTE Medical Director (may be more than one person)
- 1 FTE Resource Center Director (per center; may need two)
- 1 FTE In-Home Supports Director

**Manhattan:** Two Sub-Teams

- A. Lower Manhattan (1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant)
- B. Upper Manhattan (1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant)

**Bronx:** One team centrally located, recommended by the provider  
1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant

**Queens:** Two Sub-Teams

- A. Astoria/LI City to Forrest Hills (West) (1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant)
- B. Forrest Hills to LI (East) (1 FTE team lead, 4-6 FTE coordinators, 4 hours a week Psychology consultant)

The NY START Organizational Chart - Team 2 is included as Attachment A1.

These recommendations are based on the size, population density and diversity of each borough.

In addition, the successful applicant will be required to have the following START Resource Center personnel:

1. One Resource Center Director
2. One Nurse/Assistant Director
3. 25 Qualified Direct Support Professionals/Resource Center Counselors per Resource site

## 2. START Clinical Staff Qualifications and Responsibilities

The START Clinical Teams Manual, Attachment C, includes descriptive information regarding START Staff Qualifications and Responsibilities.

### **3. START Services & Linkage Elements**

#### **1. The START Team Approach**

Active communication and collaboration begin with the START team itself. There are various methods used that, in spite of the fact that START team members operate in the field independently, require that the entire team works together to support individuals and the system. To help ensure the successful delivery of START Services, the successful applicant will need to utilize technology that allows for timely data entry, proper case planning, networking and communications. The successful applicant should be prepared to meet the following protocols:

##### **a. Morning Triage Calls**

Members of the team participate in a Triage call every weekday morning. Triage calls provide a time for START Coordinators to review any calls they may have received since the previous day. The Respite Director or designee provides updates on the guests at respite and reviews respite admissions/discharges as necessary. This is also a time to discuss crisis/emergency needs of individuals referred or already part of the START program and receive direction/support from supervisory staff. Follow-up for crisis contacts is also determined at this meeting along with dissemination of intake assignments for emergency referrals.

##### **b. Staff Meetings**

Each START team conducts weekly staff meetings to review systems related issues, resource center operations, and other service elements. Recurring Team Meetings are intended to ensure all necessary information is communicated to the entire START Team and to provide meaningful dialogue regarding the care and treatment of individuals supported by START through coordination and support of their respective systems. In doing this the following agenda items should be included in all START Recurring Team Meetings:

- Review of any individuals on the active caseload who are experiencing difficulties, crises, significant events and/or are experiencing circumstances and situations that may lead to crisis events. This includes individuals whose early stage(s) of crisis intervention may have occurred.
- Review status of guests at resource centers and any upcoming plans for discharge.
- Review the planned resource center schedule for the week and any openings.
- Review any new administrative/operations procedures, policies and/or problems/issues with current processes that may warrant further discussion and/or changes to current operational processes.
- Review individuals on waitlist (if applicable) as well as recent referrals.
- Review any significant administrative or procedural problems or changes.

##### **c. Peer Reviews**

Peer-review is an essential component of the program's internal process for quality assurance. START completes internal peer-reviews to improve the development of Cross-Systems Crisis Prevention and Intervention Plans, respite discharge summaries, and maintenance of medical records. START Coordinators and the Team Leader, Regional Director, Clinical Director, and/or Respite Director participate in peer-reviews as deemed appropriate by the Regional Director. Peer-reviews should occur at least once every three months.

##### **d. Live Supervision**

Live supervision techniques are part of the core training and supervision protocol for all START respite personnel and includes review of videotaped meetings and activities to improve the skills and effectiveness of the respite team.

## 2. Linkages, Outreach, and Follow-up

The START systems linkage program is presented in the diagram in Attachment B.

START develops relationships with community partners in order to bridge service gaps and improve service outcomes. The success applicant will be required to make all necessary good faith efforts to develop formal affiliation and linkage agreements with mental health and medical providers, inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists and other experts in the field. Affiliates are partners with signed linkage agreements whom START maintains frequent and ongoing collaboration with as part of the infrastructure.

The successful applicant will be required to sign an affiliation agreement with the National Center for START Services at the UNH/IOD, which will allow the National Center for START Services to offer trainings and linkages with other START teams nationally.

The successful applicant will work with numerous partners providing services in the community; partners are defined as those agencies with which START does not have a formal affiliation agreement, but with whom they work in collaboration. In adhering to the goal of systems accountability, the approach is adaptable to the changing needs of the people and systems supported.

The successful applicant will develop critical linkage agreements with agencies that exist to provide support along the crisis support continuum. Affiliations with Mobile Crisis Management, First Responders and local Law Enforcement agencies will facilitate increased opportunities for diversion, collaboration with hospitals regarding admittance, discharge planning and transition, as well as crisis plan development and emergency respite. NY START programs must work closely and collaboratively with established first responders and local law enforcement agencies in NYC. Roles and responsibilities must be clearly established and defined as part of this process to ensure effective crisis response. Successful applicants should be prepared to address the joint trainings that will be required to bridge the gaps in knowledge and practice that exist between agencies.

The successful applicant will also develop a plan to address how they will interface with the education system and local schools serving individuals with I/DD.

Given the wide spectrum of individuals needing services, the changing landscape with regard to research and training, and the commitment to success across providers and systems, it is suggested that any applications take into account what has been learned from the data collection and analysis of the needs of this population over time. A NY START advisory councils should be formed to assist with this process, and the proposed provider should have a plan to assure that this occurs.

Outreach serves to support the systems of care. START personnel are in frequent contact with service providers and individuals to insure that they continue to receive effective services. This includes home visits and phone contact to remain in touch so that needs are responded to in a timely fashion. The successful applicant will be required to provide planned outreach. All active cases must receive at least monthly phone contact to check in and ensure that the individual continues to do well.

START Coordinators maintain ongoing contact with family members and other caregivers. Follow-up meetings are scheduled to evaluate the effects of treatment strategies, update crisis prevention plans, and foster active communication among providers and with direct caregivers. One critical way the important information that is gathered at meetings is shared is through minutes from meetings. Minutes from all meetings are taken by START team members (usually the START Coordinator but may also be other team members as needed) as part of their contribution to the linkage approach to care. This includes goals and objectives of the meeting and the plan of action and follow-up. Notes from each meeting are disseminated by the START team within 24 hours or the next business day after the meeting occurred to all who attended the meeting.

START Coordinators and other members of the clinical team provide outreach support through:

- Home visits
- Assistance in attending appointments with mental health providers
- Attendance at admission and discharge planning meetings for psychiatric inpatient stays and emergency and planned START respite stays
- Visits to residential and day providers to provide consultation and training
- Other community-based contact as needed and available

Follow-up is another important element of the START approach to service linkages. The successful applicant will be required to follow individuals referred to START for up to a year (or more as needed). Individuals placed on the inactive status will remain part of the system and be reactivated should the need arise.

### 3. Systemic and Clinical Consultation and Training

All START Coordinators will be required to be trained to provide a systems approach to team consultation. START staff members incorporate an understanding of the context/structure in which the system makes decisions and implements action to assist a team in problem solving and service planning. START Coordinators receive ongoing supervision in order to improve their own skills to provide a systemic approach that encourages engaging all members of the team, the use of functional analysis techniques, and fostering active communication and collaboration of all team members.

Clinical Consultations/service evaluations: Members of the START Clinical team include experts in the field of psychiatry and psychology working with individuals with I/DD and behavioral health needs. START-approved instruments are used to collect data. START respite staff are trained and supervised in data collection methods. In addition, START Coordinators provide an analysis of individual records and service outcomes through the development of comprehensive service evaluations.0020

#### a. Clinical Education Team Meetings

The START Clinical Education Teams (CETs) meet monthly. This is a forum designed to improve the capacity of the local community to provide supports to individuals with I/DD and behavioral health needs through clinical teaching.

The team consists of START Coordinators and providers of services in the community. Members from the local community of service providers are invited and included in the process. These partners include, but are not limited to, local mental health centers, emergency services and inpatient, residential, day program providers.

The goal of the CET is to help service system providers learn how to best support people while improving the capacity of the system as a whole through information sharing, learning, and collaboration among team members.

Because this is an educational forum, each individual presented will have his or her identity hidden to protect confidentiality. The training is less about the person presented than it is the descriptions of the problems faced, strengths and resources, as well as diagnosis and treatment information so that the individual serves as an example for discussion and further examination. However, it is expected that the discussion will generate ideas about possible remedies to improving services and clinical outcomes to explore for the individual presented.

Each month, up to two people are reviewed. START Coordinators will initially select individuals but later reviews may come from community partners. The meetings take two hours to complete each month. START Coordinators receive a summary of recommendations and provide follow-up information to the team at subsequent meetings so that all can learn from the process.

These education teams do not involve natural supports or the individual. This is training rather than consultation.

#### b. Training for Providers/Families

All members of START provide training to providers and/or families when requested. Training for the Cross-Systems Crisis Prevention and Intervention Plan (CSCPIP) or respite recommendations are common topics of trainings completed. However, other specialty trainings are completed by the Clinical or Medical Directors, or Program Director, depending on the request or topics involved. Training network providers helps build education and capacity within communities. Offering training is essential in the framework to support community capacity in working with individuals with I/DD.

#### 4. Cross-Systems Crisis Prevention and Intervention Planning

The successful applicant will be required to provide Cross-Systems Crisis Prevention and Intervention Planning. The Cross System Crisis Prevention and Intervention Plan (CSCPIP) is an individualized, person-specific written plan of response that provides a concise, clear, concrete, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral health crisis. The goal of the CSCPIP is to identify problems that have or may arise and map out a strategy that offers the tools for the circle of support to assist the individual to address problems and prevent crises from occurring.

START Coordinators facilitate individual CSCPIP meetings. Whenever possible, the START Coordinator, the individual, members of the mental health service team (which could include an outpatient therapist, a representative from the clinical home provider, psychosocial rehabilitation provider), members of the developmental disabilities service team (which could include the targeted case manager, residential and day program providers), and the individual's natural supports (family members, friends, and other interested parties) meet to develop a plan to assist the individual and his or her caregivers during times of difficulty.

The successful applicant must attempt to write a full and comprehensive CSCPIP within 60 days of initiating the process. The CSCPIP should be modified as needed and be reviewed frequently, minimally at least twice a year.

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. The use of crisis services most often follows severe maladaptive behaviors on the part of the individual, e.g., assault or property destruction. Crisis prevention planning can provide a strategy to assist an individual and the people who provide support to better cope in times of difficulty.

The CSCPIP process has five goals to accomplish this task:

1. Reaching an understanding regarding communication of needs through challenging behaviors: A primary goal of the collaborative planning process is for all concerned parties to reach consensus regarding what an individual may be communicating through their challenging behaviors. Family caregivers and other people providing support and assistance can better introduce alternative strategies to help an individual get his or her needs and wishes met when they understand the “meaning” of a given challenging behavior. When effective, this strategy helps to prevent a crisis from occurring.
2. Developing/improving upon coping strategies for the individual and caregiver: The CSCPIP outlines options for individuals and their caregivers to cope with feelings or difficulties that may increase the likelihood of challenging behavior(s) if not addressed. For example, the plan may delineate “early warning signs” that may indicate an individual is experiencing anxiety. The plan outlines relaxation techniques to assist in reducing the person’s anxiety, based on what is known about the individual.
3. Preventing the system from going into crisis: The roles and responsibilities for specific professionals and service providers are delineated in the plan. The CSCPIP helps service providers respond more effectively in times of crisis. It is helpful when the plan is as specific as possible in defining who should be contacted, when, and what they will do. The plan may also include important facts about the individual to help the service providers contacted better assist the caregivers. To ensure that the plan is taken seriously, each plan is signed and approved by all involved parties.
4. Identifying signs/ behaviors that may also indicate symptoms of acute mental health symptoms: These are carefully monitored with recommended interventions and often involves mental health providers in the planning process.
5. Simplifying access to services: It is important that access to emergency services be as easy as possible. Lists of services and important contacts are provided to families, caregivers and other direct support providers as part of the CSCPIP.

## 5. Comprehensive Service Evaluations

Comprehensive Service Evaluations (CSEs) provide an in-depth overview of an individual’s service history in order to identify opportunities to strengthen service outcomes for individuals with intellectual/developmental disabilities and their families in the community.

The CSE takes about 30 days to complete and is an important tool to assist teams in improving their understanding of the client and of his or her service needs.

### CSE Guidelines

- It is important to review all available records, and to seek them out when not readily available (remember we do not want to “strain the system by assigning this to case

manager or others; our job is to assist in attaining records so that the team remains engaged in the process).

- Draft reports are reviewed with the START Clinical Director prior to sending them to the individual's team.
- Draft reports are sent to the team for review and discussion. Then, after meeting with the team's team, an action plan will be included in the final report.
- Summaries include "reported" information along with interpretation from the START team. Do not just copy what you find in records; explore their meaning.
- Test scores must be reviewed with the Clinical Director, and interpretation of implication of the scores should be included in the report.
- Recommendations often include other assessments that are needed. Please include who you would recommend conduct these assessments whenever possible.
- The START team assists the team in follow-up with recommendations from the CSE.

## 6. Crisis/Emergency Assessment and Intervention

### a. Emergency Meetings

It is often necessary to participate in emergency team meetings when someone is experiencing an acute psychiatric emergency or behavioral challenge. Emergency meetings are often facilitated by START Coordinators to ensure all team members are informed and involved in the issues surrounding the emergency in order to better support the individual.

Another important service provided by START is providing emergency assistance during times of difficulty. In order for our community partners to be able to reach START, there will always be at least one designated START Coordinator on-call for each team in Region 4 (i.e., 24 hours a day, 7 days a week). The Program Director or Clinical Director serves as the back-up for the on-call system. Typically, the on-call responsibilities rotate between START Coordinators. The Team Leader maintains the schedule for the on-call system and ensures the region is always covered.

If emergency assistance is requested from START there are several things that must occur. The START Coordinator will:

- Identify the problem or reason for the call.
- Consult with all parties involved if necessary to determine nature of the problem.
- Assist the caller with developing a safety plan to ensure the safety of all involved.
- Determine what assistance can be provided (e.g., ongoing phone consultation, reviewing of crisis plans, alerting additional staff, initiation of Mobile crisis management, scheduling of face-to-face consultation). The START Coordinator must *never* communicate the concept that there is nothing that can be done to help.
- Present information to START clinical team during triage calls.
- Follow up to determine if additional assistance is necessary.

Emergency calls come from a variety of sources. START may receive emergency calls for assistance from the following, but not limited to: hospital emergency departments, mobile crisis teams, clinical homes, community providers, families, law enforcement, and the individuals needing assistance or experiencing the emergent situation.

START is expected to respond to a crisis call in a timely fashion, and to assess emergency service needs through face-to-face evaluations whenever possible. The START contractor must provide immediate telephonic response and perform onsite evaluations as appropriate. Review of outcomes helps determine if there are obstacles to this important goal being met.

All instances of crises for individuals supported by START should include next-day follow-up by the START coordinator assigned to that individual. The START coordinator will become aware of the resolution, as well as what strategies were necessary for stabilization. If the crisis outcome included placement in a higher level of care such as a mental health inpatient unit, the next day follow-up should include a face-to-face meeting at the hospital or facility to discuss goals of the admission and discharge planning. START will assist in the engagement of all stakeholders, caregivers, and providers in the treatment and service planning process.

In all circumstances of crises for individuals eligible and/or currently supported by START, the information obtained from the response to the crisis should be included and/or considered when developing/revising the individual's CSCPIP. Each person involved with START will have a CSCPIP that should be reviewed with the service team and revised as needed, especially after an emergent situation has occurred.

In most situations, a START representative will seek to complete a face-to-face assessment and/or consultation within two hours of the emergency call being received. However, there may be situations when this will not occur, such as when the person experiencing a crisis is placed in a different setting (i.e., another respite facility or hospital bed) or when the person is deemed to not be an appropriate recipient for START service. Still, it is our goal to assist all callers and provide a response and/or intervention when necessary. All calls and interventions will be documented.

#### b. Prescreening for Emergency Use of Resource Center

START Coordinators prescreen for emergency resource center admission at START and co-evaluate for a full array of crisis and emergency services with first responders.

Should other potential guests present with urgent needs for resource center admission without available beds in the respective region, the START Director will inquire and collaborate with other START Directors about emergency respite availability and potential out-of-region admission, if in-home supports is not adequate.

### 7. START Mobile In-Home Community Support Services

START in-home supports are designed to assess and stabilize an individual in his or her natural setting. This service is part of the mobile crisis capacity of START, and the START Coordinator determines the need for supports. In most cases the provision of in-home supports is planned with the full knowledge about the individual and the setting. However, the provision of supports may occur in response to an emergency or crisis seven days a week, and will depend on the person's crisis plan and his or her need for services.

Once contacted, the team will be expected to have in-home supports in place within two hours of the plan to provide services. This means that the mobile in-home supports team will be located throughout the region so that they can provide timely support. The goal of the in-home support is to assist the person's current support provider or family in implementing successful strategies to prevent the exacerbation of a problem,

implement crisis intervention strategies, and provide observational assessment of the person and their circumstances. In-home support does not replace existing services or staff. The in-home supports will be provided by qualified, trained personnel who will be part of the local mobile crisis network which is made up of START Coordinators and on-call clinicians who will provide assistance and support as needed. It is expected that services will be provided for up to 72 hours per intervention period. Prior to the end of this period the individual will be reassessed by a START Coordinator and the team will determine the follow-up services and supports needed, including planned or emergency respite at the START Therapeutic Respite facility.

## 8. START Resource Center Services

### a. Facility

The START services will be provided in a resource center located within each team's area of operation. Facility locations will be determined by the successful applicant in conjunction with OPWDD and the Center for Start Services. The successful applicant will *not* be required to purchase or lease such property with the funding provided under the contract awarded pursuant to this RFA. In the event an applicant currently has access to a suitable property based on the requirements attached hereto as Attachment D, Best Practice Guidelines for NY START Resource Centers, this should be included in your response for review in accordance with section VI, B, 8. Up to an additional 5 points will be added to the applicant's technical score based on the facility meeting the START model's best practice recommendations for property suggested for resource center use.

### b. Resource Center Services

When determining clinical appropriateness for eligible potential guests for START Therapeutic Resource Center, START Coordinators confer with the START Director, START Assistant Director, START Resource Center Director, and START Clinical Director (as appropriate) regarding the current clinical presentation and needs of the potential guest(s).

In adherence to the expectation of effective service delivery, START Therapeutic Resource Center programs provide a proactive clinical service approach along with the opportunity for those in need to access services with regard to proximity of the facility and design of the program space. Therefore, START Resource Center programs should allow for enough space to provide a therapeutic environment for all guests. This requires enough community space for programming, meeting space for staff and community partners, and individual bedrooms for guests. The surroundings should be home-like but clinically appropriate to support individuals who may need limited access to daily items (e.g., sharps) for safety. The staffing ratio allows for individualized programming. Personnel must be trained to support potentially volatile individuals.

START Resource Center is a community-based therapeutic program that provides assessment and supports in a highly structured setting. The START Resource Center program requires clear emergency back-up policies and procedures and a highly trained staff to provide the needed supports and service to guests at respite. It is closely linked with the START Clinical team and includes evaluations by the START Medical and Clinical Directors in addition to ongoing collaboration with START Coordinators.

The START Resource Center program provides community-based, short-term respite exclusively for potential guests eligible for and enrolled in the START program experiencing acute, chaotic and/or other needs that may also be identified as a "crisis." The intent of this respite with the START program

is crisis prevention, stabilization, assessment, treatment and tracking via providing a change in environment and a structured, therapeutic community-based home-like setting.

The individuals served at the program are considered to be guests, and do not have unsupervised access to sharps, flammable materials, cleaning supplies, medications, hygiene products, or food to insure safety. Unless approved, they do not have unsupervised community access. This is a therapeutic setting and is not intended to replicate a home environment.

#### 1. Planned Resource Center Use

Half of the beds in the four bed resource Center facility are designated as “planned respite beds.” Planned respite beds at START are intended to serve people who have not been able to use respite in more traditional settings due to ongoing mental health or behavioral issues. Families and others participating in the program must be approved as eligible for these services, but once approved they schedule visits as needed (and when available).

The goals of planned use of resource centers are to: provide a break from the daily life experiences of both the caregiver and guest, monitor the effects of treatment, conduct coping skills training, work on crisis prevention, provide positive experiences to look forward to, offer training to providers and caregivers, and increase recreational opportunities for individuals who often lack the ability to access these supports in the community.

The successful applicant will not be required to provide or fund transportation for potential guests scheduled for START planned resource center services. These guests are required to have confirmed transportation from their permanent residential setting to the resource center home prior to admission, and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Director and/or Resource Center Director (as applicable) must approve any transportation provided by the START Team.

#### Length of Stay

START planned resource center services are designed to be very short-term and generally will not exceed five consecutive calendar days. As START planned resource center services are limited, guests may receive no more than 36 days of planned access per calendar year with the recommendation of no more than one visit per month. The START Director may grant exceptions to these limits with the agreement of the Resource Center Director and Clinical Director. Length of stay is determined prior to admission.

#### Planned Resource Center Visits

Planned resource center visits do not include an overnight stay. Planned resource center visits are provided to any START service recipient and are not restricted to people living with their family. An individual can visit the resource center for dinner, a recreational activity, or to just “check in” for a few hours. Some families visit with the guest to become familiar with the facility and the staff prior to scheduling an overnight visit.

## Scheduling

The first planned resource center admission is facilitated by the START Coordinator in collaboration with the Resource Center Director or designee. Following the first planned admission to a resource center, all subsequent admissions are scheduled between the families and the START Director and communicated to the START Coordinator.

Activities, services, assessments and data collection for guests in the START resource center are driven by information provided in the resource center admissions summary, Cross-Systems Crisis Prevention and Intervention Plan, and any and all other supporting documentation or dialogue provided prior to or at admission. All activities, services, assessments, and data collection are individualized and dictate much of the daily activities schedule.

Although there are certain activities that take place as part of regularly scheduled programming, the needs of the guests guide the specifics of these activities. All activities are based on an individual's goals/objectives and tailored to the individual's needs. The START program policy and procedures guide will also document assessments and the protocols for implementing them while at the resource center.

At the conclusion of a guest's stay, staff will meet with the guest and their caregivers about the visit to discuss what was learned, and answer any questions the guest and/or caregiver may have. Guests are also encouraged to complete an anonymous survey about their experience while at the resource center.

Planned resource center discharge summaries are written by the Resource Center Director or designee quarterly and will be sent to the START Coordinator for distribution to the guest's team within one week of their most recent stay.

## 2. Emergency Resource Center Access

Emergency resource center services are provided at the START resource center facility located in each region. Half of the 4-bed resource center facility operated by START are designated for emergency respite purposes. Unlike planned respite, which is offered primarily to families, all START service recipients can access emergency respite as needed. Emergency respite is designed to provide out-of-home housing and services for people who, for a short period of time (30 days or less), cannot be managed at home or in their residential program.

The goals of emergency respite at NY START resource centers include: clinical assessment, hospital diversion, stabilization, reunification with home and community settings, training caregivers and providers, initiating collaborative contacts/consultation with treatment teams, step down from mental health inpatient services, positive social experiences, behavioral support and planning, assessment and refinement of treatment approaches, coping skills development and enhancement, and family support and education.

## Prescreening and Coordinating Potential Admissions

Crises occur at all hours of the day and all days of the year. As such, scheduling emergency admissions to the START resource center home may necessitate a significant amount of planning take place within a very limited timeframe. Planning and troubleshooting for emergency admissions occur within one hour of the request through direct contact between the START Coordinator and the Resource Center

Director/designee. In many cases, potential guests for START emergency resource center access are new to the program. When coordinating guests' emergency admissions the assigned/on-call START Coordinator will contact the Resource Director to discuss the clinical needs of the potential guest, bed availability, and expected length of stay (not to exceed 30 consecutive days per admission).

It is the responsibility of the START Coordinator to collaborate with the Resource Director throughout the admissions process. The final decision about admissions occurs between the Resource Director/designee and START Coordinator under the supervision of the Director of START Services. If needed, consultation with the START Clinical or Medical Directors will occur to make the final determination with regard to the appropriateness of the admission.

General Rules for times/dates on admissions:

- Emergency admission to resource centers generally occur between the hours of 8:00 AM and 7:00 PM Monday through Friday
- Previous guests of the START resource center in need of emergency respite services may be admitted outside of the designated admissions hours
- Admissions after hours and on weekends will be considered on a case-by-case basis

Potential guests scheduled for START emergency resource center services are required to have confirmed transportation from their permanent residential setting to the resource center prior to admission and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Director or Resource Center Director (as applicable) must approve any transportation provided by the START team.

#### Admissions Meeting

Upon or prior to arrival at START resource center, the guests' care provider and a START Coordinator participate in a brief meeting to review a brief history, issues or concerns, and identify goals/objectives for resource center services, assessments and data to be collected during the guest's stay or in home supports. The START resource center team facilitates this meeting. Other participants in the resource center admissions meeting may include the Resource Center Director, Nurse, Resource Center Counselors, Clinical Home provider, Residential Provider, family, etc.

A designated START Coordinator participates in all START emergency admission meetings. START Coordinator will also visit the individual while at resource center to help evaluate progress and service needs, and maintain contact and exchange of information with families or support providers.

#### Documentation

START Resource Center staff complete relevant and appropriate documentation for all guests in care. Many of the forms selected are specifically designed to meet the needs of the program, while some more generalized forms are agency or state-required forms. Each form selected for documentation with START has been carefully reviewed and approved by the Resource Center Director and START Team. \*\*It is imperative that all documentation identified be completed prior to the end of each Resource Center Counselor staff's assigned work shift.

Guests of a START Emergency Resource Center admission will have an approximate discharge date identified upon admission. This date will be determined by goals and objectives established with the team at intake. This date may require adjustment based on the individual's progress.

All guests receiving START Emergency resource center access will have weekly discharge planning meetings facilitated by the resource center team and the respective START Coordinator. These meetings will provide a forum for dialogue to assess significant events, progress toward goals as well as discuss the potential discharge date, transition to home environment, and any necessary follow-up care.

Weekly collaborative meetings are required and full team participation is needed in order to maximize the effectiveness of the resource center stay and prevent the need for future crisis services whenever possible. Meetings will include participation by the clinical home provider, the Medicaid Service Coordinator or care coordinator, residential provider (if applicable), family member/legal guardian, and any other applicable team member. Meetings may occur face-to-face, via teleconference, or a mixture of the two. The START Coordinator will attend all meetings. The START Coordinators must be present for face-to-face meetings whenever possible.

Guidelines for assessment of target behaviors: Because people are admitted to START after incidents have occurred, there may be an absence in the occurrence of target behavior while at the resource center. This should not preclude assessment of what may have resulted in difficulties, the provision of clinical and psychological supports and dialogue and discussion with the guest's home setting assist in preventing future difficulties once the person returns home. In order for this to occur it is essential that ongoing collaboration between resource center staff, START Coordinators, and home providers occur on an ongoing basis in order to get a better understanding of the conditions that precipitated the emergency resource center admission.

At the conclusion of a guest's stay at the START resource center, staff in conjunction with the assigned START Coordinator will meet in person with the guest, their caregiver, and clinical home provider during a discharge meeting about service delivery and process what occurred, what was learned, and answer any questions the guest, clinical home provider, and/or caregiver/transport may have. Guests are also encouraged to complete an anonymous survey about their experience at the resource center.

Following discharge, the Resource Center Director will collaborate with Resource Center Counselors, START Clinical Director, and the assigned START Coordinator to develop a Discharge Summary of the guest's stay to be completed and disseminated no later than one week after discharge. The Discharge Summary is then forwarded to the START Coordinator along with relevant data collected on behavior tracking, etc., for distribution and dialogue with the individual's clinical home and relevant care providers. START emergency resource center services are designed to be short-term and generally will not exceed 30 consecutive calendar days. However, a measure of success in improving service outcomes is the reduction of readmissions over time. As such, a guest's length of stay for crisis admission may be extended to ensure adequate data and maximum therapeutic benefit. Any decision to exceed the above-identified maximum length of stay will be determined by the START Director and Resource Center Director.

## 9. START Advisory Council

The Advisory Council is critical to ensure effective service delivery in the context of the START program. It consists of stakeholders, experts, and personnel from START. The successful applicant will be required to form the Advisory Council and to organize meetings of the Advisory Council. The successful applicant will be a member of the Advisory Council. The Advisory Council meets quarterly to provide support and review progress and discuss future directions. The Advisory Council enhances our capacity to remain accountable to everyone involved.

## 10. Data Collection and Reporting

It is essential that all START programs continue to evaluate service needs and outcomes through the ongoing process of data collection and evaluation both for reporting purposes and to improve service effectiveness over time. This is a core element of the START philosophy – you must continuously measure what you are doing and for whom you are doing it.

The successful applicant will be required to report de-identified health information about individuals receiving START services to the START Information Reporting System (SIRS). The SIRS has the ability to provide reporting by case load, by region, and by state. START collects data at a variety of levels including, but not limited to, individual demographics, service event/encounters, resource center services and outcomes, and administrative activities.

### a. Quarterly Reports

The successful applicant will report requested data on a quarterly basis to OPWDD and the University of New Hampshire. The START Program Director is responsible for reviewing the aggregated data and submitting the reports.

### b. Annual Reports

The success applicant will be required to compile an annual report to review with the Advisory Council. From analysis and discussion of the outcomes documented in the report, the team should develop goals and objectives for the project in the coming year.

## V. MINIMUM QUALIFICATIONS FOR SELECTION

The minimum qualifications that must be met for an applicant to be awarded a contract under this RFA are as follows:

1. Must be a not-for-profit organization authorized to do business in New York (including not-for-profit corporations formed under New York State Law, local government units, or organizations created by an act of the New York State Legislature for charitable purposes which include providing services to persons with developmental disabilities);
2. Must not be on OPWDD's Early Alert list at the time the application is submitted;
3. Must be current on the submission of Consolidated Fiscal Reports (CFRs) at the time the application is submitted;
4. Must be authorized by OPWDD to provide HCBS waiver services or be eligible to become an authorized OPWDD waiver provider by the contract start period;
5. Must be an enrolled Medicaid provider of waiver services or be eligible to become an enrolled Medicaid provider of waiver services by the contract start period;
6. Must be pre-qualified in the NYS Grants Gateway. Additional information on prequalification and the Grants Gateway can be found on the NYS Grants Reform website at: <http://grantsreform.ny.gov/>;

7. Be in compliance with the charities registration requirements of the New York State Attorney General.

Applications which do not meet the above minimum qualifications will be disqualified from receipt of award.

## **VI. ADMINISTRATIVE CONSIDERATIONS**

The following administrative considerations apply to this RFA and the contract(s) to be entered into with the successful applicant(s):

### **A. Health Information Portability and Accountability Act (HIPAA)/ Mental Hygiene Law Section 33.13:**

Health Information Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule) was established by the Federal Department of Health and Human Services (HHS). The Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) provides comprehensive federal protection for the privacy of health information. The Privacy Rule is carefully balanced to provide strong privacy protections that do not interfere with patient access to, or the quality of, health care delivery. HIPAA has an impact upon how OPWDD and contractors will deal with protected health information of our individuals with intellectual/developmental disabilities. New York State Mental Hygiene Law Section 33.13 also requires disclosure of clinical records to be limited to that information necessary in light of the reason for disclosure.

### **B. Public Officers' Law:**

New York State Public Officers Law Section 73 (8) bars former state officers and employees from appearing or practicing or rendering any services for compensation in relation to any matter before their former state agency for a period of two years from the date of their termination. Additionally, there is a permanent bar against any such activity before any state agency in relation to any case, application, proceeding or transaction with which such officer or employee was directly concerned and personally participated or which was under his or her active consideration.

### **C. Restriction on Contact with OPWDD Employees**

From the date of issuance of this RFA until contracts are awarded and approved by the NYS OSC (the "restricted period"), applicants and prospective applicants are prohibited from making ANY contact with OPWDD personnel relating to this procurement other than contact with the following designated OPWDD staff:

The Designated Contacts for this procurement are:

1. For technical assistance with the Grants Gateway, please email [grantsreform@ITS.ny.gov](mailto:grantsreform@ITS.ny.gov).
2. For program or service delivery related questions:

Wendy Colonno  
NYS Office for People With Developmental Disabilities  
Bureau of Health and Community Support  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Wendy.R.Colonno@opwdd.ny.gov](mailto:Wendy.R.Colonno@opwdd.ny.gov)

OR

Alan Galgana  
NYS Office for People With Developmental Disabilities  
Bureau of Behavioral and Clinical Solutions  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Alan.M.Galgana@opwdd.ny.gov](mailto:Alan.M.Galgana@opwdd.ny.gov)

3. For contract related questions:

Amanda Mitchell  
NYS Office for People With Developmental Disabilities  
Contract Management Unit  
44 Holland Avenue  
Albany, New York 12229  
(518) 474-5513  
Email Address: [amanda.s.mitchell@opwdd.ny.gov](mailto:amanda.s.mitchell@opwdd.ny.gov)

**D. Security of Application:**

Prior to contract award, the content of each application will be held in confidence and no details of any application will be divulged to any other applicant. Information communicated to OPWDD by applicants prior to completion of contract award and any other required New York State contract approvals shall be maintained as confidential, except as required by Federal or State law, including but not limited to the Freedom of Information Law. Notwithstanding the foregoing, OPWDD may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose.

Following final contract approval by all required state agencies, disclosure of the contents of all applications and pre-award communications shall be available to the public to the extent required by Federal or State law, including but not limited to the Freedom of Information Law.

All applications, the contract, and related documentation will become OPWDD records, which, in accordance with the Freedom of Information Law, will be available to the public after the contract award. Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application. If OPWDD agrees with the proprietary claim, the designated portion of the application will be withheld from public disclosure unless legally required to be released. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material will be deemed a waiver of any right to confidential handling of such material.

**E. Confidentiality of Information:**

The successful applicant shall treat all information, in particular information relating to OPWDD service recipients and providers, obtained by it through its performance under contract, as confidential information, to the extent that confidential treatment is provided under New York State and Federal law, and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations under the contract. The successful applicant is responsible for informing its employees of the confidentiality requirements of this agreement.

## **F. Publication Rights:**

Materials/documents produced by the successful applicant in the fulfillment of its obligations under contract with the OPWDD become the property of OPWDD unless prior arrangements have been made with respect to specific documents. The successful applicant may not utilize any information obtained via interaction with OPWDD in any public medium (media - radio, television), (electronic - internet), (print - newspaper, policy paper, journal/periodical, book, etc.) or public speaking engagement without the official prior approval of OPWDD Senior Management. The successful applicant bears the responsibility to uphold these standards rigidly and to require compliance by their employees and subcontractors. Requests for exemption to this policy shall be made in writing, at least 14 days in advance, to:

Wendy Colonno  
NYS Office for People With Developmental Disabilities  
Bureau of Health and Community Support  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Wendy.R.Colonno@opwdd.ny.gov](mailto:Wendy.R.Colonno@opwdd.ny.gov)

## **G. Insurance Requirements:**

The successful applicant shall agree to procure and keep in force during the entire term of this agreement, at its sole cost and expense, policies of insurance written with companies acceptable to the OPWDD in the following minimum amounts:

Premises Bodily Injury & Property Damage Liability Insurance: Limits of not less than \$1,000,000 each person, \$1,000,000 each accident or occurrence for bodily injury liability and \$300,000 each accident or occurrence for property damage liability.

Automobile Bodily Injury & Property Damage Liability Insurance with minimum limits of \$1,000,000 for injury to or death of any person, \$1,000,000 for each accident or occurrence for property damage liability.

Certificates of insurance naming the State of New York and OPWDD as additional insured shall be submitted with signed contracts. Each policy shall be issued by an insurance company or insurance companies rated B+ or better by A.M. Best & Co. and shall provide that no policy cancellation, non-renewal or material modification shall be effective except upon thirty (30) days prior written notice to OPWDD. OPWDD shall each be furnished a Certificate of Insurance prior to or simultaneously with execution of the contract and the Certificate of Insurance shall constitute a warranty by the successful applicant that the insurance required by this section is in effect.

### Workers' Compensation and Disability Benefits Insurance Coverage Requirements

Successful applicants shall provide OPWDD proof of coverage from Workers' Compensation Insurance and/or Disability Benefits covering the obligations of the applicant in accordance with Workers' Compensation Law. If successful applicants are exempt from requirements otherwise requiring one or both of these insurances, proof of such will be required in a form acceptable to OPWDD with the signed contract.

## **H. Additional General Duties and Responsibilities:**

The successful applicant must also:

- Maintain a level of liaison and cooperation with the OPWDD necessary for the proper performance

of all contractual responsibilities.

- Agree that no aspect of its performance under the contract to be entered into as a result of this RFA will be contingent upon State personnel, or the availability of State resources, with the exception of all proposed actions of the successful applicant specifically identified in the contract as requiring OPWDD's approval, policy decisions, policy approvals, exceptions stated in the contract to be entered into can be expected in such a contractual relationship or the equipment agreed to by the OPWDD as available for the project completion, if any.
- Meet with OPWDD or START representatives to resolve issues and problems as reasonably requested by OPWDD.

#### **I. Information Security Breach and Notification Act.**

The New York State "Information Security Breach and Notification Act" also known as the "Internet Security and Privacy Act" took effect December 9, 2005. The Legislature and Governor have enacted the Law in response to past and continuing identity theft and security breaches affecting thousands of people. The Law requires any person or business that conducts business in New York State and that owns or licenses computerized data that includes private information (including but not necessarily limited to social security numbers, credit and debit card numbers, drivers license numbers, etc.) must disclose any breach of that private information to all individuals affected or potentially affected in an expeditious manner. Contractors shall comply with the provisions of the New York State Information Breach and Notification Act. Contractors shall be liable for the costs associated with such breach if caused by the Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of the applicant's agents, officers, employees or subcontractors. You may view a copy of the Law at <http://public.leginfo.state.ny.us/MENUGETF.cgi?COMMONQUERY=LAWS> by searching for "INTERNET SECURITY AND PRIVACY." The law is found at Article 2 of the State Technology Law and at Article 39-F of the General Business Law.

#### **J. Work Outside Contract**

Any and all work performed outside the scope of the grant contract awarded pursuant to the RFA, with or without consent of OPWDD, shall be deemed by OPWDD to be gratuitous and not subject to charge by the Contractor.

#### **K. Limits on Administrative Expenses and Executive Compensation**

If the successful applicant is a "covered provider" within the meaning of 14 NYCRR § 645.1(d) at any time during the term of the contract to be awarded pursuant to this RFA, then during the period when such applicant is such a "covered provider":

- a. the applicant will be required to comply with the requirements set forth in 14 NYCRR Part 645, and any amendments to such Part 645 that are effective during the term of the contract;
- b. the applicant's failure to comply with any applicable requirement of 14 NYCRR Part 645, including but not limited to the restrictions on allowable administrative expenses, the limits on executive compensation, and the reporting requirements, may be deemed a material breach of the contract and constitute a sufficient basis for, in the discretion of OPWDD, termination for cause, suspension for cause, or the reduction of funding provided pursuant to the contract; and

c. the applicant will be required to include the following provision in any agreement with a subcontractor or agent to provide services under the contract:

[Name of subcontractor/agent] acknowledges that it is receiving “State funds” or “State-authorized payments” originating with or passed through the New York State Office for People with Developmental Disabilities in order to provide program or administrative services on behalf of [Name of CONTRACTOR]. If at any time during the life of this Agreement [Name of subcontractor/agency] is a “covered provider” within the meaning of Section 645.1(d) of OPWDD regulations, [Name of subcontractor/agent] shall comply with the terms of 14 NYCRR Part 645, and any amendments to such Part 645 that are effective during the term of the contract. A failure to comply with 14 NYCRR Part 645, where applicable, may be deemed a material breach of this Agreement constituting a sufficient basis for suspension or termination for cause. The terms of 14 NYCRR Part 645, as amended, are incorporated herein by reference.

#### **L. Subcontracting**

The application must indicate if any part of the applicant’s program will be provided by a subcontractor (including an organization or an individual who is an independent contractor). To the extent subcontractors have been identified, please name the individual or organization that would be the subcontractor, describe the qualifications and scope of services to be provided by the contractor, and provide a statement of the percentage of the work to be performed by each subcontractor. Subcontractors must also meet the Minimum Qualifications for Selection set forth in section VII, below.

#### **M. OPWDD’s Rights as to All Applications**

OPWDD reserves all rights with respect to applications, including, but not limited to:

1. Change any of the scheduled dates as provided in section II, Calendar of Events;
2. Modify the RFA;
3. Prior to the Application Due Date, direct applicants to submit application modifications addressing subsequent RFA amendments;
4. Prior to the Application Due Date, amend the RFA to correct errors or oversights, or to supply additional information, as it becomes available;
5. Seek clarifications and revision of applications;
6. Withdraw the RFA at any time in OPWDD’s sole discretion;
7. Disqualify any applicant whose conduct and/or application fails to conform to the requirements of this RFA;
8. Make an award under the RFA, in whole or in part;
9. Eliminate any mandatory, non-material RFA requirements that cannot be complied with by all the prospective applicants;

10. Waive any requirements that are not material;
11. Reject any or all applications received in response to this RFA;
12. Negotiate with the successful applicant within the scope of the RFA in the best interests of the State;
13. Utilize any and all ideas submitted in the applications received;
14. Unless otherwise specified in the solicitation, every offer is firm and not revocable for a period of 180 days from the Application Due Date;
15. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an application and/or to determine an applicant's compliance with the requirements of the solicitation;
16. Conduct contract negotiations with the next responsible bidder, should the agency be unsuccessful in negotiating with the selected bidder; and
17. Verify information provided in applications; reject any application that contains false or misleading statements, or which provides references that do not support an attribute, condition, or qualification claimed by the applicant.

#### **N. Debriefing**

Once an award has been made, applicants may request a debriefing of their application(s). Please note that debriefings will be limited solely to the strengths and weaknesses of the applicant's own application(s) and will not include discussion of other proposers' applications. Requests for debriefing must be submitted no later than ten (10) business days following the date of award or non-award announcement.

#### **O. Bid Protests**

Applicants wishing to file a protest of award(s) must notify the OPWDD, in writing, of its intent to protest within ten (10) working days of its receipt of notice of non-award. The protest should:

- Identify the name of the RFA and the award date; and
- Indicate the applicant's understanding of the reason(s) they were denied the award (i.e. summarize the deficiencies identified during the debriefing) and state the justification for the bid protest.

Bid protests must be mailed to:

Lisa F. Davis  
NYS Office for People With Developmental Disabilities  
Contract Management Unit, 3<sup>rd</sup> Fl.  
44 Holland Avenue  
Albany, New York 12229  
Email: [Lisa.f.davis@opedd.ny.gov](mailto:Lisa.f.davis@opedd.ny.gov)

## VII. QUESTION AND ANSWER PERIOD

Substantive questions related to this RFA must be submitted via e-mail to one of the following designated contacts by Friday, September 11, 2015, the Last Day for Submission of Written Questions, in section II, Calendar of Events. Each question must, to the degree possible, cite the specific RFA section to which it refers.

Wendy Colonno  
NYS Office for People With Developmental Disabilities  
Bureau of Health and Community Support  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Wendy.R.Colonno@opwdd.ny.gov](mailto:Wendy.R.Colonno@opwdd.ny.gov)

OR

Alan Galgana  
NYS Office for People With Developmental Disabilities  
Bureau of Behavioral and Clinical Solutions  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Alan.M.Galgana@opwdd.ny.gov](mailto:Alan.M.Galgana@opwdd.ny.gov)

OPWDD will post official answers to the questions from all prospective applicants on OPWDD's website ([http://www.opwdd.ny.gov/opwdd\\_resources/procurement\\_opportunities](http://www.opwdd.ny.gov/opwdd_resources/procurement_opportunities)) by Thursday, September 24, 2015. Responses posted on this date will address questions submitted in writing prior to the Conference, as well as responses to questions offered at the Conference. See section IX for more information on the Conference.

The answers to all questions will be in the form of a formal addendum, which will be annexed to and become part of this RFA and any ensuing contract(s). All answers to questions of a substantive nature, as well as copies of the questions, shall be posted to OPWDD's internet site at [http://www.opwdd.ny.gov/opwdd\\_resources/procurement\\_opportunities](http://www.opwdd.ny.gov/opwdd_resources/procurement_opportunities).

## VIII. INSTRUCTIONS FOR PREPARING THE APPLICATION

Applications are due Monday, October 5, 2015, 3:00 PM as stated in section II, Calendar of Events of this RFA. Applications received after the Application Due Date will not be accepted. *All required components of applications must be entered into the Grants Gateway by that date and time for further consideration.* Mailed, Emailed or facsimiled submissions will not be accepted.

An applicant must submit an application for each team of which an application is submitted. While additional data may be presented, the following must be included with each application. Provide the information in the prescribed format in which it is requested. Failure to follow these instructions may result in disqualification. The following three components will comprise a complete application:

- A. Cover Letter**
- B. Technical Proposal**
- C. Cost Proposal**

An application that is incomplete in any material respect may be eliminated from consideration. The following outlines the required information to be provided by applicants for each component of an

application submission to constitute a complete application. All applications will be subject to verification by OPWDD.

#### **A. Cover letter**

A cover letter is an integral part of the proposal package. The cover letter must be on the applicant's official letterhead and be signed by an individual who is authorized to contractually bind the successful applicant. The content of the letter must include the following:

1. Acknowledge that the applicant has read the application, understands it, and agrees to be bound by all of the conditions therein.
2. Include the applicant's name, address, telephone and fax numbers, and the name(s), address(es), telephone number(s) and e-mail address(es) of the applicant's contact(s) concerning the application;
3. Acknowledge that the costs set forth in the Cost Proposal are firm costs that are binding and irrevocable for a period of not less than 180 days from the date of application submission;
4. Acknowledge that the applicant understands and accepts the provisions of this RFA, and all Attachments thereto;
5. State that by submitting a response to the RFA, the applicant accepts the provisions of the aforesaid documents and agrees to execute a contract in accord with the terms of the State of New York Master Contract for Grants.
6. Contain a specific statement addressing each of the numbered requirements contained in Section V, Minimum Qualifications for Selection. Applicants must state specifically whether they are in compliance with *each* of the minimum requirements.

#### **B. Technical Proposal**

The Technical Proposal must address all of the following seven (7) items, in the following order provided, and under each of the provided headings. REMINDER: If applying for both teams, please provide two (2) technical proposals, labeled "Team 1" and "Team 2".

1. **Philosophy and Mission.** A statement of the philosophy and mission of the agency or organization submitting the application.
2. **Vision and Goal.** A description of the applicant's vision and specific goals and objectives for START services in relation to this RFA.
3. **Proposed Staff.**
  - a. A description of the staff currently employed by the applicant and who meet the qualifications described in Section IV, D, 1 and 2, and their availability and willingness to provide NY START Services. Provide this description for both the staff who will provide direct services and the staff who will provide clinical supervision. Provide their educational and experiential qualifications and their current titles.

- b. For any staff that is not already employed by the applicant, a description of the strategies and steps the applicant will take to have qualified staff working by the beginning of the contract term, which shall be no later than January 1, 2016.
- c. A description of how the applicant will ensure that any staff that leave employment before the end of the contract will be replaced by staff that meets the qualifications for the position.

**4. Experience** A description of your agency's approach to and experience in providing psychiatric interventions and behavioral support services to individuals with intellectual and other developmental disabilities. Describe any similar programs the applicant has operated in the last five years.

**5. Description of Services.** A clear description (approximately 20-40 pages) of the proposed NY START Services OPWDD Region 4 that addresses the items listed below. Reference the letter for each item in your response (e.g., 5a, 5b).

Describe in detail how your program will meet the following requirements, as described in detail in section IV, Scope of Work, of this RFA:

- a. An ongoing team approach, which includes: daily weekday triage calls, staff meetings, peer-review, and live supervision;
- b. Affiliations/linkages/outreach and follow-up, including the development of a crisis support continuum (expected First Quarter 2016);
- c. Formation of START clinical teams that are located strategically within the region, such that response time to an emergent situation is two hours or less;
- d. Description of how cultural competencies will be developed and maintained;
- e. Assessment, intervention, and prevention, in accordance with NY START model;
- f. Systemic and Clinical consultation and training, including: expertise in systems approach to team consultation; functional analysis techniques; and, data collection methods;
- g. Clinical Education Teams, which include: monthly case review meetings with community service providers; and, additional need- or request-based training to providers and families;
- h. Cross-systems crisis prevention and intervention planning, including: development of Cross System Crisis Intervention Plan (CSCPIP); and, facilitation of CSCPIP meetings;
- i. Crisis/Emergency assessment and intervention, including 365/24/7/within 2 hours whenever possible on-call response capacity; pre-screening for emergency resource center access; and, strategy to accommodate a crisis/need for crisis admission when resource centers are at capacity;
- j. Immediate telephonic response and on-site assessment within two hours whenever possible;
- k. Mobile In-Home Community Support Services, including assessment and stabilization in natural setting; 2-hour window period for in-home supports implementation; team located throughout the region; provision of in-home support services for up to 72 hours per intervention period;
- l. Provide emergency and planned Therapeutic Resource Center Services (expected First Quarter 2017), including
  - i. ability to operate one therapeutic resource center facility
  - ii. ability to sufficiently staff the resource center at the ratio of 3 staff to 4 individuals during awake hours and 2 staff to 4 individuals during the overnight
  - iii. proximity of program space and adherence to two hour travel timeframe
  - iv. design of program space in accordance with specifications
  - v. meeting all elements in therapeutic resource center protocol (Planned Resource Center Admission: Length of Stay, Planned Resource Center Visits,

Scheduling)(Emergency Resource Center Admission: Prescreening and Coordinating Potential Admissions, Admissions Meeting, Documentation)

- vi. Additionally, please identify the approach you would utilize to implement the model and the projected time needed to initiate the program (not including property acquisition).
  - m. Adherence to all START Team personnel descriptions (see section IV of this RFA);
  - n. Adherence to staffing levels, training requirements and clinical supervision;
  - o. Ensure staff participation in ongoing START training and clinical supervision to include use of video-recording;
  - p. Provide staff attendance at Advisory Council meetings;
  - q. Utilize computer equipment/technology for field-based data entry and case planning, networking, and emailing via internet; and
  - r. Data Collection/Reporting, timely submission of data, participation in evaluations based on the data entered into SIRS.
- 6. Technology.** Description of how your agency will utilize technology for office-based, field-based, and site-based communication, documentation, data collection, and data entry in adherence to START program fidelity requirements. Also describe how your agency will comply with HIPAA and HITECH requirements.
- 7. Development Plan for Services.** Provide the estimated timeframes required for full implementation of the START program as describe in this RFA, using the Workplan template within The State of New York Master Contract for Grants. The State of New York Master Contract for Grants is annexed as Attachment E to this RFA. Specifically include time estimates for each item in Step 5 above, and specifically include benchmark dates for the following elements of the NY START program:
- a. Crisis communication system;
  - b. Establishment of linkages with providers in the region;
  - c. Achievement of full staffing; and
  - d. Establishment of in-home supports.
- 8. Property for Resource Center Use.** A response to this proposal item is required in the event an applicant intends to provide property for use as the START resource center in relation to performance of the Scope of Work detailed in section IV of this RFA.
- a. Identify the property by physical address;
  - b. Describe in detail how the property fits with the best practice guidelines in Attachment D;
  - c. Describe any renovations necessary to bring the property into compliance with the best practice guidelines in Attachment D; and
  - d. Describe any activities that may be necessary to transition individuals who may be receiving services in the location.

### **C. Cost Proposal.**

Submit a Cost Proposal for each team you are applying for, if applicable. REMINDER: If applying for both teams, please provide two cost proposals, labeled "Team 1" and "Team 2".

Applicants must complete the Expenditure Based Budget form, identified as Attachment B-1, found within the State of New York Master Contracts for Grants, Attachment E, of this RFA. OPWDD's review will include an assessment of the cost categories for reasonableness.

The resource center component of the Cost Proposal must include a budget for six months of operational costs for the therapeutic resource center program. This budget must include staffing costs and the following non-personnel costs: Food, household products, OTC medications, vehicles and repairs, utilities (heat, electricity, water and sewer) and activities (outings and supplies). The budget should not include costs of real estate acquisition, renovation, construction, alteration or renewal; lease costs; property maintenance (including lawn maintenance, snow plowing, repairs) and sprinkler and fire alarms.

Cost Proposals may not exceed the amounts in the following table, **Available Funding**. Amounts proposed must be on an annualized basis and may not exceed the annual amounts noted in the table. Cost Proposals must be delineated in this annualized manner. Cost proposals exceeding these amounts will be rejected as non-responsive.

The following table outlines the funding available for each Team, each year of the contracts that may result from this RFA:

**Available Funding**

<b>Year of Contract</b>	<b>Team 1 Brooklyn/Staten Island</b>	<b>Team 2 Bronx/Manhattan/Queens</b>
1	\$1.3 million	\$1.6 million
2	\$4.0 million	\$4.5 million
3	\$4.7 million	\$5.2 million
Total	\$10.0 million	\$11.3 million

Year 1 - The funding for the first year is 60% of total anticipated yearly costs for the START Clinical teams. The START program will phase in staff during the first year, so it is expected that full staffing will be achieved closer to the end of the first year.

Year 2 – The funding for year two funding includes the full cost of staffing, both START clinical teams, \$25,000 per team for multi-modal consultations, and resource center operational costs for 75% of a year.

Year 3 – The funding for year three includes the anticipated costs for fully operational START Clinical teams and resource centers, as well as \$25,000 per team for multi-modal consultations.

Applicants will not be allocated separate compensation for travel expenses, including transportation, meal and lodging costs, if any, under the contract. Such costs should be factored into the rates entered on the operating and personnel budgets.

OPWDD will not be responsible for expenses incurred in preparing and submitting the Technical or Cost Proposals. Such costs should not be included in the Cost Proposal.

The successful applicant(s) that move onto the interview process will be required to provide additional information regarding the use of community habilitation revenue for in-home stabilization supports. More information will be provided to the successful applicant(s) prior to their interview date.

## **IX. LETTERS OF INTENT AND MANDATORY APPLICANT'S CONFERENCE**

### Letters of Intent

Vendors intending to submit applications in response to this RFA must submit a Letter of Intent by Friday, September 4, 2015, as specified in section II, Calendar of Events, to one of the following designated contacts:

Alan Galgana  
NYS Office for People With Developmental Disabilities  
Bureau of Behavioral and Clinical Solutions  
44 Holland Avenue  
Albany, New York 12229  
Email Address: [Alan.M.Galgana@opwdd.ny.gov](mailto:Alan.M.Galgana@opwdd.ny.gov)

The letter of intent must:

- Reference the title of this RFA;
- Provide the current mailing address, email address, and telephone number(s) for the person who will be the applicant's designated point of contact throughout the duration of this RFA; and
- Be printed on the applicant's official letterhead and signed by an authorized official.

Subsequent to the date for submission of Letters of Intent, prospective applicants who do not submit Letters of Intent will not be considered for award of contracts and will not be advised of subsequent changes in the scope of this RFA. Submitting a Letter of Intent is required in order for a prospective vendor to submit an application and attend the Mandatory Applicant's Conference.

Applicants must notify Alan Galgana ([Alan.M.Galgana@opwdd.ny.gov](mailto:Alan.M.Galgana@opwdd.ny.gov)) of any and all changes related to the point of contact provided in the Letter of Intent. OPWDD is not responsible for any miscommunications that occur throughout this RFA as a result of an applicant's failure to provide notification of changes in the point of contact information.

Letters of Intent will also serve to register the vendor for the Mandatory Applicant's Conference. The Conference is described in detail below.

### Mandatory Applicant's Conference

Applicants will be required to participate in the Mandatory Applicant's Conference via telephone conference call. Conference call details will only be provided to vendors who submit a Letter of Intent by the due date. Non-attendance of any vendors will result in disqualification from the application process and therefore, from receipt of prospective award. Attendance will be taken.

The goal of the Conference will be to provide an overview of the current project, to respond to applicants' previously submitted questions about the RFA, and to answer additional questions articulated during the teleconference. All questions and answers will be made available to all attendees of the Conference by Thursday September 24, 2015.

Each applicant will be required to send an e-mail to Wendy Colonno (Wendy.R.Colonno@opwdd.ny.gov) confirming their intention to attend the Mandatory Applicant's Conference by Friday, September 11, 2015. Confirmation must include the agency's name and the name(s) of the person(s) who will be attending. Conference call information will be distributed upon receipt of applicant's confirmation e-mail.

## **X. EVALUATION OF APPLICATIONS**

### **A. General**

An Evaluation Team comprised of OPWDD staff from the Divisions of Service Delivery and Person Centered Services, and other relevant units will conduct an initial review of the applications to determine whether the Minimum Qualifications for Selection set forth in section V have been met. Applications meeting the Minimum Qualifications will be disqualified and only applications meeting the Minimum Qualifications will be scored.

Applications will also be reviewed by OPWDD to determine if they contain all of the submittals specified in this RFA. Applications that are incomplete in any material respect may be disqualified as non-responsive.

The applications will be evaluated for the purposes of (1) examining the responses for compliance with this RFA and (2) selecting the applicant whose combination of technical merit and cost would most benefit OPWDD. The selection process may also include OPWDD verification of information provided and interviews, if deemed necessary or desirable by OPWDD. The evaluation process will be conducted in a fair and impartial manner by a multidisciplinary Evaluation Team comprised of OPWDD staff. Representatives of the University of New Hampshire START Program may provide technical assistance to the Evaluation Team.

During the evaluation process, the content of the applications will be held in confidence and will not be revealed except as may be required under the Freedom of Information Law (FOIL) or as otherwise required by law. FOIL provides for an exemption from disclosure for trade secrets or information the disclosure of which would cause injury to the competitive position of commercial enterprises. If the application contains any such trade secret or other confidential or proprietary information, it must be accompanied by a written request to OPWDD in the application not to disclose such information, stating with particularity the reasons why the information should not be available for disclosure. OPWDD reserves the right to determine upon written notice to the applicant whether such information qualifies for the exemption from disclosure under the law.

### **B. Scoring**

#### Technical Proposal Evaluation

Applicants may achieve a maximum of 85 points for the Technical Proposal component of each application (for each team proposed, when multiple teams are proposed by one applicant). The Technical Proposal evaluation criteria numbers 1 through 7 are set forth in section VIII B, Instructions for Preparing the Application, of this RFA. Number 8 will provide up to 5 bonus points beyond the maximum 80 points for responses to numbers 1 through 7, for applicants electing to propose use of a preexisting viable property for use as a START resource center. The number of points that may be earned for each of the 8 scoring criteria are:

- Item #1 – 5 points
- Item #2 – 5 points

- Item #3 – 10 points
- Item #4 – 10 points
- Item #5 – 30 points
- Item #6 – 10 points
- Item #7 – 10 points
- Item #8 – 5 bonus points

For applications to be advanced to the next phase of the evaluation process, the Cost Proposal Evaluation, a minimum score of 55, or the top 3 scores, for each team’s Technical Proposal must be achieved.

Cost Proposal Evaluation

Applicants may achieve a maximum of 20 points for the Cost Proposal component of each application (for each team proposed, when multiple teams are proposed by one applicant). Application(s) providing the *lowest* cost in response to section VIII C, Instructions for Preparing the Application, of this RFA will receive the total available 20 points. Scores for the remaining higher cost applications will be calculated according to the following formula:

Cost Proposal Score = P/Q times 20 points, where P = Price of lowest priced application and Q = Price for application being scored.

The maximum total score for this RFA may be 105 points if an applicant received full points for all components- technical and cost- and all 5 bonus points when a resource center is proposed.

**C. Interviews by OPWDD**

Mandatory interviews of the top three applicants will be conducted for each team at 44 Holland Avenue, Albany, NY 12229. The interview will seek to clarify and/or differentiate the level of qualifications of the top three applicants. The interview will focus on each applicant’s descriptions of required technical content and strategies for the application of technical components. The interview questions will be based on a 5-point Likert scale, with 1 as the lowest score and 5 as the highest score on each question. The winning applicant will have earned the highest score on interview questions. The interview outcome is noncumulative and separate from the score obtained via Evaluation of Applications. Candidates will be notified of the date, time and place of the interview. Senior staff of the applicant who would be responsible for providing the requested services should be present and participate in the interview. OPWDD may allow participation at an interview by telephone or video conference in its discretion.

**D. Tie Scores**

Agencies may engage in discrete bidding for either one or both teams (Team 1: Brooklyn/Staten Island or Team 2: Manhattan/Bronx/Queens) located in Region 4. However, successful applicants will only be awarded a contract for one team. If one applicant applies for both teams and scores highest for both teams during the interview process, or if two applicants receive equal scores during the interview process for the same Team, the contract(s) shall be awarded based upon the following considerations, in the order provided:

1. Number of years an applicant has delivered crisis/mental health services to the I/DD population, with preference given to a greater number of years;

2. Demonstrated history of collaborative approaches to program operations involving mental health/IDD service providers;

If tie bids cannot be determined by the above methods, the award will be made by random selection.

## **XI. NOTIFICATION OF AWARD**

Upon completion of the evaluation process outlined in section X, the Evaluation Team will make a recommendation to the Commissioner of OPWDD for award(s). The successful applicant(s) will be notified through tentative award letter(s) issued by OPWDD on approximately Friday November 13, 2015, consistent with the Preliminary Contract Award Announcement date in section II, Calendar of Events.

## **XII. CONTRACT**

Unless modified as provided herein, this contract shall begin on January 1, 2016 and end on December 31, 2018. One two-year optional renewal may be negotiated at the end of the three-year term.

The successful applicant(s) will be required to sign and comply with the terms and conditions delineated within the State of New York Master Contract for Grants, each attached hereto as Attachment E.

Following completion of the contract documents and required support by the applicant(s) and OPWDD, the contract will be submitted for approval to the New York State Office of the Attorney General and the New York State Office of the State Comptroller for final State approval.

Validity of contracts resulting from this RFA are pending approval of the New York State Office of the State Comptroller (OSC). The contract(s) will not be final and binding until approved by the Attorney General and State Comptroller. Upon these approvals, all terms of the contract(s) become available to the public.

### Contract Termination

The OPWDD retains the right to cancel this contract without reason, provided that the Contractor is given at least thirty (30) days notice of OPWDD's intent to cancel. This provision should not be understood as waiving the OPWDD's right to terminate the contract for cause or stop work immediately for unsatisfactory work, but is supplementary to that provision.

The OPWDD reserves the right to stop the work covered by this RFA and the ensuing contracts at any time that it is deemed the successful applicant is unable or incapable of performing the work to their satisfaction. In the event of such stopping, the OPWDD shall have the right to arrange for the completion of the work in such a manner as it may deem advisable and if the cost thereof exceeds the amount of the offer, the successful applicant and its surety shall be liable to the State of New York for any such cost on account thereof. In the event that the OPWDD stops the work as provided thereof, together with the reason thereof, and the Contractor shall have ten (10) working days to respond thereto before any such stop order shall become effective.

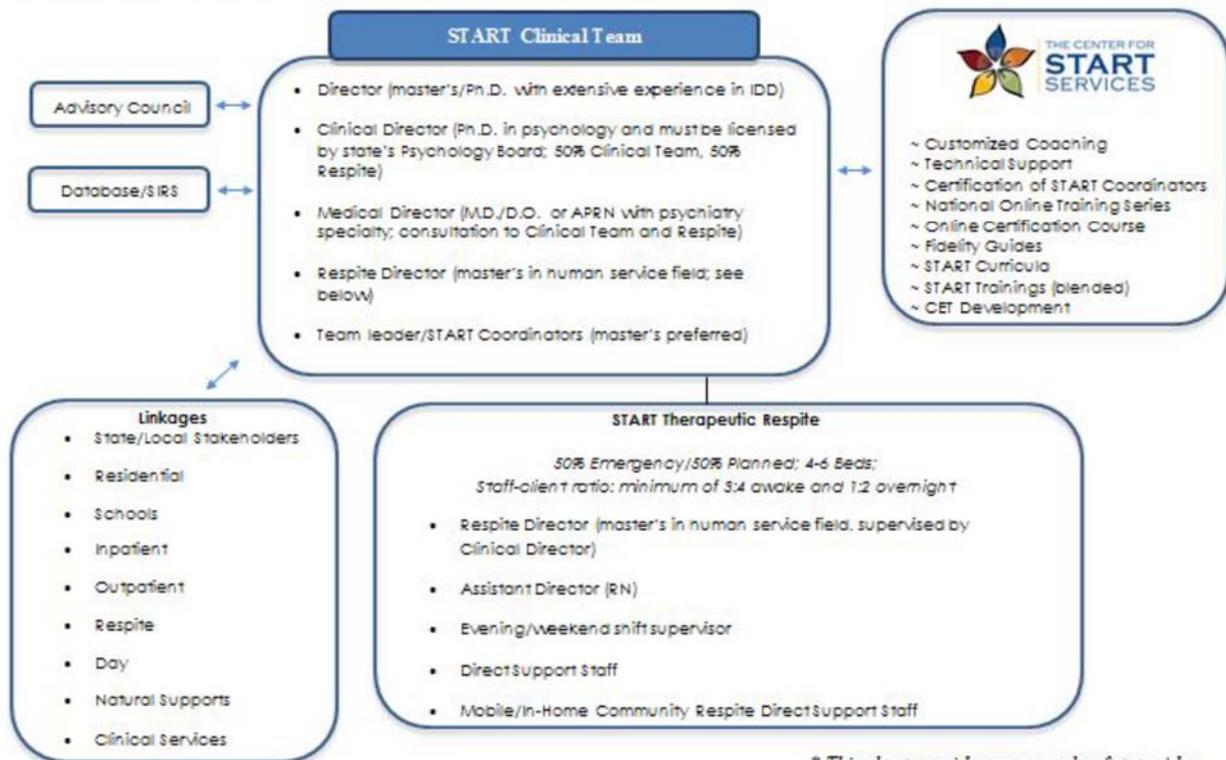
### Contract Amendment Process

During the term of the contracts, the contracts may be amended as new laws or regulatory mandates are issued affecting the services and provisions under the Contract resulting from this RFA. OPWDD reserves the right to consider amendments which are not specifically covered by the terms of the contracts but are judged to be in the best interest of the OPWDD. Contract amendments are subject to pre-audit by the OSC and shall take effect upon written notification by OPWDD.

# ATTACHMENT A

## START Organizational Chart

### NY START ORGANIZATIONAL CHART\*



*\* This chart provides an example of statewide START implementation*

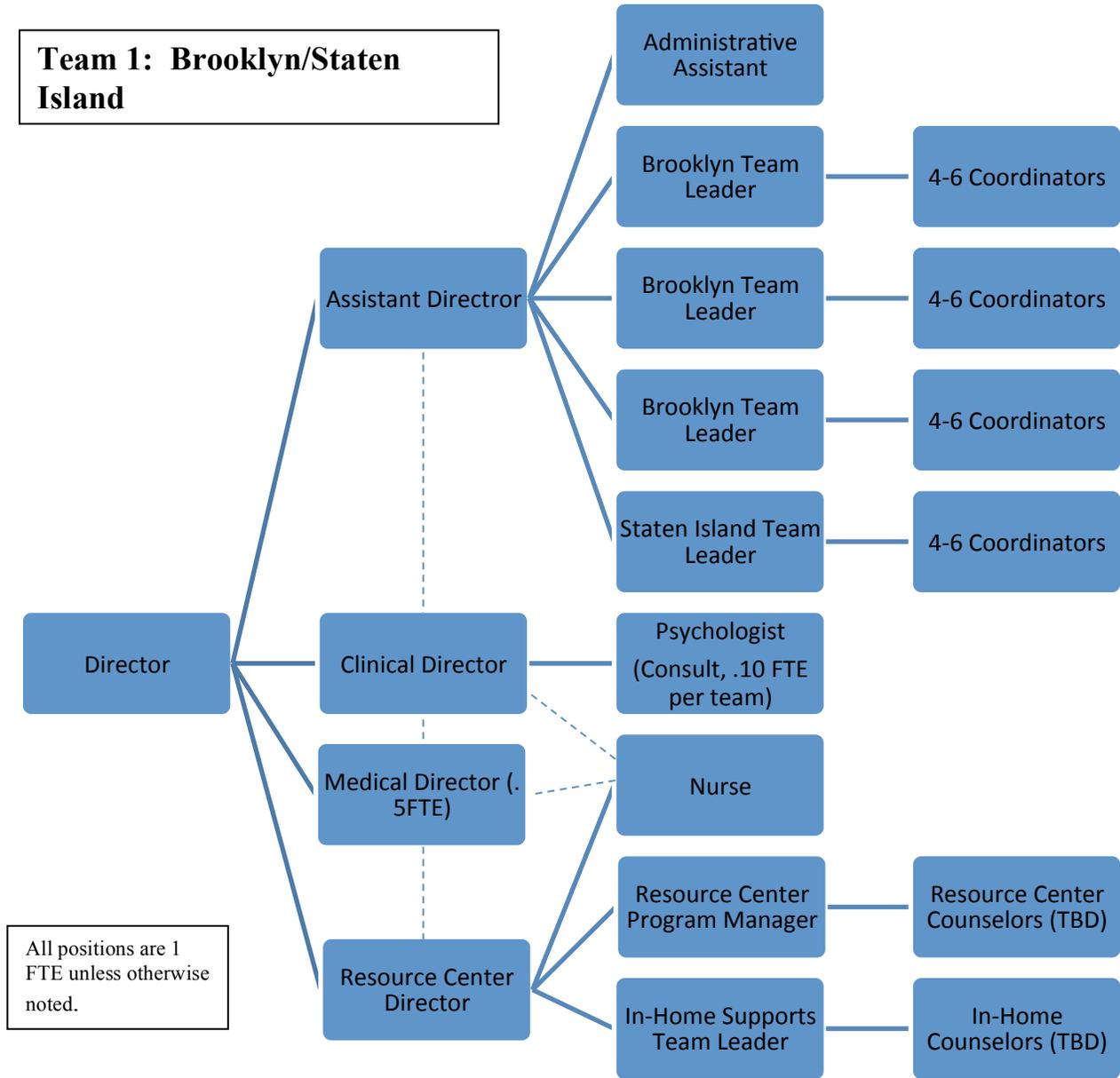
ATTACHMENT A1

NY START Organizational Chart –  
Team 1



A program of the Institute on Disability/UCED, University of New Hampshire

**Team 1: Brooklyn/Staten Island**



All positions are 1 FTE unless otherwise noted.

ATTACHMENT A2

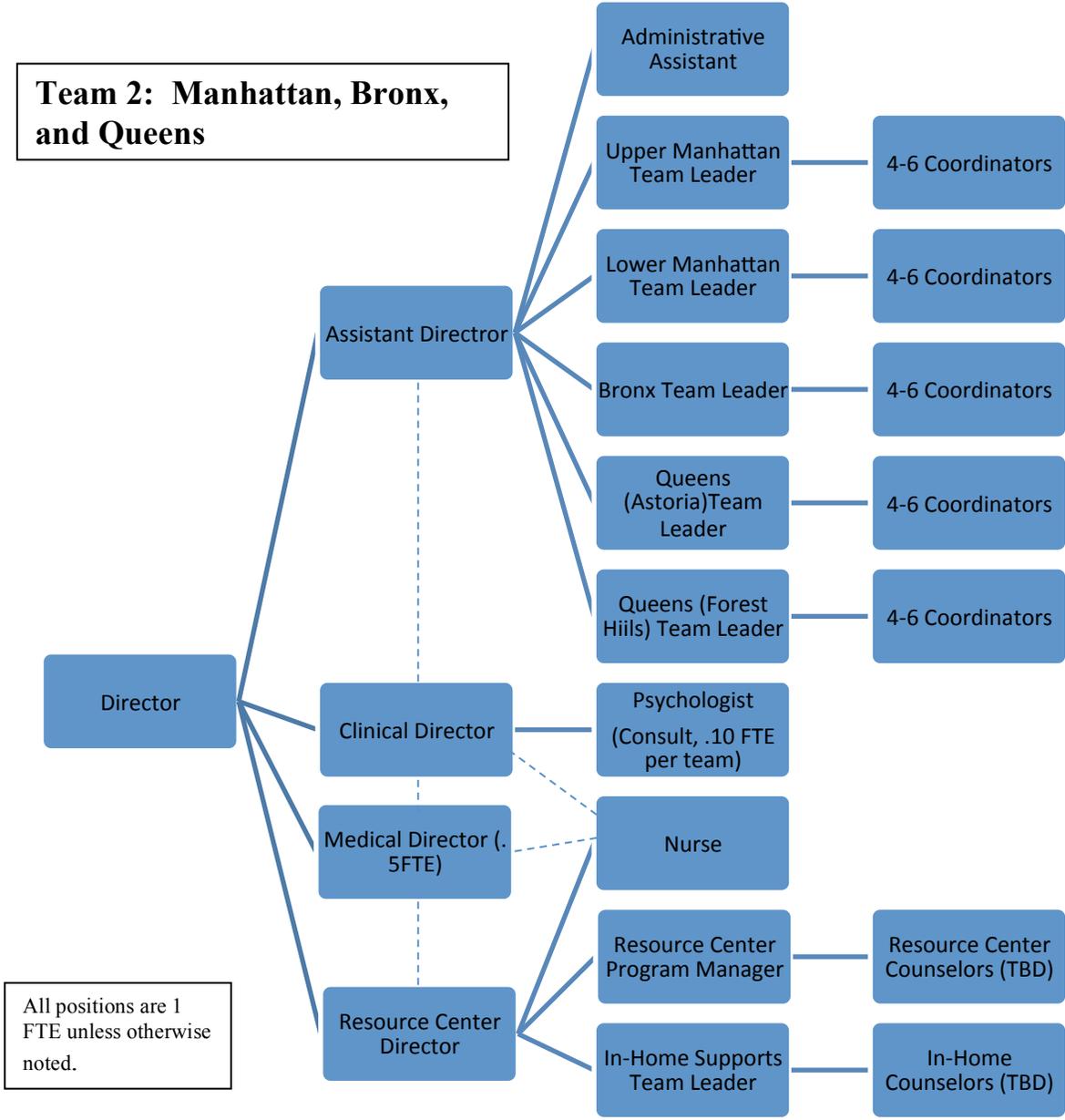
NY START Organizational Chart –  
Team 2



THE CENTER FOR  
**START**  
SERVICES

A program of the Institute on Disability/UCED, University of New Hampshire

**Team 2: Manhattan, Bronx, and Queens**



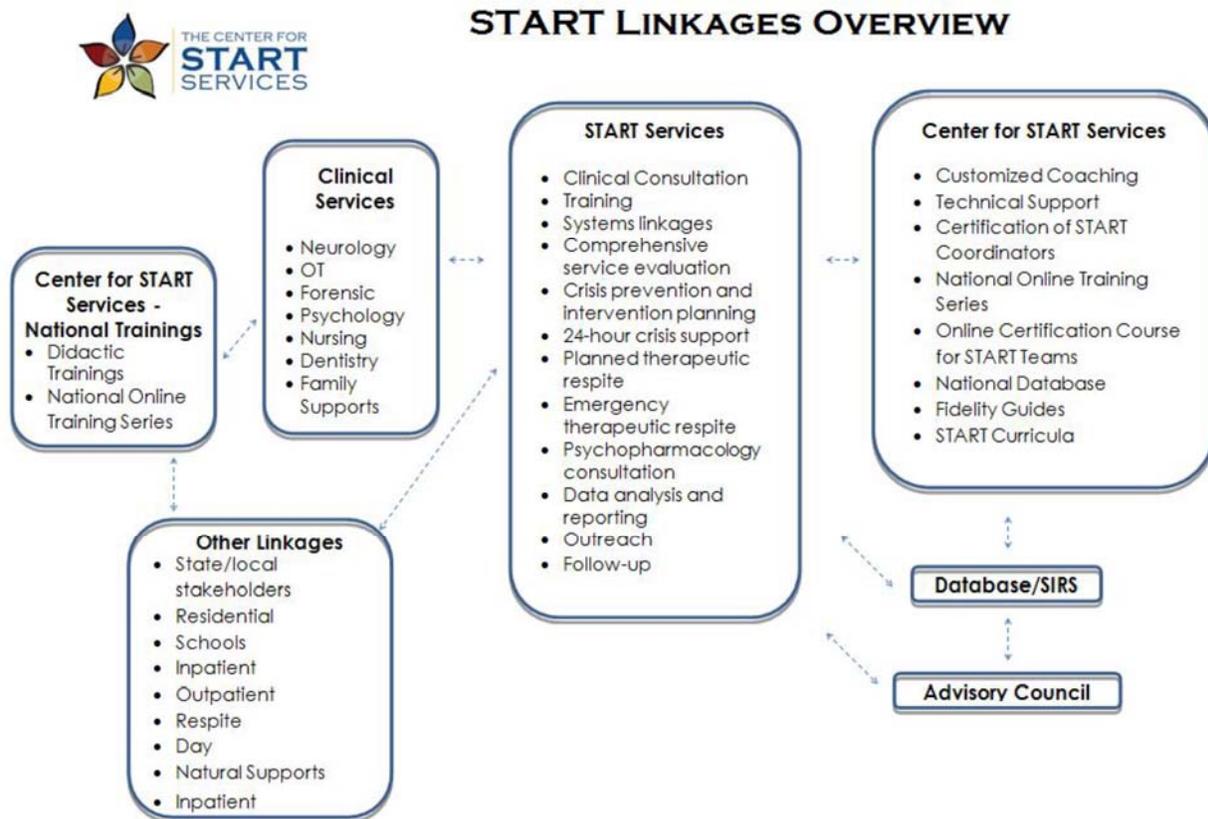
All positions are 1 FTE unless otherwise noted.

# ATTACHMENT B

## START Systems Linkage Program

### START Services & Linkage Elements

The START systems linkage program is presented in the diagram that follows:



ATTACHMENT C

# START Clinical Teams Manual

# SECTION I:

## Overview of START & Coordinator Certification

- Introduction
- Center for START Services Overview

### The START Systems Linkage Approach

- The Three A's
  - START and the Tertiary Care Approach to Interventions
  - The STRENGTH of START
- START Coordinator Overview
    - Overview
    - Required Qualifications
    - Responsibilities
    - Training Phases and Competencies
    - Certification

# INTRODUCTION

Welcome to the 2014 edition of the START Clinical Team Manual. The purpose of this manual is to provide readers with essential information needed to develop a START program and maintain fidelity to the START model. This manual includes information pertaining to:

- The history of the START model;
- The process of how typical START programs develop, including the START Coordinator Certification process;
- An overview of the structure, roles, and responsibilities of a START Clinical Team;
- Important information about how to conduct Comprehensive Service Evaluations, Cross-Systems Crisis Prevention and Intervention Plans, Emergency Mental Health Evaluations, Systemic Consultation, and Clinical Education Trainings; and
- The importance of data collection, reporting, and Advisory Committee meetings

This manual was developed through more than 20 years of technical assistance and program development related to the START model. This version of the START Clinical Team Manual was developed in collaboration with all members of the National START Network Members of the START Network, which is comprised of START programs and START Coordinators from across North America. These teams provide regular feedback and input that contributes to the continued enhancement of this manual, which is revised and published annually.

# CENTER FOR START SERVICES OVERVIEW

The START (**S**ystemic, **T**herapeutic, **A**ssessment, **R**esources, and **T**reatment) model serves a target population of people diagnosed with co-occurring diagnoses of intellectual and developmental disability (IDD) and behavioral (mental) health needs.

## Mission Statement

The START mission is to enhance local capacity and provide collaborative, cost-effective support to individuals & their families through exemplary clinical services, education, and training, with close attention to service outcomes.

START has been providing person-centered service supports and clinical, emergency, and therapeutic emergency and planned services since 1989 and was founded by Joan Beasley, Ph.D. in Northeast Massachusetts. START was first cited as a model program by the U.S. Surgeon General's Office in the 2002 report, *CLOSING THE GAP: A National Blueprint to Improve the Health of Persons with Mental Retardation*. The Center for START Services was founded in 2009 at the Institute on Disability UCED at the University of New Hampshire to respond to a nationwide demand to develop START services and provide technical support, education, and guidelines to ensure model fidelity.

START promotes person-centered approaches and training for individuals, families, and caregivers with evidence-based positive mental health approaches, wellness plans and other therapeutic tools, provision of multi-modal clinical assessments, enhancing therapeutic recreational experiences, and optimal utilization of existing resources through:

- Linkages with partners;
- Active service user, family, and other circle of support involvement;
- Promotion of improved expertise across systems of care; and
- Services designed to fill service gaps.

# THE START SYSTEMS LINKAGE APPROACH

START is designed to improve the care of individuals with IDD through the combined effects of a well-trained work force, utilizing a multidisciplinary and coordinated approach to assist individuals with IDD and behavioral challenges. The START philosophy is based on a systems linkage approach, which emphasizes focusing on solutions, active communication, and group decision-making in the system of care, in addition to a better understanding of individual clinical and treatment needs to improve service outcomes. As a result the program requires person-centered, evidence-informed practices, continuous training and skill building of practitioners, active participation of stakeholders, collection and analysis of data, and ongoing opportunities for collaboration and modification of services in response to individual and trend-related outcomes, along with the changing needs of the system.

A major component of the START program is to improve the capacity of the system as a whole to engage individuals with IDD to avoid the exacerbation of behavioral challenges. This is accomplished through increasing the systems' knowledge of the population so they are better able to provide more effective services. Perhaps the most important emphasis of the program is that START works to fill in gaps in the system while engaging providers of primary medical, mental health, and other services to work with individuals with IDD through linkages, supports, and increased knowledge of the population. As a result, the START program improves the capacity of the community at large to effectively serve this population in a coordinated and integrated manner rather than providing a segregated system of support.

## THE THREE A'S

The Three A's as outlined below provide an overview of the cornerstones to the START Model, which support the systems approach that is described throughout this manual.

### **ACCESS to Care and Supports:**

Care must be inclusive, timely, and community-based. START provides a systemic linkage approach to improve access to all services including those of our affiliates and partners.

### **APPROPRIATENESS of Care:**

Appropriateness of care is reflected in the ability of service providers to meet the specific needs of an individual. This requires linkages to a number of services and service providers because individual needs range and change over time. It also requires

expertise to serve the population. It is important to remember that when problems are presented, they may not be the presenting problem.

### **ACCOUNTABILITY:**

The third essential element for effective service provision is accountability. There must be specific and measurable outcomes of care. Service systems must be accountable to everyone involved in the provision of care and this includes funding sources. Outcome measures must be clearly defined, and review of data must be frequent and ongoing. The service delivery system must be accountable, first and foremost, to the persons receiving care. Outcome measures need to account for whether an individual's service/treatment plan is effective over time. The service recipient's satisfaction is an important outcome measure as well. Accountability measures should also pay attention to cost. Services must be cost effective, and when insuring access and appropriateness, they can also be treatment effective. The three only conflict when attention to appropriateness of care and the need for access are lacking.

Finally, accountability is a measure of the ability of a system to adapt to changes in individual service needs. Systems must have a structure that can readily adapt to changes in the demands that are placed upon them. Analysis of data must be used as a barometer of where a service delivery system has succeeded and where it must now go. Data should be multi-dimensional and should include both qualitative as well as quantitative measures.

The START Model emphasizes that appropriate services are to be readily accessible and provided in a timely fashion. Data collection and review determine the need for modification of resources to comply with this requirement as needed. The program is designed to evolve over time to meet the needs of the population and the system of care.

## **START SERVICE ELEMENTS**

In order to promote effective services and supports, the required START Program service elements that are coordinated by Clinical Teams include:

- An ongoing team approach
- Mobile crisis response and services
- Affiliations/linkages/outreach and follow-up, include linkages with mobile crisis teams
- Data collection protocols
- The role of START to support community placement and prevent

facility placement

- Systemic and Clinical consultation, positive behavior support
- Training/Clinical Education Teams
- Cross-systems crisis prevention and intervention planning
- Emergency assessment and response
- Clinical assessments and service evaluations
- Statewide systems linkages across START teams/sharing of resources
- Advisory Council/ongoing assessment of service outcomes (data, documentation)

## THE TERTIARY CARE MODEL AND START

(Beasley, Klein and Weigle, 2014)

The START Program and the systems linkage perspective can be examined in the context of the World Health Organization's (WHO) public health three-stage prevention model.

### **Stage 1: "Prevention"**

In the START program, prevention ("primary prevention") includes strengthening the service system's ability to successfully engage individuals with IDD by focusing on quality of life, improving access to services, identifying gaps in the system, and improving competencies for all including self-advocates, families, direct support staff, and clinically trained professionals. Linkages across systems allows for the sharing of knowledge and resources. Direct services provided by START programs in this stage specifically include: identifying gaps in service systems and helping to build the infrastructure to fill them; providing hands on training to providers of direct support, caregivers, professionals, and community participants (e.g., police, emergency room staff); sharing technical information and advice among participants, families, service providers; and ensuring there is a coordinated continuum of care in place to respond to individuals' arising needs. This level of intervention provides universal benefit to START service recipients as well as to the service system and communities as a whole.

### **Stage 2: "Intervention"**

The START Intervention ("secondary prevention") activities are centered on individual service recipients and include: integration of health and wellness activities; ongoing assessment of all bio-psycho-social factors and proper intervention; clear delineation of communication abilities and interventions as needed; identification of triggers that lead to crises for an individual; robust cross-systems crisis prevention and intervention planning

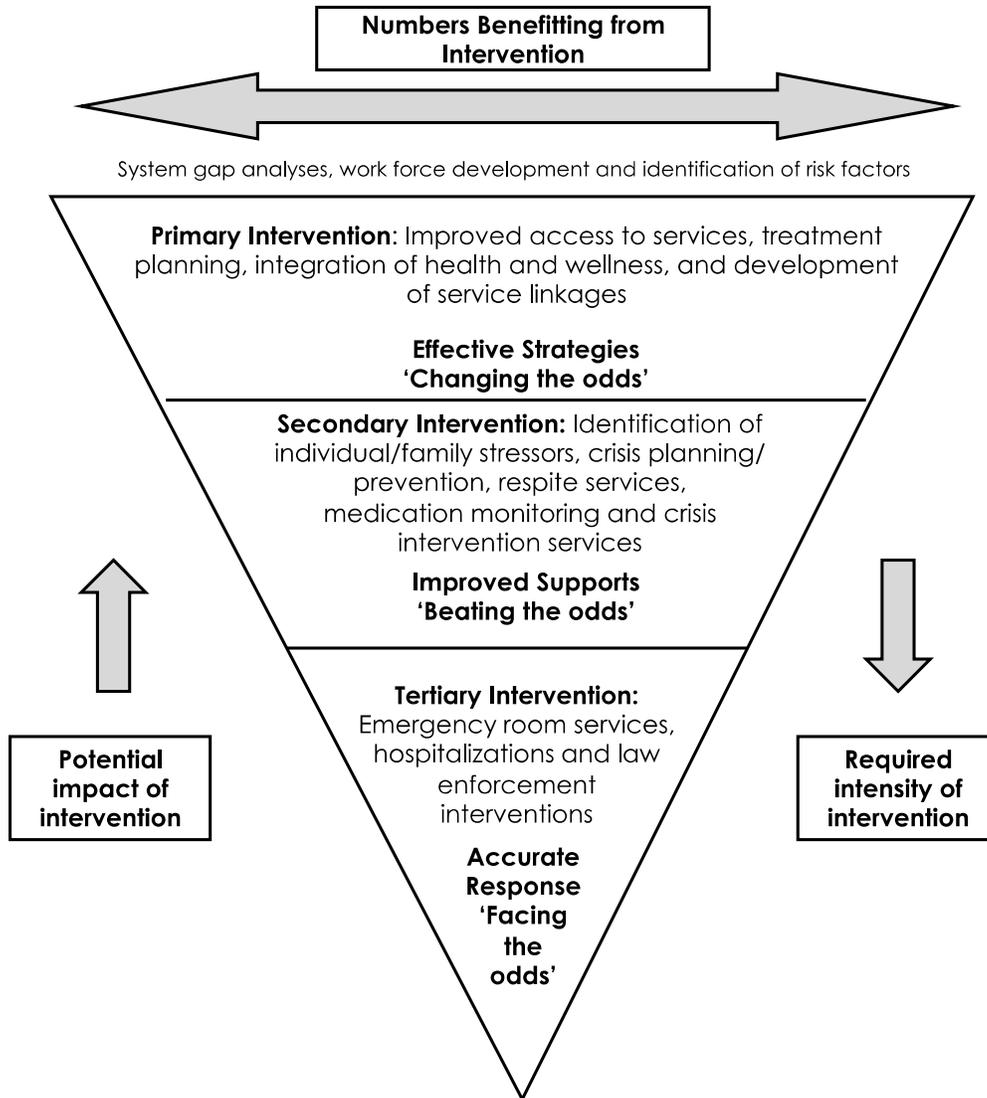
that includes access to the START therapeutic Center for planned supports and crisis prevention/intervention services; determination of appropriate ongoing interventions and supports to decrease the likelihood of crises; and development of interdisciplinary teams around an individual to continually work toward improving quality of life and adaptive functioning for that person.

### **Stage 3: "Crisis management"**

The third prevention level can be considered management of crises when they do occur despite best efforts to avoid them. The Management level is clearly outlined in the cross-systems crisis prevention and intervention plans; thus, the tools to address the situation are outlined and all participants have previously agreed upon the steps that will follow in managing the crisis. This level includes more intensive care such as the use of after-hours crisis response, START Center Emergency beds, in-home emergency supports, psychiatric hospitals, and crisis stabilization units. Also, START provides direction and support in bringing persons to stabilization and helping them return to prior levels of functioning in their home environments through ongoing support, training, and development of newly identified interventions as clinically indicated.

As indicated in the diagram below, the greatest and most substantial benefits are the direct result of primary prevention. The ability to have a sustained impact decreases dramatically once tertiary or crisis management services are provided. In addition, third stage services have the greatest associated financial costs. As the public health model indicates, the use of effective primary or global prevention strategies can "change the odds" to reduce emergency service needs. The development of an infrastructure at the primary prevention level also allows for improved outcomes in the secondary and tertiary levels when needed, as the system builds capacity to assist individuals.

Tertiary Care and START ( Beasley, Klein and Weigle, 2014)



# THE STRENGTH OF START

*The STRENGTH Approach* (O'Connell 1998) builds upon the Tertiary Care Model and the systems linkage focus of START Teams. It provides a foundational understanding and a means of tapping into the strength of the system to identify barriers and overcome challenges.

## The STRENGTH\* Approach

In order to build capacity within a system, it is necessary to move from planning to control challenging behavior, to the implementation of solutions where challenging behavior is no longer the focus of all of our attention and service provision. The **STRENGTH** community mental health approach can offer guidance to promote a more solutions based service-planning approach. These principles and perspective can be applied to and provide a basis for START Services.

**Solution** focused case review helps the system of support translate information into more functional and purposeful service provision. The concept of solution focused work shifts the discussion from where things have not been working to where they need to go.

In order to be solutions focused you need a strategic plan (**Trajectory preview**). The START team assists with development of this plan through the identification of a common goal. The system then can share responsibility for meeting this joint goal and can see the light at the end of the tunnel.

This occurs through **Resource** Development, where the resources needed are accessed to mobilize the team in a direction to support the strategic plan. It includes assessments and access to clinical support but also resources to assist the individual and caregiver in managing stressors through education and alternative supports. This can include proactive crisis prevention planning and positive behavior support plans.

We often fail to remember what has worked in the past and the last time the person was doing well. Although this is called an **Exceptions** analysis because what has brought people together in the crisis situation, remembering and learning from past successes provides an opportunity to reframe the problem and move forward.

This requires **Noticing** the positives and **Goal** setting, both designed to support a successful and more functional solutions-focused strategic plan.

The **Tenacity** to document and monitor successes provides hope for the entire system when situations faced can be very complex. This occurs with careful measure of progress as you work with the individual and their system of support.

Finally taking advantage of **Human** capacity within the individual, natural support and all stakeholders is an essential element in solutions focused work. The discussion shifts from what is not working to what can and is working over time.

### The STRENGTH\* Approach to treatment and service planning

	Main Theme	Operating Principles	Response to Problems
<b>S</b>	Solution Focused	Join with system toward common understanding of new possibilities	Crisis saturated dialogue is diminished
<b>T</b>	Trajectory Preview	Proactive strategic planning that is solutions based	Immediate problems transcended. Hope is instilled
<b>R</b>	Resource Development	Access resources that will promote successful outcomes	Support systems are mobilized to help overcome problems
<b>E</b>	Exceptions Analysis	Discover what has helped in the past and build on those skills and circumstances	Problems are reframed as not always happening
<b>N</b>	Noticing Positives	Notice what is already good and getting better	Success and positives overshadow focus on problems and deficits
<b>G</b>	Goal-Setting	Set short term goals that result in quick solutions, and long term sustainable goals based on emerging strengths	Problems are managed through enhanced capacity of the system with careful planning
<b>T</b>	Tenacity Review	Monitor and document successes in the system moving forward	Resilience in the network helps to overcome obstacles
<b>H</b>	Human-Capacity Development	Identify and build on competence and potential within the person, natural supports, care providers and stakeholders	Crises are no longer the primary narrative

\*Based on the STRENGTH Model (O'Connell, 1998)

# START COORDINATOR OVERVIEW

## What is START Coordinator Certification?

START Coordinators undergo intensive training and certification and serve in the position because of their talents and dedication to the IDD community. In order to become certified START Coordinators, training participants:

- Participate in expert trainings and technical assistance related to hallmarks of the START Model including Comprehensive Service Evaluations, positive psychology and strength based approaches, systemic consultation, Cross-Systems Crisis Prevention and Intervention Plans, and mental health conditions and challenging behavior as they occur in people with intellectual disability (IDD)
- Complete trainings, readings and data collection as outlined, and attend meetings to improve their knowledge about individuals with IDD and mental health needs
- Enhance their capacity to establish linkages to improve service outcomes
- Are expected to share what they have learned with their agencies, schedule presentations, and provide feedback about national START trainings to help refine additional training needs
- Prove competencies through work samples, preparation of clinical summaries, completion of one (independent) Comprehensive Service Evaluation and one (independent) Cross-Systems Crisis Prevention and Intervention Plan, and other evaluation measures such as peer-review meetings and journal reflections

### *START Coordinators:*

- Serve as a vital resource in their communities and have expertise in mental health conditions and challenging behavior in people with IDD
- Enhance the capacity of other providers and supports to develop a comprehensive and responsive community-based system
- Gain the necessary experience to become mentors to others, while increasing their expertise in mental health conditions and challenging behavior associated with IDD with a goal to reduce gaps and improve service outcomes

- Receive continued training and technical support to enhance knowledge, linkages, and expertise in dual diagnosis

## **\*START COORDINATOR POSITION DESCRIPTION & QUALIFICATIONS**

Although position descriptions are located in Section II, the following overview provides a general snapshot of the tasks and responsibilities that are relevant to a START Coordinator.

- \* START Coordinator interns are personnel imbedded in existing service systems who are required to meet the same qualifications and work at least 20 hours a week as START Coordinator interns. Additional information for START Coordinator Interns is found in a separate guide.

### **Tasks and Responsibilities of START Coordinators:**

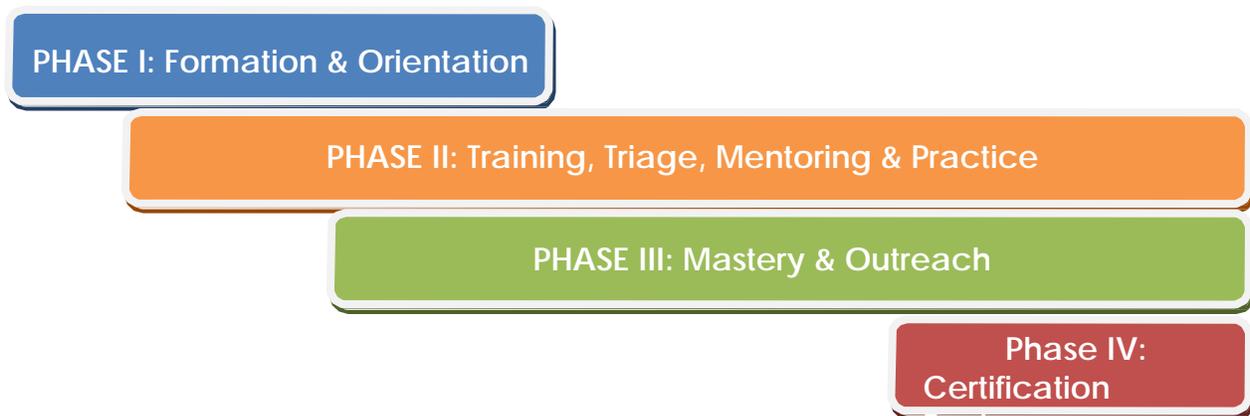
*(Details, such as the number of hours worked and caseload, vary.)*

- Participate in didactic trainings and additional trainings as required
- Provide systemic consultation
- Participate in National Center for START Services trainings and events
- Prepare agendas and document outcomes for individual mentoring sessions held with Center for START Services
- Maintain linkages and relationships with community partners
- Assist with referrals for consultation and treatment as needed
- Ensure the coordination of support meetings and crisis plan development for individuals served through START
- Participate in recurring meetings with START leadership, clinical team, and Resource Center
- Provide home visits and visits to day and vocational settings as needed
- Develop Comprehensive Service Evaluations, Cross-Systems Crisis Prevention and Intervention Plans, intake/assessments, intervention and outcome plans for respite admissions, Resource Center, or inpatient hospital admissions and any other applicable documentation of services provided
- Maintain an active caseload of individuals (variability occurs depending on activity level of cases and the project scope)
- Provide on-call support on a rotational basis as part of a START Team

- Participate in the START Network, which brings together projects from across North America through an online resource center, conference calls, select study groups and a national meeting if recommended.

## TRAINING PHASES

Training and certification schedules may be tailored individually for each START project in order to be responsive to its particular needs. Typical training schedules, however, are completed within 12 months for full-time START Coordinators and within 18 months for those serving in a part-time role. Within each project, START Coordinators progress at varying speeds. The following phases, however, outline the typical trajectory related to START Coordinator Certification. Some portions of Phases II, III, and IV traditionally overlap.



### *Phase I: Formation & Orientation*

During Phase I, the participants for the START Coordinator Certification and Clinical Team are chosen and the Center for START Services provides an *Overview of the START Model*, the *Roles and Responsibilities of START Coordinators*, and information specific to the project. Choosing appropriate staff members to serve as START Coordinators is important to the program's success. The Center conducts a rigorous interview process, but a candidate's supervisor should also be engaged and supportive of the training process. It is vital for both START Coordinators and their supervisors to understand the training program's requirements, the START program's mission and long-term goals, and to have regular and open communication.

### *Phase II: Training, Triage, Mentoring & Practice*

Intensive training and mentoring provided by the Center for START Services begins during Phase II. Trainings are typically delivered through a blended learning approach and include both synchronous (in-person) and asynchronous (online) trainings. Project managers work with participants to

schedule regular triage and mentoring calls, monthly team meetings, and additional meetings. On occasion, the Center for START Services will require and provide additional trainings provided by experts in the field to enhance knowledge on specific topics as needed.

All project managers at the Center for START Services have expertise in improving service outcomes for individuals with IDD, their families, and communities, as well as an in-depth working knowledge of the START model. Project managers encourage and guide START Coordinators in the practice of the lessons learned throughout the training process. Learning tasks include:

- Referrals and intakes
- Comprehensive Service Evaluations
- Cross-Systems Crisis Prevention & Intervention Plans
- Clinical Education Teams
- Emergency Assessments
- Systemic Consultation
- Outreach
- Working with families
- Developing linkage agreements
- Data collection
- Case presentations and peer-review sessions

### **Phase III: Mastery & Outreach**

As START Coordinators progress in their training and practice, there are more opportunities to demonstrate mastery of the competencies they have developed. Sharing lessons learned with other staff members through mini presentations, information sharing, systems collaboration, linkage agreements, case presentations, and peer-review sessions are just a few examples of how a Coordinator demonstrates mastery of competencies. Throughout the training process, Coordinators track the time they spend on various activities (see the section on data collection) as well as service time (see the section on Quality Assurance). Coordinators keep a log of the work they conduct during the Mastery and Outreach phase of the training process, as this type of information is routinely shared during monthly project meetings and used to report to stakeholders.

### **Phase IV: Certification Review**

Prior to becoming a certified START Coordinator, candidates must meet all requirements as outlined in their training schedule and must be able to demonstrate competencies as outlined in the START Competencies section. This includes the approval of one independently written Comprehensive Service Evaluation, one independently written Cross Systems Crisis Prevention and Intervention Plans, and the successful

completion of one Clinical Education Team Meeting. For Resource Center Directors, two Resource Center Admission and Discharge Summaries require approval by the Center for START Services staff. Once these benchmarks have been met, the START Coordinator Certification presentation is scheduled.

Certification reviews may be conducted either in-person or online. Candidates must demonstrate competencies on the START model through a variety of presentation components:

- Develop the presentation using Clinical Education Team (CET) standards
- The following skills should be demonstrated in the presentation:
  - An understanding of psychiatric disorders in the context of Intellectual and Developmental Disabilities
  - A basic understanding of the medications prescribed
  - A bio-psycho-social analysis of the individual's strengths and needs
  - Demonstration of a wellness and solutions based approach
  - An systemic analysis through the use of an eco-map
  - Demonstrated effectiveness in working with the system through outreach, education, and linkages

Upon successful completion of the certification review, START Coordinators will receive confirmation and a certificate from the Center for START Services.

## **CERTIFICATION REQUIREMENTS (GENERAL)**

Upon hire, START Coordinators immediately begin training and preparing for certification. Each Coordinator is given a guide that outlines specific requirements for completion of the training. While each START Project has a specific set of requirements that are tailored to meet the needs of a particular region, state, the following requirements are typically required for certification as a START Coordinator. It is important to note that this is a general list of requirements and does not include all aspects of START Coordinator Certification. An all-inclusive guide is given to START Coordinators upon hire:

### ***Trainings, Meetings, National Online Training Series, Calls, Mentor Meetings, and Additional Meetings and Trainings as Scheduled***

- An attendance rate of 85% or higher is required
- Preparation for meetings and presentations as outlined

### ***Comprehensive Service Evaluation, Systemic Consultation, and Cross-Systems Crisis Prevention and Intervention Plan Trainings***

- Complete at least one independently written successful Comprehensive

Service Evaluation and one independently written Cross-Systems Crisis Prevention and Intervention Plan, each of which must be reviewed and approved by the Center for START Services (it is ideal to complete and have two of each approved since we expect that the first approved plan involves lots of feedback and shaping of the process)

### ***Caseload Capacity***

- This is set according to your project's needs. A typical active caseload capacity is between 10-15 cases for half-time coordinators; and 15-30 for full-time coordinators (active refers to the number of individuals currently being served, not the total number of individuals served over time)

### ***Reading List***

- Coordinators must fulfill reading requirements as outlined in the scheduled training curriculum that is provided, as well as other assignments as presented

### ***Information Sharing, Updates & Data Tracking***

- Data tracking must be submitted monthly as outlined in the training schedule
- Weekly schedules and any barriers to fulfilling trainings and tasks should be sent to the START project manager
- Coordinators are required to share what they have learned via the START project with their agencies/organizations through presentations and information sharing in their communities (include this work in your data tracker)

### ***Feedback***

- Coordinators should participate in training surveys to help the Center for START Services assess its work and respond to feedback as appropriate

### ***Identification as a START Coordinator***

- Coordinators typically send revised job descriptions to their project manager that includes the work of START in their position descriptions. Exact details will be provided during your training.

- Your voicemail greeting should indicate you are a START Coordinator.

**Sample forms for Comprehensive Service Evaluations and Cross-Systems Crisis Prevention and Intervention Plans may be found in their respective sections; Clinical Education Team (CET) information is located in the CET section.**

**Please remember:** each project has specific requirements that are customized to meet its needs. The above list is simply an example of typical, general requirements. START Coordinators and their supervisors should refer to the customized START Coordinator Curriculum packet that is shared with participants during the first training to ensure they meet the requirements for their program.

## **CERTIFICATION**

Certification as a START Coordinator illustrates that an individual has excelled and proven they are proficient in the competencies as outlined. Through rigorous trainings, supportive mentoring, and competency evaluations, START Coordinator certification verifies the ability to develop improved strategies to support individuals with IDD and behavioral health care needs. These strategies work to improve service outcomes for individuals with IDD, their families, and their communities.

Certification as a START Coordinator is valid for two years. In order to maintain status as a certified START Coordinator, individuals must participate in a certain number of trainings as outlined and their START team must demonstrate fidelity to the START Model. Expectations regarding quality assurance are outlined in Section X.

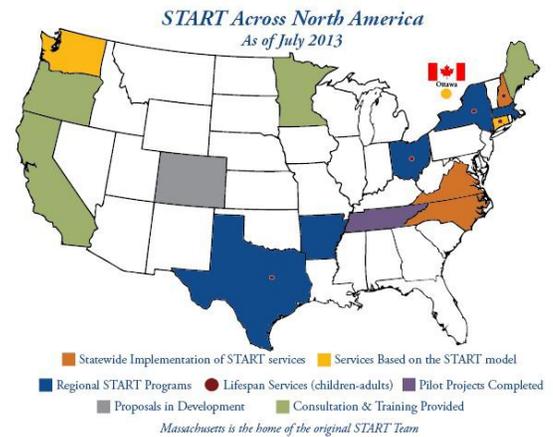
# SECTION II:

## Clinical Teams Overview

- Clinical Teams Overview
- The START Team Approach
- START Network
- Affiliations and Linkage Agreements
- START Program Certification
- Sample Clinical Team Organizational Chart
- Sample Clinical Team Job Descriptions

# CLINICAL TEAMS OVERVIEW

The Center for START Services provides an array of services across North America, and not all START Projects look the same. Some projects consist of a single organization that incorporates components of the START Model into its work; other projects implement the START Model statewide to enhance their work and strengthen systems of care to improve service outcomes for individuals with IDD, their families and communities.



Thus, START Projects are developed according to individual state, provincial, or regional needs. However, all START Teams must have a Clinical Team as their basis of functioning. Therapeutic Resource Centers are optional, as are emergency response services, but all projects must begin with and maintain the core Clinical Team to be certified START Teams.

When fully implemented START:

1. Promotes the development of least-restrictive, life-enhancing services, and supports to the people referred.
2. Provides timely 24-hour-a-day, 7-days-a-week responses to the system of care in support of individuals with IDD and behavioral health care needs. In times of crisis this means immediate telephonic access and in-person assessments within two hours of the request whenever possible.
3. Includes clinical treatment, assessment, and stabilization services in the context of short-term therapeutic Resource Center including:
  - a. emergency (hospital prevention, transition to community, and acute assessment and treatment);
  - b. acute solution-focused/crisis intervention; and
  - c. planned (ongoing support for the individual and provider for individuals with complex needs who primarily live with family members or other natural/unpaid supports).
4. Facilitates the development and implementation of individualized cross-systems crisis prevention and intervention plans.
5. Provides support and technical assistance to partners in the community including but not limited to: individuals and their families, Mobile MH Crisis Teams, residential and day providers, outpatient and inpatient MH providers.

6. Provides state-of-the-art assistance through a highly trained workforce, access to experts in the field, linkages with local and national resources, and the commitment to ongoing consultation and training for the START programs and their partners.
7. Creates and maintains affiliation and linkage agreements with community partners in order to clarify roles and responsibilities, overcomes existing barriers in the system, and enhances the capacity of the system as a whole.
8. Provides systemic consultation to teams to improve opportunities for mutual engagement and understanding, fosters a team approach that clarifies roles and responsibilities, and facilitates cooperation and collaboration in the context of a comprehensive understanding of the individuals served.
9. Assesses the needs of the population program-wide and works with stakeholders to ensure that effective service delivery takes place.
10. Measures outcomes and modifies strategies to meet the aforementioned goals.

START Clinical Teams consist of the following personnel.

Individual job descriptions can be found at the end of the section:

- A master's level or equivalent Director who also supervises the Resource Center Director and the Clinical Team Leader (a complete description of the START Resource Center program and its personnel is located in the START Resource Center Guide, available online exclusively to START projects)
- START Coordinators who provide 24-hour crisis support, linkages, outreach, and consultation services
- A psychiatrist who serves as the Medical Director
- A licensed clinician who serves as the Clinical Director

It is highly recommended that at least 50% of the START clinical team (including the START Resource Center Director) have a Master's Degree or higher in psychology, social work or a related field. Position descriptions, qualifications and responsibilities for all Clinical Team positions, and a sample organizational chart can be found later in this section.

A primary goal of all START Programs is to promote effective person-centered supports and services for persons with IDD and behavioral health needs. Service elements aim to accomplish goals to improve access, appropriateness and accountability – the three cornerstones of the START model.

In order to enhance the START Program's service, to promote partnership and collaboration in the community in addition to supporting teams and families with getting their needs met, all programs should have discretionary

funds available to them. The needs of the system are continually changing and START Programs must be flexible enough to meet these needs. All discretionary funds should require prior approval, but should be available and can be used in certain circumstances. These circumstances may include (but are not limited to): specialty evaluation or assessment, for consultation from experts in the community surrounding a complex case, transportation costs for families to attend necessary appointments and/or to get to and from the START Resource Center.

### A Note About Per Diem On-Call Staff

Most START Clinical Teams are designed to provide 24-7 on-call response but in certain situations, START Clinical Teams may employ per-diem on-call staff. On-call emergency back-up staff cover after hours (after 7:00 pm and until 7:00 am M-Th), Fridays after 5:00 pm and weekends (until 7:00 am on Monday) only. They do not carry a caseload and they must meet the minimum qualifications for the START Coordinator position. Expertise in local mobile mental health crisis response is preferred.

Per Diem emergency on-call staff need to:

1. View overview of START and discuss/review with Clinical Director or Director prior to being on call;
2. Visit Resource Center and learn about the program and criteria prior to being on- call;
3. View emergency evaluation training and discuss/review with Clinical Director or Director prior to being on-call;
4. Become familiar with all forms and documentation requirements;
5. Complete a minimum of two observations on-site with START Coordinator, Clinical Director or Director. This can be during business hours.
6. Receive coaching at all times: no per diem on-call staff should make decisions independently without backup from team; a certified Coordinator or admin staff must provide coaching and back-up.

Note: Although not recommended, in emergencies when per diem staff is needed ASAP, all training and orientation can be accomplished in one day of training.

The START Advisory Council serves as a critical community champion of the START project. Members of the Advisory Council share their expertise by providing knowledge of constituent perspectives; connections to local, national or international resources, colleagues or peers; and philanthropic support or other forms of needed assistance. The Advisory Council has no governing function within the organization.

Advisory Councils serve as a critical resource to START projects, and they:

- Link critical supporters to the project and keep them connected through quarterly meetings;
- Create links to key community professional and technical expertise;
- Enlist assistance from others when needed;
- Review quarterly updates and annual reports, providing vital guidance and feedback;
- Attend events such as annual meetings and special gatherings;
- Keep START activities top-of-mind among key stakeholders;

## THE START TEAM APPROACH

Active communication and collaboration begin with the START team itself. In spite of the fact that START team members operate in the field independently, various methods are used to ensure that the entire team works together to support individuals and the system. The following are some of the protocols that are required for START programs:

### Morning Triage Calls

Members of the team participate in a Triage call every weekday morning. Triage calls provide a time for START Coordinators to review any calls they may have received since the previous day. The Resource Center Director or designee provides updates on the guests and reviews admissions/ discharges as necessary. Triage calls also include a bio-psycho-social review of all guests. This is a time to discuss crisis/emergency needs of individuals referred or already part of the START program and receive direction/support from co-workers and supervisory staff. Follow-up for crisis contacts is also determined at this meeting along with dissemination of intake assignments for emergency referrals.

### START Clinical Team Meetings

Each START team conducts weekly staff meetings to review clinical and systems-related issues. START Clinical Meetings are intended to ensure all necessary information is communicated to the entire START Team and to provide meaningful dialogue regarding the care and treatment of individuals supported by START through coordination and support of their respective systems. In doing this the following agenda items should be included in all recurring START Clinical Team Meetings:

1. Review of any individuals on the active caseload who are experiencing difficulties, crises, significant events and/or are experiencing circumstances and situations that may lead to crisis events. This includes individuals whose early stage(s) of crisis intervention may have occurred.

2. Review status of guests at the Resource Center including progress toward admission goals and any modifications that may be needed and upcoming plans for discharge.
3. Review the planned Resource Center schedule for the week and any openings.
4. Review any new administrative/operations procedures, policies, etc. and/or problems/issues with current processes that may warrant further discussion and/or changes to current operational processes.
5. Review all recent referrals.

### **Peer-Review**

Peer-review is an essential component of the program's internal process for quality assurance. In addition to external audits and reviews, START completes internal peer-reviews to improve the development of Cross-Systems Crisis Prevention and Intervention Plans, Resource Center discharge summaries, and maintenance of medical records. START Coordinators and the Team Leader, Regional Director, Clinical Director, and/or Resource Center Director participate in peer- reviews as deemed appropriate by the Regional Director. At a minimum, peer- reviews should occur on a quarterly basis.

## **Live Supervision**

Live supervision techniques are part of the core training and supervision protocol for all START personnel and includes review of videotaped meetings and activities to improve the skills and effectiveness of the team.

# START NETWORK

All START Programs are part of the START Network, which is comprised of other active START teams across North America. All START Programs share resources, information and expertise through structured learning environments facilitated by the Center for START Services. The Center for START Services currently provides the following START Network opportunities:

- **Conference Calls:** Conference calls are held annually with teams across North America. The calls allow projects to share updates, news, and resources to increase awareness of the diversity of START projects and provide networking opportunities among participants.
- **Annual Luncheon.** The Center for START Services typically hosts an annual national forum for networking among START programs in various locations.
- **Study Groups:** The START Network provides opportunities for collaborative learning through a number of study groups. The Clinical Director's Study Group, Resource Center Director's Study Group, Clinical Team Leader Study Group and Medical Director's Study Group meet either monthly or quarterly to discuss issues directly related to their positions (more information can be found at the Online START Network & Resource Center).
- **Online START Network & Resource Center:** The Center for START Services has developed an online resource center for all START teams. Links to past trainings, publications, and more provides vital value-added resources for all START Programs.

The Center will continue to enhance its online offerings for the START Network in an effort to cultivate strong connections and collaboration among all START teams.

# AFFILIATIONS AND LINKAGE AGREEMENTS

Inherent in developing effective systems of support is the development of affiliations and linkages between the START program and other existing community services and support providers. It is the responsibility of the Director to develop these agreements and assure the continuation of these affiliations.

START programs link with the Center for START Services in multiple capacities from individualized training and program development support, to materials, to National Online Training opportunities and the use of the START Information Reporting System (SIRS).

It is also critical that START programs form affiliations and linkage agreements with local entities with whom they collaborate. Affiliation and linkage agreements can and need be formalized (in writing) in some cases, but can be informal agreements in others. It is the role of the Director of the START program to reach out to and meet with these partners to not only educate them about START's role in the community, but to outline how they will work collaboratively. These service providers may include medical or therapy providers, emergency service teams, schools, inpatient psychiatric hospitals, residential and day providers, and local first responders. A sample Affiliation Agreement can be found at the end of this section.

# START PROGRAM CERTIFICATION

Once START programs have gone through the development phases, and their Coordinators have been certified, they must meet requirements for continued Program Certification. Minimum requirements include:

- 85% participation of certified personnel in annual training offered by the Center for START Services
- Program fidelity as evaluated through
  - Record Reviews
  - START Network participation, including data collection and information sharing across the network, and continued certification of all new START Coordinators
  - Demonstration of evidence informed protocols
  - Demonstration of clinical and systemic analysis through conducting Clinical Education Team Meetings
  - Demonstration of mastery of Live Supervision techniques

These requirements will be outlined specifically for each Program to ensure their individual needs and START standards are being met. Quality Assurance and fidelity measures are outlined in Section X.

# START ORGANIZATIONAL CHART Needs special editing\*

## START Clinical Team

( Advisory Council )

Database/SIRS

- Director (master's /Ph.D. with extensive experience in IDD)
- **Clinical Director** (Ph.D. in psychology and must be **licensed**; or Master's in clinical field; 0% **Clinical Team**, 50% ) Resource Center. If Clinical Director is not a licensed psychologist, one must be available to be part of and/or consult to the team.
- **Medical Director** (M.D./D.O. or APRN with psychiatry specialty; consultation to **Clinical Team** and **Respite**)
- Resource Center Director (master's in human service) see below)
- Team leader/START Coordinators (master's preferred)
- START Coordinators (master's preferred)

- Customized Coaching
- Technical Support
- Certification of START Coordinators
- Notional Online Training Series
- Online Certification Course
- Fidelity Guides
- START Curricula
- START Trainings (blended)
- CET Development

### Linkages

- State/Local Stakeholders
- Residential
- Schools
- Inpatient
- Outpatient
- Respite
- Day
- Natural Supports
- Clinical Services

### START Therapeutic Respite

- 50% Emergency/50% Planned; 4-6 Beds;  
Staff-client ratio: minimum of 3:4 awake and 12 overnight*
- Respite Director (master's in human service fields, supervised by Clinical Director typically)
  - Assistant Director (RN)
  - Evening/weekend supervisor
  - Direct Support Staff
  - Mobile/In-Home Community Respite Direct Support Staff

\* This chart provides an example of statewide START implementation

## **POSITION DESCRIPTIONS & QUALIFICATIONS**

The following descriptions provide basic qualifications and general lists of responsibilities and tasks that are relevant to members of a START Clinical Team (Position descriptions for START Therapeutic Support Services can be found in the START Therapeutic Supports Manual).

## **START Coordinator (1 FTE)**

### **Required Qualifications:**

A Master's Degree in Social Work, Psychology, Counseling or other human service field with 2 years experience working with people who have IDD and mental health and/or challenging behavior needs.

\*\*For some START Programs, a Bachelor's Degree in Social Work, Psychology, Counseling or other human service field with 5 years experience working with people who have IDD and mental health and/or challenging behavior needs is acceptable. This is an exception and the START Program should work collaboratively with the Center for START Services when this is necessary.

AND

- The ability to work with complex systems and an interest in the population is essential.
- Independent and organized work skills along with communication and writing skills are necessary.
- Experience working with families and individuals.
- Ability to complete START Coordinator Certification within 12 months following employment (May be 18 months for part-time coordinators).
- 

### **Responsibilities:**

- Must work a designated number of hours each week
- Participate in didactic trainings and additional trainings as required
- Provide systemic consultation
- Participate in National Center for START Services trainings and events
- Prepare agendas and document outcomes for individual mentoring sessions held with Center for START Services
- Maintain linkages and relationships with community partners
- Assist with referrals for consultation and treatment as needed
- Ensure the coordination of support meetings and crisis plan development for individuals served through START
- Participate in recurring meetings with START leadership, clinical team, and Resource Center program
- Provide home visits and visits to day and vocational settings as needed
- Develop Comprehensive Service Evaluations, Cross-Systems Crisis Prevention and Intervention Plans, intake/assessments, intervention and outcome plans for Resource Center admissions or inpatient hospital admissions and any other applicable documentation of services provided
- Maintain an active caseload of individuals referred for START Services (variability occurs depending on activity level of cases and the project scope)
- Provide on-call support on a rotational basis as part of a START Team
- Participate in the START Network, which brings together projects from across North America through an online resource center, conference calls, select study groups and a meeting at a annual conference as recommended

## **DIRECTOR (1 FTE)**

### **Required Qualifications:**

A Master's Degree in Social Work, Psychology, Counseling or other human service field with 2 years experience working with people with IDD mental health and/or challenging behavior needs

AND

- 2 years supervisory experience
- Must be a certified START Coordinator or the ability to complete the START Coordinator Certification process within 6-12 months of hiring.
- Prior experience as a START Coordinator and/or START Clinical Team Leader preferred

### **Primary Responsibilities:**

- Supervise/oversee Clinical Team and Resource Center facility
- Establish community linkages and serve as liaison to community partners
- Based on feedback of Clinical Teams, identify training/support needs of the community
- Coordinate trainings utilizing expertise of psychologists and psychiatrists, Team Leaders, and specialists within the community
- Identify and coordinate necessary trainings for team members
- Maintain communication with other regional START Directors
- Ensure the collection of required data and documentation on consumer access and utilization of START services
- Provide support as needed to clinical team and Resource Center 24/7/365

## **CLINICAL DIRECTOR (1 FTE)**

### **Required Qualifications:**

Ph.D. in Psychology and licensed by the state's/province's Psychology Board

OR

Masters Degree in Mental Health, Psychology or Social Work and licensed by the state's/province's Board with a minimum of 7 years clinical experience working with the IDD/MI population

AND

Extensive experience in Intellectual and Developmental Disabilities (IDD), specifically with people who have IDD and mental health and/or challenging behavior needs

- Experience developing and implementing behavior support plans preferred.
- If the Clinical Director is a master's level clinician, there MUST be a Ph.D Clinical Psychologist available for consultation and support to assist with evaluations, interpreting psychological testing and case consultation

### **Primary Responsibilities:**

- Provide oversight and consultation on behavioral supports and other written documents
- Review all START related documentation and provide input.
- Provide training and consultation to staff, families and providers including ongoing organization and conducting of CETs
- Assist START Coordinators with preparation for START Coordinator Certification
- Participate in recurring team meetings as necessary
- Develop behavior support plans as necessary for guests at the Resource Center who require more extensive safety measures
- Participate in discussion regarding potential Resource Center admissions
- Provide on-site consultation as needed for guests receiving Center based and/or Mobile Supports

## **MEDICAL DIRECTOR**

### **Required Qualifications:**

M.D./D.O. or APRN with specialty in psychiatry or developmental pediatrics, licensed to practice in the state.

Extensive experience treating individuals with Intellectual and Developmental Disabilities (IDD) necessary

### **Primary Responsibilities:**

- Provide consultation and training to staff
- Collaborate with primary treating physicians of individuals supported by START
- Consultation to psychiatric hospitals regarding treatment of individuals with IDD and mental or behavioral health needs
- Participate in recurring team meetings as necessary
- Provide on-site consultation and treatment as needed for guests receiving Resource Center service

## **CLINICAL TEAM LEADER (1 FTE)**

### **Required Qualifications:**

Master's degree in social work, counseling, psychology or human service field with a minimum of 2 years experience providing services to with people who have IDD and mental health and/or challenging behavior needs

AND

- At least one year supervisory experience
- Must be a Certified START Coordinator within 12 months of employment as team leader
- Prior experience as a START Coordinator preferred

### **Primary Responsibilities:**

- Provide administrative supervision to START Coordinators and provide daily clinical triage support
- Maintain linkages and relationships with community partners
- Ensure the coordination of support meetings and crisis plans for individuals served through START
- Share on-call responsibilities to ensure 24/7 response to crisis situations within one hour of call telephonically and within 24 hours of call face-to-face
- Participate in recurring meetings with START leadership, clinical team, and Resource Center
- Development of cross-systems crisis plans, intake/assessments, intervention and outcomes and any other applicable documentation of services provided
- Maintain a small, active caseload (about 5 cases) until START Coordinator Certification is achieved. Following certification, team leader caseload should be fluid and temporary to provide opportunity to support START Coordinators when needed

## **ADMINISTRATIVE ASSISTANT**

### **Required Qualifications:**

Two years of experience in administrative assistant/secretary positions (preferably in the healthcare field). Knowledge of medical record keeping and third party reimbursement processes. Basic knowledge of Microsoft Office suite.

### **Responsibilities:**

- Maintaining all START records in accordance with the state's/province's Record Service manual requirements
- Recording minutes of START recurring Team Meetings and Daily Triage Calls
- Maintaining central record of all completed START Daily Logs
- Contact individuals/guardians for reminders of scheduled planned Resource Center visits
- Complete entry of START data element

# START AFFILIATION AND LINKAGE AGREEMENT- SAMPLE

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## Services Linkage Agreement

The purpose of START is to provide community based prevention and intervention services to individuals, ages 16 years and older with a diagnosis of intellectual and/or developmental disability (IDD) and behavioral health needs. The goal of START involvement is to support providers to help individuals remain in their home or community placement with crisis response, training, and consultation. To do so, START establishes collaborative linkages with system partners. The purpose of this affiliation agreement is to establish a collaborative framework in order to improve outpatient supports, community linkages, improve treatment outcomes and decrease the need for hospitalization and/or loss of community placement.

### **The START Program agrees to:**

- Provide and coordinate training and technical assistance to providers, families and community partners.
- Establish integrated service linkages between the provider, family and other support agencies.
- Coordinate community treatment planning meetings and regular team meetings for START participants.
- Work with area agencies and other providers to identify high-risk individuals and through the development of cross-systems crisis planning, place emphasis on crisis prevention.
- Work in collaboration with START Coordinators in developing cross-systems crisis plans for identified individuals.
- Collaborate with START around referred individuals treatment planning needs and actively participate in clinical education training (CET) sponsored by START.
- Provide on-going written and verbal communication with START Coordinators with regard to treatment planning, cross-systems crisis planning, treatment coordination issues, and psychopharmacological concerns.

- Provide consult to Emergency Rooms and local psychiatric facilities regarding intellectually/developmentally disabled individuals (during business hours at this time) with behavioral health issues.

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**Community Mental Health Center agrees to:**

- Provide mental health/psychiatric assessment and treatment to adults with Intellectual Disability (ID) and co-occurring serious and persistent mental illness (SPMI) who receive services from the community house
- Provide psychiatric emergency services to individuals with ID when psychiatric symptoms rise to a level necessitating them being brought to the Hospital Emergency Room. This may at times include admission to the Hospital from the Hospital Emergency Room.
- Collaborate with Community Services/START to provide coordinated planning and service delivery for individuals served by both agencies
- Participate in interagency education and training activities that are relevant, as resources permit
- Commit to working collaboratively to promote access to START respite and crisis support services as these are developed. This will be done with the intent of reducing utilization of Hospital and expediting disposition from the Hospital Emergency Room. In order for this to proceed, it will be essential to clarify respective roles and processes for staff from both agencies. The level of collaboration possible is contingent upon the outcome of this interagency planning.
- Collaborate with Community Services in the development of Crisis Plans for individuals served by both agencies, as time and resources permit

**Community Services agrees to:**

- Inform Community Mental Health Center of START individuals being supported
- Coordinate participation at relevant trainings for staff, families, and community partners provided by The Center for START Services.
- Coordinate consultations of the START coordinators, with staff, families, and community partners
- Develop in collaboration with Community Mental Health Center Cross-System Crisis Plans for individual START is helping
- Participate in Team monthly meetings to review individuals followed by dual agencies

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START Regional Director

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Date

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Printed Name Community Mental Health Center Director

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Date

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Printed Name Community IDD Services Director

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Date

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# SECTION III:

## Referral & Intake Process

- Referral Process and Services Outline
- Assessments
  - ABC
  - Recent Stressors Questionnaire
  - MEDS
  
  - Family Experiences with Mental Health Providers for Persons with Intellectual and Developmental Disabilities (FEIS)
- Guidelines for Facilitating a START Meeting
- Sample Forms

# REFERRAL & INTAKE PROCESS

Each START project works with a Center for START Services team member (typically a Project Manager) to develop and approve a referral and intake process tailored to meet their project's specific needs.

The following outline provides an example of how one statewide project developed its referral process. It is included here only as an example. Each START Team should develop its own process and share it with their Center for START Services Project Manager for review before implementation.

## START REFERRAL PROCESS AND SERVICES OUTLINE

Referrals will come from each area agency in the geographic location in which the START team supports. The Clinical Team Leader will determine who will be assigned to the case within each agency.

START Referral packets are completed by agency service coordinators or case managers but can be initiated at the request of any person on the individual's team. Sample referral and intake forms can be found at the end of this section.

1. Each agency will have a person designated to receive referrals. These should be sent electronically in a secure, HIPAA-compliant manner.
2. Referrals will go to a designated member of the local agency with copies e-mailed to the Clinical Team Leader upon receipt of referral. Case assignments will be determined at a triage meeting with the Clinical Team Leader and/or START Regional Director. This should occur no later than three business days of receipt of referral and may occur sooner in emergency situations.
3. Intake meetings with the team should be scheduled by the assigned START Coordinator within 24 hours of case assignment to occur within five to seven business days from the date of the case assignment or sooner if possible. It is important to note that the Intake/Assessment process will likely take more than one meeting. It is ideal that these meetings occur face-to-face but phone or video conferencing is acceptable when necessary. All **initial** intake meetings should be done face-to-face
4. Assessments to be completed at intake include: Recent Stressors Questionnaire (repeated every 12 months or when crisis occurs) and the Aberrant Behavior Checklist (ABC; every 12 months or at discharge from START services). The Aberrant Behavior Checklist (ABC) is also completed

at intake and discharge, or yearly if the case remains active. The FEIS is conducted at the time of intake and then again at 12 months. The MEDS is used by START programs that have a Therapeutic Resource Center and it is repeated when a person is admitted to the Center (more information below)

5. Services provided will be determined by the team in consultation with the Clinical Director and Clinical Team Leader once the referral is reviewed and discussed at an intake meeting. A START Plan will be completed outlining services that will be provided to each individual. The START Plan will be reviewed regularly by the Clinical Director, Team Leaders and Coordinators to ensure services are provided in a timely manner. A sample START Plan and instructions are below.
6. Active caseloads will be balanced and will not exceed 15 active individuals for half-time Coordinators and 30 active individuals for full-time Coordinators.
7. The START Coordinator should ensure that all data is collected throughout this process. Please refer to Section IX: SIRS for more information regarding data collection elements and procedures.

**It is strongly encouraged that individuals be referred to the START project if:**

- The individual being referred is currently at or has been to a psychiatric hospital or any other inpatient psychiatric unit within the past 24 months.
- The individual has been referred for additional staffing due to challenging or problem behaviors or has been receiving additional staffing for an extended period of time.
- The individual referred has a history of multiple community placements over the past 12 months due to challenging behavior.
- The individual referred has complex mental health needs that have required crisis intervention, calls to 911, and frequent medication changes.
- The individual is at risk of losing their work or home placement due to challenging behavior or unmet mental health needs.
- The individual is presenting with complex behavioral, medical, and/or trauma-related issues and has appeared to have deteriorated over recent months or years.

**As START Coordinators you will be able to offer the following services:**

1. Systemic consultation: START Coordinators apply systemic practices in order to assist the team in communication, collaboration, and developing a common understanding of problems faced, while at the same time fostering a plan to improve services and outcomes. This

includes work with ID and MH systems, school systems, families, stakeholders, and providers.

2. Individual meetings with the person referred, family members and their case manager or service coordinator: The intent of these meetings is to get input from the person referred about his or her service needs. This should occur on a regular basis. It is important to note that the START Coordinator does not provide services directly to individuals, but it is important that they know the person well enough to assist the team. This cannot occur without having a clear understanding of the individual and their wishes.
3. Comprehensive Service Evaluations: This consists of a record review and assessment of the individual's long-term service and support needs in collaboration with their team.
4. Cross-Systems Crisis Prevention and Intervention Planning: This provides a map of interventions to assist in preventing crises and intervening in times of difficulty. The plan should be developed with all system supports and team members' input with clear delineation of roles and responsibilities among members. The goal is to collaborate and develop a safety net for the person and system that supports the individual. This plan should be reviewed at regularly scheduled intervals (at least annually) or when a crisis occurs to modify and adjust the plan to improve effectiveness.
5. Training: Utilizing training opportunities and reviews of current literature and research, START Coordinators provide information needed in the consultation process to local area agencies and service providers. In addition, START Coordinators will provide in-service trainings to their area agencies after attending didactic trainings with Center for START Services team members.
6. Outreach: START Coordinators reach out to families and teams to insure that communication and collaboration take place as the system works together to improve services and service outcomes. Outreach includes phone calls, home visits, and visits to day settings to make observations and offer suggestions to the team.
7. Emergency Response and crisis support: START Coordinators assist in trouble-shooting and accessing needed services, and facilitate team meetings in times of difficulty.

8. Referral and follow-up with other evaluations as needed: START

Coordinators assist with accessing additional evaluations as needed and support the team throughout the process, including the implementation of an action plan once evaluation results have been attained.

# ASSESSMENT INSTRUMENTS

Thorough and ongoing assessment of the person's functioning, medical status, medications, and possible medication side effects are an integral part of the START Coordinators' role. The purpose of completing these assessments is to better inform the team about how the person is doing, potential factors affecting the person's current functioning, and how intervention affects their functioning. Assessments to be completed at intake include: Aberrant Behavior Checklist (ABC), repeated every 12 months or when a case is made inactive; and Recent Stressors Questionnaire (RSQ), repeated every 12 months or when crisis occurs. The Family Experiences with Mental Health Providers for Persons with Intellectual and Developmental Disabilities (FEIS) is completed at the time of intake and then 12 months following the initiation a referral to the START Program. The MEDS is used by START programs that have a Resource Center and it is repeated each time a person is admitted. Below is a description of each tool; more information and training is available on the website.

## ABC (AMAN & SINGH, 1998)

*The Aberrant Behavior Checklist (ABC)* was developed by Aman and Singh (1986). It is a symptom checklist for assessing problem behaviors of children and adults with intellectual disability at home, school, residential facilities, ICF/ID's, and work training centers. This rating scale is an "informant" rating scale, meaning that a person/caregiver who knows the individual well fills out the form. The ABC is used worldwide and is translated into dozens of languages due to its strong psychometric properties and utility in clinical settings and research. It is easily used to track progress. For example, ABC scores from intake to one year of START services have been shown to decrease.

The manual purchased by your START office has information including normative data, however, much is outdated. The ABC is best interpreted simply as a marker for types of problem behaviors and then scores are used for tracking improvement or worsening of these symptoms. Three key subscales, however, do suggest a possibility of particular psychiatric conditions and they are: Irritability (depression, bipolar disorder, ADHD, PTSD); Lethargy (depression); Hyperactivity-Noncompliance (depression, bipolar disorder, ADHD). When administering the ABC, it is important to always give the informant the "Individual Items with Specific Examples" list for the behaviors on the ABC, and

this is available on the START website in the ABC section. The website also has more comprehensive information on the ABC.

The ABC is administered at intake and yearly and/or when a case is made inactive. It can also be administered in times of crisis, to assess progress, or to assess effectiveness of psychiatric medications but these administrations are optional.

A comprehensive online training session for START Coordinators on the ABC was developed in 2012 by Anne Desnoyers Hurley, Ph.D. and was presented by Karen Weigle, Ph.D. It is available to START projects via the Center for START Services' Online Resource Center. All START projects should review the ABC training.

## **RECENT STRESSORS QUESTIONNAIRE (CHARLOT)**

The *Recent Stressors Questionnaire* (RSQ) was developed by Laurie Charlot, PhD. It should be implemented at intake and again at every crisis response or emergency evaluation.

The RSQ was developed as a tool to help assess individuals with IDD who are having increased emotional or behavioral problems, or are "in crisis" due to suspected acute mental health concerns. The survey touches on a number of areas, and is meant to help clinicians gather a broad range of information about factors that are known to contribute to alterations in mood, behavior and mental status.

The RSQ provides a "starting point" for the clinician to further explore the contribution of stressful events and factors to the current "presenting problem." Research has shown that all people (with and without ID and/or autism spectrum disorder) are at greater risk of mental health disorders when experiencing stress. The events and occurrences we each experience as stressful is individual, but some aspects of having a neurodevelopmental disorder and being a person treated with psychoactive medications likely amplify such risk. This includes the presence of an abnormal or "fragile" neurological substrate (being born with cognitive and developmental challenges and atypical brains), often having restricted life experiences (being "sheltered" at times from usual experiences), having others be in control of where one lives and works, and having functional communication challenges. Please see the website for more information.

## **FEIS (FAMILY EXPERIENCES WITH MENTAL HEALTH SERVICES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, BEASLEY, 2013)**

The FEIS is a validated instrument that has been adapted from *The Family Experience Interview Schedule* (Tessler & Gamache) to be used with families who care for family members who have an intellectual or developmental disability and co-occurring mental/behavioral health issues. This tool is designed to gain valuable information from family members regarding their experiences and satisfaction with mental health services. The FEIS uses a satisfaction rating scale with the higher the score (highest rating is 4) correlating with higher satisfaction with services. Questions asked in the FEIS address each of the 3 A's that are the cornerstone of effective service for people with IDD-Accessibility, accountability and appropriateness. More specifically, it elicits information regarding how easy/difficult it is to access services, how connected family members feel to mental health providers, how much family members believe that their challenges and concerns were taken into account when making treatment plans and if family members believe that services that were offered fit the need of the individual.

The FEIS should be done during the intake/assessment phase of START Coordination and should be done either by the START Coordinator or by another team member (Team Leader, Director, Clinical Director). For the initial completion of the FEIS, it is ideal that it be done in person, but can be completed over the phone if needed. It should also be done 12 months following the initial completion of the survey following the implementation of START Coordination, linkage and outreach services. This tool is only administered for those START service recipients who live in a family (paid or unpaid) setting.

## **MEDS (MATSON EVALUATION OF DRUG SIDE EFFECTS, MATSON & BAGLIO, 1998)**

The *MEDS (Matson Evaluation of Drug Side Effects)* was developed by Matson and Baglio (1998). It is an instrument designed specifically to suggest the presence of a side effect or adverse event related to treatment with psychiatric medicine for people with intellectual disability. The MEDS has strong psychometric properties and has been widely used in clinical settings and

research. When interpreting the MEDS, It is important to appreciate that any “medical problem” identified (such as high blood pressure) may not be due to a side effect or adverse event, however, and we want any possibility further explored by the guest's medical team.

START is using the MEDS at its Resource Centers. This is the first time a system has attempted to assess side effects and collaborate with the system members (especially psychiatric providers) to address efficacy and the need to reduce and eliminate these medications.

The MEDS is administered when a person is admitted the START Therapeutic Resource Center. A member of the START Team will interview a person / caregiver who knows the individual/guest well. Afterwards, it is important that the medical record and any new medical information be incorporated into the MEDS scores, as the informant may not have full information. The final scores on the MEDS are a combination of the informant interview and written medical information.

After discharge from a START Resource Center, a full copy of the MEDS completed for the guest is mailed to the involved medical providers, typically a general practitioner and psychiatrist, family, START Coordinator and Referring Providers. A letter explaining the MEDS accompanies this document and a sample is on The Center for START Services website in the MEDS section. This may also be sent at any time to the medical providers when someone is benefitting from START Therapeutic Resource Center.

All START projects should review the online MEDS training and complete it. Training on the START MEDS Initiative was developed by Dr. Anne Desnoyers Hurley for all START programs with Center-based Support Services, and is available on the Center for START Services' Online Resource Center. Additional information is also available on the website in the MEDS area.

# GUIDELINES FOR FACILITATING A START MEETING

## Prior to meeting

- Schedule the first meeting and insure that all stakeholders attend (this is important and may take some patience). If all cannot attend in person, use a conference phone line or video conference to allow for as much attendance as possible. To know who should be invited work with the case manager or primary provider/caregiver.
- Inform attendees, before meeting, the purpose of the meeting and intended outcomes. If it is your first meeting, the purpose is to discuss the presenting problems and how we can better address them.
- Develop a list of contact information for people in the meeting to distribute to the group so that they can communicate and share information outside the meeting.
- Meetings should be 60-90 minutes in length, no longer.
- START Coordinators should work in teams of two to allow for one person to work as a recorder and the other to be the active facilitator to prevent the START team from looking like “recorders.” This also allows the facilitator the opportunity to observe what is happening in the room and address nonverbal communication as it occurs.

## Things to Do/General Outline:

- When possible, the recorder will use written lists or flipcharts to outline with the group information discussed and who is responsible for doing what.
- Everyone introduce themselves and concerns they would like to address in the meeting.
- First (non-crisis) meeting - note (on the flipchart) who is at the meeting, their role/relationship to the client, and how long they have known the individual.
- First (non-crisis) meeting – educate team about START, your role, and how this will be a collaborative effort. Reeducate during later meetings periodically.
  - Explain, “The goal of START is to support the system serving individuals, to fill in gaps when possible, and to help the team work together to advocate for needed services.”
    - START helps teams anticipate and prevent crisis and plan for what to do when it happens anyway.

- START is here to assist in working with people with complex needs and the challenges we all face, to build bridges for stronger supports. START does not replace any member of the team; rather, it works to enhance the system of support that already exists.
  - Ensure everyone understands they are experts on the identified client or their area of knowledge and have something to contribute to the process.
  - Explore the reasons for seeking START services. Be sure you have referral information with you to refer to.
    - How have things been going since the referral was made?
    - Review ABC (challenges they face)
    - Review Recent Stressors Questionnaire and explore information with team
    - What do they hope to get from START?
- Review the agenda and ask for additions or news they want to share.
  - “What is the most important thing that we want to accomplish in today’s meeting?” Note agenda additions and comments on agenda items on the list.
- Have a blank action plan sheet to provide to all and complete it together as a group. The action plan sheet should have columns of “what” the task is, “who” will do it, and by “when.”
  - START Coordinators can offer any START Service (CET, CSPIP, CSE, Psychopharmacology consult, planned Resource Center admission, in-home resources) as needed and ensure they occur.
- If in a follow-up meeting, begin again with giving everyone the opportunity to check in with regard to achievements and concerns they want to address in the meeting. Review last meetings’ action plan and progress made to date. If no progress has been made, problem-solve why and how to proceed from this point.
  - Identify if someone else is able to assist or do the task
  - This increases accountability
- Proceed with agenda
- Ensure all people present contribute; ask for their input or thoughts and opinions.
- Keep the action plan updated with new tasks, who will do them, and by when.
  - Improves accountability
  - Keep “to do’s” for future meetings

- Type up notes and the action plan after each meeting and send to all team members
- Use clear and concise language.
- Every note should acknowledge the positives in the system. Willingness to work together is a great positive and should be acknowledged regularly.

# START REFERRAL AND INTAKE FORMS

\*\*While all forms included in this manual are highly recommended, some START Programs elect to use forms that designed differently. Adherence to the START Model requires the attainment of bio-psycho-social information outlined in these forms, not the use of the forms themselves. START forms that are required WITHOUT modification are: the CSCPIP, CSE and START Plan along with standardized assessment tools (ABC, MEDS, RSQ)

## START Referral Form

**Name of Individual:**

**DOB:**

**Date of referral:**

**Address and Phone number:**

Street \_\_\_\_\_ 1:  
Street \_\_\_\_\_ 2:  
City, \_\_\_\_\_ State, \_\_\_\_\_ Zip:  
Phone Number:

**Referred by:**

Name \_\_\_\_\_ & \_\_\_\_\_ Title:  
Area \_\_\_\_\_ Agency:  
Phone \_\_\_\_\_ Number:  
E-mail Address:

**DSM diagnoses: (DSM IV or DSM V without Axis information)**

- I.
- II.
- III.
- IV.
- V.

**Please answer all questions. For any of the areas listed below, please use the back of the page for additional space if needed. Please provide additional clinical reports, consultations and case summaries pertinent to the case as supplemental documents.**

**1) Reason for referral/concerns/issues presenting problem: How long has this been going on?**

Please describe the onset of the problems/concerns; *please describe what you would like from consultations services:*

**2) Medical issues/illnesses:**

**3) Service history including hospitalizations and residential placements:**

Date (begin with current and go backwards)	Name of hospital/service provider	Outcomes/results
_____	_____	_____

**4) Psychosocial well-being:**

- i. Emotional upsets/significant issues/areas of concern: \_\_\_\_\_*
- ii. Recent changes in social functioning: \_\_\_\_\_*
- iii. Problems with expectations and supports (day program/residential/recreational): \_\_\_\_\_*
- iv. Changes from baseline or concerns re: eating, sleeping, toileting, mood: \_\_\_\_\_*
- v. Skills and abilities: \_\_\_\_\_*
- vi. List symptoms or target behaviors: \_\_\_\_\_*
- vii. Describe how the individual was doing when he/she was doing his/her best (include medications, services, date and description of presentation): \_\_\_\_\_*
- viii. Other issues to be addressed: \_\_\_\_\_*

Contact/Treater Name	Contact/Treater Phone Number	
Primary:	Phone Number:	Alt Number:
Other Contact:	Phone Number:	Alt Number:
Other Contact:	Phone Number:	Alt Number:
Other Contact:	Phone Number:	Alt Number:
Other Contact: _____	Phone Number: _____	Alt Number: _____
Other Contact: _____	Phone Number: _____	Alt Number: _____

<p>For START Team Use</p> <p>Only:</p> <p>Intake:    /   /</p> <p>Coordinator int:</p>
--

**START Intake Form**

Referral Date:	Individual's Name:
Medicaid Number:    -   -   -	Record #:
Date of Birth:        /        /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Person completing Intake and Assessment:		Position:
Agency:		
Phone:    -   -	Cell/Pager:    -   -	E-mail:
Referral Source:	If other, please indicate:	
Area Agency:	START Coordinator:	
Family contact information:		
START Regional team:		
Phone:    -   -	Cell/Pager:    -   -	E-mail:

Legal Guardian (if any):		
Relationship to individual:	Restrictions on authority:	
Address:		
City:	State/Zip Code:	
Phone:    -   -	Cell/Pager:    -   -	Work:    -   -
E-mail:		

Primary Service Agency:		
Contact:		
Phone:     -     -	Cell/Pager:     -     -	E-mail:

Other Service Providers

Service	Provider Agency	E-mail address	Contact person	Phone

I. REFERRAL SUMMARY INFORMATION

A. Reason(s) for Referral (Please check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Physical aggression  | <input type="checkbox"/> Threats of physical aggression | <input type="checkbox"/> Verbal aggression           |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Suicidal ideation/threats      | <input type="checkbox"/> Hallucinations or delusions |
| <input type="checkbox"/> Self-injury          | <input type="checkbox"/> Change in mood                 | <input type="checkbox"/> Other:                      |

Risk Assessment attached:  Yes  No

Describe the problem(s) leading to the referral:

Duration of problem(s): When did it start? How long has it been going on?		
Target behavior(s): List and define		
Frequency and intensity of the problem/target behaviors		
Monitoring Methods: Rating scales, behavior tracking, etc.		
Description of possible precipitants: What may cause or "set off" problem(s)?		
Time of Day: When are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Settings: Where are behaviors most and least likely to happen?	Most Likely:	Least Likely:
People: With whom are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Activity: During what activities are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Description of aggravating factors: What makes this problem worse?		

Description of alleviating factors: What makes this problem better?	
When was the last time this person was doing well?	
What were the circumstances at that time and what was s/he like?	

B. Changes in Person's Behavior in Last 6 Months: Please check one in each area

Energy Level	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change
Appetite	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change
Weight	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change
Sleep Amount	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change
Sleep Pattern	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Falls asleep early in PM	<input type="checkbox"/> Sleeps too late
	<input type="checkbox"/> Awakens during night	<input type="checkbox"/> Awakens too early in AM	<input type="checkbox"/> No Problem
	Is the sleep pattern new?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Average sleeping time	Hours	Average awake time?	Hours
CPAP machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Urinary Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a new issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fecal Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a new issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a new issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Interest	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change
Sexual Activity	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> No Change

Menses (women only)	Dates of last two cycles:		
	Usual cycle length:            days	Usual days of flow:            days	
	Typical cycle: <input type="checkbox"/> regular <input type="checkbox"/> irregular <input type="checkbox"/> painful <input type="checkbox"/> not a problem		
	Menstrual flow: <input type="checkbox"/> heavy <input type="checkbox"/> moderate <input type="checkbox"/> light		
Menopausal (women only) <input type="checkbox"/> Yes <input type="checkbox"/> No		Recent onset of menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change	
Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change	
Abuse Alcohol or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug of choice, if applicable:	
Please explain the onset of any new issues or any changes of behavior, as noted above:			

C. Current & Past Treatment Summary (attach additional information, if available):

Current Psychological, Behavioral or Substance Abuse Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, summarize below:
Treatment Reason(s):	
Treatment Methods or Modalities:	
Where:	
Outcome or Progress:	

What is the evidence for success and/or failure of these treatments?	
--	--

Past Psychological, Behavioral or Substance Abuse Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, summarize below:
Treatment Reason(s):	
Treatment Methods or Modalities:	
Where:	
Outcome or Progress:	
What was the evidence for success and/or failure of these treatments?	

D. Current Medication (attach additional medication information if necessary)

Medication	Diagnosis/ Reason for medication	Dosage	Schedule	Compliant	Side effects experienced	Prescribing Doctor	Date started
				<input type="checkbox"/> Y <input type="checkbox"/> N			
				<input type="checkbox"/> Y <input type="checkbox"/> N			
				<input type="checkbox"/> Y <input type="checkbox"/> N			

E. Previous Medication Trials:

Medication	Diagnosis/ Reason for medication	Dosage	Prescribing Doctor	Date discontinued	Reason for discontinuation of medication

F. Medication, Food, Environmental, or Other Allergies:

No Known Allergies (NKA)    No Known Drug Allergies (NKDA)    Latex allergy

Medication/drug allergy & significant reaction history:  Yes    No (If yes, describe & indicate dates/year)

Medication	Allergic Reaction	Date/Year

Food and other allergies & significant reaction history:  Yes    No (If yes, describe & indicate dates/year)

Food & Other	Allergic Reaction	Date/Year

Seasonal Allergies & Significant Reaction History:  Yes  No (If yes, describe & indicate dates/year)

Seasonal	Allergic Reaction	Date/Year

II. DIAGNOSIS AND MEDICAL HISTORY

A. DSM-IV Diagnoses: For DSM-V copy exactly as written

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

B. Current Diet:

Food Consistency:  Regular  Pureed  Soft  Chopped  Other (Describe)

History of Choking Episodes:  yes  no

C. Other Medical Issues or Diagnoses:

1. Heart problems or congenital heart defect:  Yes  No

If yes, does the person require antibiotics prior to dental work?  Yes  No

2. Asthma:  Yes  No

If yes, does the person use an inhaler?  Yes  No

Does the person take oral medications to control asthma  Yes  No

Date of last asthma attack: \_\_\_\_\_

3. Diabetes:  Yes  No

If yes:  Type I (Insulin Dependent)  Type II (Non-Insulin Dependent)  Gestational

Does the person take oral medications to control diabetes?  Yes  No

Does the person receive insulin injections?  Yes  No

Can the person self-administer insulin injections?  Yes  No

Is the person currently on a sliding scale insulin?  Yes  No

4. High blood pressure:  Yes  No

5. Seizure disorder:  Yes  No

Date of last of last seizure? \_\_\_\_\_

How many seizures has the person had in the last month? \_\_\_\_\_

How long do the seizures typically last? \_\_\_\_\_

Is the person currently followed by a neurologist?  Yes  No

Does the person have a "PRN" medication for seizure activity?  Yes  No

PRN medications for seizures must have specific written guidelines from the physician.

5. High cholesterol:  Yes  No

6. Kidney problems:  Yes  No

7. History of urinary tract infections:  Yes  No

Date of last UTI: \_\_\_\_\_

8. History of MRSA infection:  Yes  No

Date of MRSA infection: \_\_\_\_\_

Location of MRSA infection: \_\_\_\_\_

9. Does the person currently have a/any open skin wounds or lesions?  Yes  No

10. Bleeding problems:  Yes  No

11. Cystic Fibrosis:  Yes  No

12. Head or spinal cord injury:  Yes  No

If yes, when did the injury occur? \_\_\_\_\_

If yes, Please provide specifics regarding type of injury and how it occurred?

\_\_\_\_\_

13. Multiple Sclerosis:  Yes  No
14. Spina Bifida:  Yes  No
15. Muscular Dystrophy:  Yes  No
16. Orthopedic impairment:  Yes  No
17. Cerebrovascular disease:  Yes  No
18. Parkinson disease:  Yes  No
19. Huntington's disease:  Yes  No
20. Hyperthyroidism:  Yes  No
21. Hypothyroidism:  Yes  No
22. Vitamin B12 deficiency:  Yes  No
23. History of migraine headaches:  Yes  No

Date of last migraine: \_\_\_\_\_

What triggers the migraine? \_\_\_\_\_

24. GERD/acid reflux  Yes  No
25. Dental problems  Yes  No

E. Other Disabilities:

- Autism spectrum  Cerebral Palsy  Deaf  Hard of hearing
- Fragile X  Prader-Willi  Speech/Communication  Substance abuse
- Traumatic brain injury  Vision impairment  Blind  Undetermined
- Other (please indicate):

F. General Physical Description

Height:	Weight:	Hair Color:	Eye Color:
Please describe any other unique physical characteristics (i.e. tattoos, scars, skin complexion, etc.):			

G. Etiology (Cause) of Intellectual Disability:

- Down syndrome     Environmental exposure     Fetal alcohol syndrome     Fragile X  
 Hydrocephalus     Infectious disease     Prenatal infection     Stroke  
 Traumatic brain injury     Undetermined  
 Other (please indicate):

H. Cognitive Disability Functioning:

Area	Level	Test(s) Performed	Test(s) Date	Result(s)	Report Available?
Cognitive IQ					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptive					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Please attach any available reports and/or documentation from additional reports performed.

I. Sensory & Physical Functioning:

Area	Impairment	Issue description include acute sensitivities – sight, sound, tactile, environmental, etc.	Equipment
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tactile	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Communication			
Ambulation			

J. Basic Skills – Level of Assistance

Skill	No Prompt	Verbal Prompt	Gestured Prompt	Partial Assist	Full Assist	Description
Mobility	<input type="checkbox"/>					
Eating & drinking	<input type="checkbox"/>					
Dressing	<input type="checkbox"/>					
Toileting (urine)	<input type="checkbox"/>					

Toileting (feces)	<input type="checkbox"/>					
Menstruation	<input type="checkbox"/>					
Bathing (shower)	<input type="checkbox"/>					
Bathing (bath)	<input type="checkbox"/>					
Fire evacuation	<input type="checkbox"/>					
Telephone use	<input type="checkbox"/>					
Money skills	<input type="checkbox"/>					

K. Developmental History & Biopsychosocial Timeline (Attach additional information if needed.)

Stage	Major issues?	Description of significant factors or Issues	Dates/Yr (approx.)
Prenatal development & birth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Childhood development, behavioral and/or medical	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Puberty & adolescent development, behavioral and/or medical	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Adult behavioral and/or medical	<input type="checkbox"/> Yes <input type="checkbox"/> No		

L. Family Medical History

Document family history of medical, neurological, psychiatric, and developmental conditions. Note such occurrences as overt symptomology, suicide attempts and completions, substance abuse, psychiatric hospitalizations, and any other psychological or behavioral treatments

Relative	Description
<input type="checkbox"/> Father	
<input type="checkbox"/> Mother	
<input type="checkbox"/> Brother	
<input type="checkbox"/> Sister	

<input type="checkbox"/> Grandfather <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	
<input type="checkbox"/> Grandmother <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	
<input type="checkbox"/> Other (identify):	
Additional Information:	

M. Hospitalization and Developmental Center Admission History (Attach additional information, if needed.)

Psychiatric or Substance Abuse Hospitalizations

Hospital & Location	Primary Reason	Involuntary?	Dates	Discharge summary avail?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Medical or Surgical Hospitalizations

Hospital & Location	Primary Reason	Dates	Discharge summary avail?
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No

4.			<input type="checkbox"/> Yes <input type="checkbox"/> No
----	--	--	--

Developmental Center Admissions

Center & Location	Primary Reason	Involuntary?	Dates	Discharge summary avail?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

N. Primary Care Physician and Psychiatrist

Doctor	Location	Date of Recent Visit	Visit Frequency	Notes available?
Primary:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatrist:				<input type="checkbox"/> Yes <input type="checkbox"/> No

O. Specialty Consultations (Include Ind. & Family Therapies and Dental)

Name	Specialty	Location	Date of Recent Visit	Report/Notes available?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

P. Lab and Medical Test Results

Test	Facility	Results	Date	Report available?

Blood tests				<input type="checkbox"/> Yes <input type="checkbox"/> No
EEG				<input type="checkbox"/> Yes <input type="checkbox"/> No
Imaging				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional information:				

### III. NATURAL SUPPORTS, ACTIVITIES & SERVICES

For each section please describe, note changes, dates, and especially any systemic responses to the problem(s) which resulted in this referral.

Current Living Situation:

- Community                       Supervised group living                       Supported living  
 Foster care home support                       AFL                       Independent or <6 hours  
 Homeless, shelter                       Homeless, unsheltered                       Other:  
 Family, list with whom:

Provider, if applicable:	Living since:     /     (mm/yy est.)
Describe:	

Factor	Changes?	Describe	Dates
Moves	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Losses	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Staff changes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Housemates	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Prev. living Situation	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Spends most time with:	
<input type="checkbox"/> Family:	<input type="checkbox"/> Housemate:
<input type="checkbox"/> Friend(s):	<input type="checkbox"/> Support worker:

Educational Activity:

- |  |  |
|--|--|
| <input type="checkbox"/> High School, full mainstream  | <input type="checkbox"/> High School, partial mainstream |
| <input type="checkbox"/> High School, segregated class | <input type="checkbox"/> Compensatory Education          |
| <input type="checkbox"/> Traditional College           | <input type="checkbox"/> Non-traditional College         |
| <input type="checkbox"/> None                          | <input type="checkbox"/> Other:                          |

School:	Enrolled since:    /    (mm/yy est.)
Describe:	

Factor	Change?	Describe	Date
School or classroom	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Teacher(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous educational activities	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Vocational Activity (✓ all that apply):

- Full time job       Part time job       Workshop       Pre-Work training  
 Volunteering       Job coach       None

Activity:	Engaged since:    / (mm/yy est.)
Activity:	Engaged since:    / (mm/yy est.)
Describe:	

Factor	Change?	Describe	Date
Loss of job	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Co-worker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Job coach	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous work situation(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Community Activity (✓ all that apply):

- Day Program       Special population recreation       Faith-based group  
 Inclusive/mainstream recreation       Informal activities with family or friends  
 Clubs/support groups       Individual interest pursuit  
 None

- Participates with assistance from:  Family     Friend(s)     Support workers

Activity:	Since:    /    (mm/yy Est.)
-----------	--------------------------------

Activity:	Since: / (mm/yy Est.)
Activity:	Since: / (mm/yy Est.)

Factor	Change?	Describe	Date
Activity ceased	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Leader/instructor changes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Support worker Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Co-Participant Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous activities	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional comments:			

IV. HISTORY OF STRENGTHS & CHALLENGES (Including criminal/court activity & other target issues)

A. Strengths, Motivations, and Likes Assessment

Describe the strengths of the individual. Include in what activities he/she excels, personal strengths, interpersonal strengths. Whenever possible, be very behaviorally specific:
Describe what motivates the individual. Include <u>anything</u> that motivates the individual, especially those that he/she describes. Please be very specific.

Describe the general likes of the individual. Include anything the person likes (i.e. people, places, things, colors, activities, community events, etc.):

B. Criminal and/or Court Involvement – include all charges regardless of disposition (Include all youth and adult involvement):

Probation     Parole     None     Other:

Date (Est.)	Criminal Charge	Outcome/Disposition
/		
/		
/		

Disposition Recommendations: recommended assessments, services and supports.

VII. SUMMARY AND RECOMMENDATIONS

Summary and Impressions:

Recommendations	Description
<input type="checkbox"/> Additional assessments	
<input type="checkbox"/> Suggested targeted behavior/ symptom monitoring	

<input type="checkbox"/> Psychosocial/residential/day services modifications (describe recommended individual habilitation plan)	
<input type="checkbox"/> Other (Identify):	
<input type="checkbox"/> Other (Identify):	
<input type="checkbox"/> Other (Identify):	

VIII. SOURCES OF INFORMATION

A. Individual Interviews

Name	Program/Organization (if any)	Relationship	Date
1.			/ /
2.			/ /
3.			/ /
4.			/ /
5.			/ /
6.			/ /

B. Records Reviewed

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /

		/ /
		/ /

C. Other

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

D. Additional Sources What other agencies or supports should be included in record requests?

Where and from whom has the individual received supports that is not included in this intake?

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

## **START (Action) Plan Guide**

### **Why?**

- To project the level of involvement necessary for each case referred
  - To outline the necessary steps to provide clinical support for the individual referred
  - To outline the necessary steps to provide outreach and consultation to the system of support
- To track trends over time.
- To measure progress.
- To provide concrete data to the stakeholders regarding services rendered as well as indicating a need for additional funding in some cases.

### **DEMOGRAPHIC INFORMATION:**

**Date of START Plan Completion or Updates:** Indicate the date in which the initial START Plan is completed. Updated information can be included in following columns ONLY when necessary. Ex: a new START coordinator assigned to the case requires updating in the START Plan

**Referral Source:** Indicate who initiated the START referral. This can include community and state run service providers, natural supports and other stakeholders.

**Name of Person Referred (SIRS# or other identifying code):** If a code is not available, list the first initial and full last name of the person being referred.

**Funding Source:** Indicate which funding source applies to this individual. Funding sources can include: DD Waiver, IDD Waiver, Medicaid, Medicare, Medicaid/Medicare, private insurance, state allocated funds

**START Coordinator:** Indicate who the assigned START coordinator will be.

**Date of Referral:** List the date indicated on the START referral form.

**Date of Intake:** List the date the intake meeting occurred.

**Reason for Referral:** List as many reasons as apply. Separate numbers with commas. If you select 4 (other), please provide brief explanation.

### **CASE INVOLVEMENT/INTENSITY**

**Date of START Plan Completion:** List the date of initial START Plan completion in column one. Date of subsequent completions are listed in following columns.

**Projected Level of Involvement:** Choose which description most adequately describes the team's current functioning on a scale of 1-4 (see key)

**Involvement Intensity:** This is also based on a scale from 1-4. Involvement intensity aims to describe how involved a START coordinator feels they will need to be in order to render START services. Guidelines are listed in the Ratings Key.

**Level of Person’s Current Stability:** Coordinator should conclude person’s current level of stability on a scale of 1-4 based on descriptions listed in the Ratings Key.

**Frequency of CET/ Crisis Plan Follow Up Contacts:** If it is projected that the referred individual’s case will be presented at a CET or that a Crisis Plan will be developed, predict level of involvement for follow-up meetings or contacts on a scale of 1-4 using the “Frequency of Meetings” scale located in the Ratings Key.

**Frequency of Systems Linkage Contacts:** If it is anticipated that the referred individual’s team would benefit from a series of systems linkage meetings or contacts, use information gathered at intake to gauge how frequent these will occur (using the same 1-4 scale used for the above category).

**Anticipated Primary Mode of Contact:** Indicate the primary mode for contact-this may be predicted given the geographical locations of team members.

**Approval by Clinical Director:** This must occur when the START Plan is being completed by a START Coordinator who is not certified. Once the coordinator is certified, approval by clinical director is not necessary. However, the plan should be used and referred to as part of case review and clinical supervision and support.

**“PROJECTED/CURRENT SERVICES TO BE PROVIDED” TABLE**

**Order In Which Services Will Be Provided:** To the best of your ability, indicate in what order START services will be rendered using the table on the START Individual Action Plan. Begin by using “1”. For example: **Intake-1, Outreach Visit-2, Consultation/Linkages-3, Systems Linkage Meetings-4, Crisis Plan-5, In-home supports-6.** There may be up to 16 rankings. Number all that apply (for example, if the START program does not currently provide therapeutic respite services, these services will not be ranked)

**Services and Definitions**

Service to be provided	Definition and Examples
Triage call/ emergency assessment	An emergency phone call received on the START crisis line that requires immediate triage and response, likely resulting in an emergency assessment. Assessment can be conducted in a number of settings including: family home, residential setting, day program, hospital emergency department, etc. In an emergency situation, this may be the mode in which the initial referral is received.
Intake meeting/Preliminary	Preparing for and meeting with the individual’s team to complete initial Intake/Assessment paperwork. This includes completion of the initial

assessment	ABC and RSQ as well.
CSE	Completion of the Comprehensive Service Evaluation including receiving and reviewing records; interviewing the individual and system of support; writing the CSE; and reviewing recommendations through development of an action plan.
Cross Systems Crisis Intervention and Prevention Plan	Completion of the Cross Systems Crisis Intervention and Prevention Plan: collecting and reviewing relevant information; completing brainstorming form with team; developing/writing the plan and distributing; reviewing and revising the plan; and training on and implementing the plan with the system of support.
CET	Preparing for and holding a Clinical Education Team meeting regarding the individual referred
CET follow-up	Reviewing and identifying relevant recommendations with START Clinical Director; assist system of support with implementing recommendations.
Medication Consultation	START Coordinator and Medical Director providing consultation regarding the individual's medication regimen. Services can include: collaboration with the individual's team prior to a psychiatric appointment; accompanying the team to the appointment; medication history review by START team; and outreach provided by the Medical Director to the prescribing psychiatrist.
Medication consultation follow-up	Any follow-up needed in order to facilitate any recommendations as a result of the consultation. This follow-up can be in the form of face-to-face meetings or phone or email contact.
Team case consultation	This includes any consultation provided by the START Team directly to the individual's team. Examples: consultation regarding behavior support plans, person centered planning, transition planning, educational meetings specific to the individual's diagnostic and clinical needs.
Consultations/Linkages	This category includes times in which the START Coordinator will facilitate consultations with psychiatric or multidisciplinary team of experts. Can also include START Coordinator linking the individual to services including case management/care coordination, outpatient mental health services, day supports or in-home supports.
Outreach visits	Any time in which the START Coordinator provides education or outreach to the system of support related to general issues or specific to the individual referred. Individuals in which the START Coordinator may provide outreach to: families/natural supports; residential programs, day programs, schools, mental health facilities or any entity that may seek or need additional outreach and education.
Anticipated center-based	Mark "Y" or "N" depending on whether it is projected that the individual

supports?	referred will utilize START center-based supports (respite) within quarter
Planned	Mark if it is projected that the individual will utilize START center-based supports (respite) for planned admissions. Project the number of visits that will be facilitated throughout the quarter.
Emergency	Mark if it is projected that the individual will utilize START center-based supports for an emergency respite stay.
Site-based	Mark if it is projected that support will be provided at the START facility
In-home	Mark if it is projected that support will be provided in the individual's place of residence

**Frequency of Contacts:** Indicate the projected frequency of contacts necessary in order to complete the service. For example, a Cross Systems Crisis Intervention and Prevention Plan's projected date of completion is 45 days. During that 45 days, the START Coordinator identifies that *bi-monthly meetings* will have to occur in order to complete, review and assist with implementation of the plan.

**Date of Completion:** Indicate the date when each service was rendered.

**ABBERANT BEHAVIOR CHECKLIST (ABC) SCORES:**

These scores will help to gather information as to whether or not the person's overall behavioral presentation has improved with the addition of START services.

\*ABC's should be completed annually and/or at time of case inactivity.

**ABC score at intake:** Record date ABC was completed and initial cumulative score here.

**ABC Score at follow up:** Record date follow up ABC was completed and cumulative score here.

**UMass RECENT STRESSORS QUESTIONNAIRE (RSQ):**

This tool helps to gather information as to possible bio-psycho-social stressors that may be factors in maintaining stability of the individual and/or the individual's system of support.

\*The RSQ should be completed at the time of intake and any crisis event that occurs.

**TEAM'S CURRENT CONCERNS AND ADDITIONAL NOTES:**

Include any current concerns in this section. If a score of 3 or higher is given in any of the above categories, a projected plan of action to address it can also be included. It is important to address both clinical treatment recommendations as well as interventions to provide outreach and education to the individual's system of support.

# START PLAN

**START PLAN \*\*Complete every 3 months for first year of case activity.**

**\*\*In second year of activity: Level of Involvement, Involvement Intensity rank 3-4: complete every 3 months**

**Level of Involvement, Level of Intensity 1-2: complete every 6 months**

## DEMOGRAPHIC INFORMATION:

Client Name:

Date of Referral:

Referral Source:

Funding:

START Coordinator:

Date Assigned:

START Coordinator:

Date Assigned:

## REASON FOR REFERRAL (1-4, please check all that apply)

4 - Externalized Behavioral Dyscontrol (may include physical and/or verbal aggression, self-injury, property destruction)

3 - Complicated Medical/Neuro

2 - Clinical Consult

1 - Other

<b>CASE INVOLVEMENT/INTENSITY</b>	<b>Date of Initial Plan:</b>	<b>Date of Update:</b>	<b>Date of Update:</b>	<b>Date of Update:</b>
Projected Level of Involvement (1-4)*				
Involvement Intensity (1-4)**				
Level of Person's Current Stability (1-4)***				
Frequency of CET / Crisis Plan Follow Up Contacts (1-4)****				
Frequency of Systems Linkage Contacts (1-4)****				
Anticipated Primary Mode of Contact (1-4)				

## Ratings Key

### Involvement: \*

- 1 - Team is stable, START Coordinator to provide monitoring, support, and outlined START services.
- 2 - Team is functioning adequately. START Coordinator will provide frequent check-ins.
- 3 - Moderate intervention is needed
- 4 - Intensive intervention is needed- Team is in crisis.

### Involvement Intensity: \*\*

- 1 - **Inactive**- Team reports individual is stable, at baseline, currently not in need of START supports. Semi-annual follow up.
- 2 - **Low**- Quarterly team meetings, CET referral, Comprehensive Service Evaluation, development of Crisis Plan.
- 3 - **Moderate**- Monthly to bi-monthly team meetings, active work on Crisis Planning, Comprehensive Service Evaluation, potential outreach visits, consultations and/or linkages to other resources.
- 4 - **High**- Monthly (or more) team, hospital, neurological or psychological consult meetings, active work on Crisis Planning, psychiatric or multidisciplinary consultation follow ups, potential outreach visits.

### Stability: \*\*\*

- 1 - Person is currently stable- Individual is at baseline.
- 2 - Person is moderately stable- Individual is experiencing episodic difficulties (is not at baseline), team has identified significant issues, individual is experiencing decreased adaptive functioning (ex: decrease in ADL's, attention to tasks, changes in sleep and/or appetite).
- 3 - Person is not stable- Individual is experiencing ongoing behavioral difficulties, placement is at risk. Additional resources have been added to support the individual. The individual is presenting with complex behavioral, medical, or trauma-related issues that have appeared to deteriorate over the past months or years.
- 4 - Person is in crisis- Individual is currently hospitalized or has had multiple emergency evaluations. Individual has lost placement or has experienced multiple placements over the past 12 months. Individual experiencing major traumatic event, i.e., loss, significant changes, etc.

### Frequency of Meetings (Avg. 1 hour): \*\*\*\*

- 1 - Minimum: 1 to 3 meetings per year
- 2 - Low: 3-6 meetings per year
- 3 - Moderate: 6-9 meetings per year
- 4 - High: 9-12+ meetings per year

### Anticipated Primary Mode of Contacts:

- 1 – CC –Conference Call
- 2 – FTF – Face to Face/Outreach contact
- 3 – CC/FTF – Combination of both modes
- 4 – NK – Not known/cannot be determined at time of review

**PROJECTED / CURRENT SERVICES (Approved by Clinical Director)**

Projected/Current Services to be Provided (update every time START plan is completed)	Order in which Services will be provided (rank 1-14)	Frequency of Contacts				Date Completed
		1 <sup>st</sup> Q	2 <sup>nd</sup> Q	3 <sup>rd</sup> Q	4 <sup>th</sup> Q	
Triage Call/Emergency Assessment						
Intake Meeting/Preliminary Assessment						
CSE						
Cross-Systems Crisis Plan						
CET						
CET Follow Up						
Rx Consult						
Rx Follow Up						
Team Case Consult						
Consultations/Linkages						
Outreach visits						
Anticipated Therapeutic Supports? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, end ranking at 11)						
Planned Center Based Supports						
Emergency Center Based Supports						
In-home Therapeutic Supports						

Recent Stressors Questionnaire	
	Completed? <input type="checkbox"/> Y/N <input type="checkbox"/>
Intake	<input type="checkbox"/> Y/N <input type="checkbox"/>
Every Crisis	<input type="checkbox"/> Y/N <input type="checkbox"/>

Use \* to indicate different responder at time of follow up

Aberrant Behavior Checklist Cumulative Score		
	Score	Date
Intake		
Annual or D/C		

Team's Current Concerns and Additional Notes:

# START ASSESSMENT INSTRUMENTS

## Aberrant Behavior Checklist (ABC) Overview

The *Aberrant Behavior Checklist (ABC)* (Aman and Singh, 1986) is an important instrument and has been used in hundreds of studies and is translated into 23 languages (Aman, 2010). The outstanding psychometric properties of the ABC have been extensively demonstrated. The ABC performs well in repeated assessments, which is important when following individuals for a long time. In addition, research showed that different informants tend to report similarly. Thus, it is a strong instrument that has great flexibility.

The *Aberrant Behavior Checklist (ABC)* is a behavior symptom rating scale for assessing problem behaviors of children and adults with intellectual disability at home, school, residential facilities, ICF/ID's, and work training centers. This rating scale is an "informant" rating scale, meaning that a person-caregiver who knows the person well fills out the form. It is easily used to track progress. For example, ABC scores from intake to one year of START services have been shown to decrease.

The ABC contains 58 items distributed on five subscales and they are: Irritability (15 items), Lethargy-Social Withdrawal (16 items), Stereotypic Behavior (7 items), Hyperactivity – Noncompliance (16 items), and Inappropriate Speech (4 items). Items are scored on a 4-point scale (0 to 3). The number of items in the scales is quite uneven, ranging from 16 to 4. Thus, it is very appropriate to always report the total score (#/174) and individual scale scores in relationship to the maximum possible score for each scale (#/ scale possible total). (see more information and examples below).

## When to Administer the ABC

The ABC should be administered for all individuals served by START at Intake and every 12 months after or when the case is made inactive. It may also be used for reevaluation at any time. The ABC scores available should also be reported when an individual is presented at a CET.

## Administering the ABC

Those who will be administering the ABC must watch the training video on the START web site in the ABC area. When asking anyone to complete a rating scale, it is important to enlist their cooperation by stressing the importance of the assessment and providing a quiet space. In addition, for the ABC it is important to always give the informant the "Individual Items with Specific Examples" list for the behaviors on the ABC. A modified version is available on the START web site in the ABC section. The list in the manual uses "outdated" language and the list on the website is updated for current use. This list gives more information about specific items on the ABC that may need clarification for the informant. I recommend keeping this with the ABC materials in a plastic sheet protector.

## Reporting ABC Scores

The ABC should always be reported in the *CET Presentation* in Section #3: “*History of any emotional, psychiatric, neurological problems throughout life from birth*”

The example below is the best way to report scores. Several people reported on the individual to be assessed. These scores show a great consistency across settings in the ratings by different informants. This is always not the case, and that would be important for interpretation. Using several informants gives us stronger information to understand the person better and therefore plan more effective supports. However, this may always not be possible.

### Sample of Reported Scores

#### Reporting of ABC Scores (Aberrant Behavior Checklist) Dates Administered: July 1, 2013

ABC Area Scores	Total possible	Parent	Work Supervisor
Irritability	45	16	28
Lethargy	48	5	10
Stereotypy	21	3	4
Hyperactivity-Noncompliance	48	14	19
Inappropriate Speech	12	7	2

## Interpreting the ABC

The ABC set and manual purchased by your START office has information including normative data, however, much is outdated. The ABC is best interpreted simply as a marker for types of problem behaviors and then scores are used for tracking improvement or worsening of these symptoms. Three key subscales, however, do suggest a possibility of particular psychiatric conditions and they are: Irritability (depression, bipolar disorder, ADHD, PTSD); Lethargy (depression); Hyperactivity-Noncompliance (depression, bipolar disorder, ADHD).

## Final Thoughts

The ABC is an outstanding instrument that can provide valuable information for initial assessment and for effectiveness of supports. Please keep the original ABC in the individual's file. Reassessment is recommended when changes have occurred in behavior and symptoms, for following an individual on a regular basis (e.g., every 6 months), or when tying the ABC to the effectiveness of psychopharmacological changes. These extra assessments are optional.

# Family Experiences with Mental Health Services for Persons with Intellectual and Developmental Disabilities\*

Respondent ID #: \_\_\_\_\_

*(Interviewer Instructions: Please use the individual's local ID from SIRS)*

Date of Interview: [Click here to enter a date.](#) Time Began: \_\_\_\_\_ Time Ended: \_\_\_\_\_

Hello my name is \_\_\_\_\_. We are conducting this survey to learn more about the mental health services in your community for people with an Intellectual or developmental disability (IDD), including autism, who also have a co-occurring behavioral/mental health need. Before I ask you about your service experiences, I would like to know a little bit about your situation at home.

What is the first name of your family member with IDD? \_\_\_\_\_

*(Interviewer Instructions: Insert the name of the individual with IDD if known. If not known, use "your family member")*

County where (name) lives: \_\_\_\_\_

County where services are received: \_\_\_\_\_

What services does (name) currently receive? (Check all that apply):  IDD Services  MH Services

Special Education  Other, please describe \_\_\_\_\_

Where does (name) receive services?  Community Mental Health Center  Private Clinic

Provider Site  PCP  School  Home/Group Home  Other, please describe

Your relationship:  Parent  Step-parent  Sibling  Grandparent  Other relative

Non-parental legal guardian  Licensed or unlicensed paid family-based provider

Other, please describe: \_\_\_\_\_

Interviewer Name and ID#: \_\_\_\_\_

**Section A: Household Information**

**A1.** In the past year, how difficult has it been caring for (name)? Choose an item.

**A2.** What is the total number of people, including yourself, presently living in your household? Please indicate everyone who lives with you at least half of the time.

<b>Relationship</b>	<b>Number of People</b>
Parents/Step-parents	
Siblings of (name)	
Children of (name)	
Other Relatives	
Other, please specify	
<b>Total in Home</b>	

**A3.** Does (name) have other siblings not living with you?  Yes  No

If yes, please specify:

<b>Gender</b>	<b>Age</b>
Choose an item.	

**A4.** Do any other members of your household help in caring for (name) on a regular basis?

Yes  No

If yes, describe who: \_\_\_\_\_

**A5.** Does your family member attend school, work or a day program during the day?

Yes  No

If yes, where does he/she go? (check all that apply)

School  Vocational Training  Work  Day program

Other, please describe: \_\_\_\_\_

## Section B: Family Evaluation of Mental Health Services

The next series of questions asks for your opinion about available services for your family member. I would like your general impressions of the mental health services you have used in the past year.

For each of these questions please rate using the following scale:

**1=Not at All 2= Very Little 3=Some, but not as much as I wanted/needed 4=All that was wanted/needed**

*(Interviewer Instructions: Do not read the option "Did not know/answer", but simply mark it if the respondent does not know or cannot answer a question.)*

**B1.** Over the past year, how much information did you receive from your family member's mental health professionals (psychiatrist, therapist, case manager, etc.) regarding his/her illness? Choose an item.

**B2.** How much assistance did you get from mental health professionals regarding what to do if there were to be a crisis involving your family member? Choose an item.

**B3.** How much information did you get from mental health professionals regarding whom to call if there were to be a crisis involving your family member? Choose an item.

**B4.** How much were you encouraged by mental health professionals to take an active role in your family member's outpatient treatment? Choose an item.

**B5.** During the past year, how much did mental health professionals respond to your concerns about your family member? Choose an item.

**B6.** How much did mental health professionals take into account your ideas and opinions about your family member's treatment? Choose an item.

**B7.** When you had your family member's permission, how much did mental health professionals involve you in his/her treatment? Choose an item.

**B8.** During the past year, how much did outpatient service providers recognize the burdens that family members like you face? Choose an item.

**B9.** For the most part, did you accompany your family member to his/her psychiatric or mental health appointments? Choose an item.

Yes No

If yes, how much contact did you have with any mental health professional on any matter pertaining to your family member's care? Choose an item.

**B10.** Were the available mental health services for your family member the ones you thought were needed? Choose an item.

**B11.** How much opportunity was there for you to express your opinion to mental health providers about the treatment your family member received? Choose an item.

**B12.** How much opportunity did you or your family member have to choose between different mental health service options? Choose an item.

**B13.** During the past year, how much opportunity did you or your family member have to choose a particular case manager or therapist? Choose an item.

**B14.** During the past year, how convenient was it for your family member to use mental health services (i.e. were services easy to access)? Choose an item.

Could not access    Difficult to access    Somewhat difficult to access    Somewhat easy to access    Easy to access

If services were not easy to access, what were the primary barriers? (Check all that apply)

Services too far away    Transportation Issues    Inconvenient hours

Other, please describe: \_\_\_\_\_

**B15.** During the past year, have the services offered been flexible enough to meet the needs of you and your family member. Choose an item.

Not flexible at all    Some flexibility, but not as much as needed/wanted    As flexible as needed

**B16.** During the past year, in general how satisfied were you with the outpatient mental health services your family member received? Choose an item.

Not satisfied at all    Somewhat dissatisfied    Somewhat satisfied    Very satisfied

**B17.** How much did you feel that the mental health system was responding to the wishes of family members like yourself? Choose an item.

**B18.** During the past year, how much say did you have in the outpatient mental health services that your family member received? Choose an item.

**B19.** How much satisfaction did you feel about your role in your family member's treatment? Choose an item.

**B20.** In the past year, did your family member use in-patient psychiatric services? Choose an item.

Yes    No

If yes, were the inpatient services that your family member received helpful to him/her in your opinion? Choose an item.

**B21.** How much help was available to you at night or on weekends if your family member had a crisis: Choose an item.

**B22.** Are there options outside of the hospital for individuals experiencing a crisis to go for help (i.e. crisis/hospital diversion beds)? Choose an item.

**B23.** Who was the primary source of information about your family member's mental health services?

- Your family member him/herself    His/her service coordinator    His/her therapist  
 His/her psychiatrist    No one    Other

If other, please specify: \_\_\_\_\_

**B24.** During the past year, how much involvement did you want to have in your family member's treatment plan? Choose an item.

- A lot    Some    Very little    None at all

**B25.** Was there any particular service that your family member needed that was not available? Choose an item.

- Yes    No

If yes, please describe the service: \_\_\_\_\_  
\_\_\_\_\_

**B26.** What advice would you give to service planners regarding the mental health service needs of persons with IDD and their families?

### Section C: Background Information

Thank you for taking the time to answer these questions. I will end the survey by asking you some general information questions about you.

**C1.** What is your age? \_\_\_\_\_

**C2.** What is your gender?  Male  Female

**C3.** Are you currently?  Married  Living with a partner  Widowed

Separated  Divorced  Never married

**C4.** What is the highest grade of school or year of college you have completed?

No schooling  Elementary Schools  High School

Some College  College Degree  Graduate/Professional Degree

**C5.** Are you currently working?

Full time  Part time  Retired  Volunteer work  Not working

**C6.** How would you describe your own health over the past year?

Excellent  Good  Fair  Poor

**C7.** Do any other family members in your home have a disability? Choose an item.

If yes, please specify below:

<b>Relationship</b>	<b>Number of People</b>
Parents/Step-parents	
Siblings of (name)	
Children of (name)	
Other Relatives	
Other, please specify	
<b>Total in Home</b>	

**C8.** Please tell me which best reflects your total family income before taxes from all sources (including (name) if he/she lives with you)?

Less than \$10,000    Between \$10,000 and \$29,000    Between \$30,000 and \$49,000

Between \$50,000 and \$69,000    Between \$70,000 and \$89,000

Between \$90,000 and \$99,000    Over \$100,000

**C9.** To the best of your knowledge, is your family member Medicaid eligible?    Yes  
 No

**C10.** Would you like to add anything before we end?

### **Section D: Interviewer Observation Questions**

*(Interviewer Instructions: Answer these questions immediately after the interview. Do not discuss them with the respondent.)*

**D1.** During the interview, was the respondent generally: Choose an item.

**D2.** In general, how quickly did the respondent respond to questions? Choose an item.

**D3.** What is your perception of respondent's intelligence? Choose an item.

**D4.** How truthful did respondent seem? Choose an item.

**D5.** Was the interview conducted: Choose an item.

**D6.** Did respondent have difficulty understanding any questions? Choose an item.

If yes, please list the question number(s): \_\_\_\_\_

**D7.** What else, if anything, will help us interpret the data or give us a better understanding of the interview situation? [Click here to enter text.](#)

**D8.** I certify that I administered this interview with the designated respondent, that I followed all question specifications, and that I will keep all information obtained during the interview confidential. Choose an item.

Please list your interviewer ID#: \_\_\_\_\_

## The Recent Stressors Questionnaire - RSQ

*Laurie Charlot, PhD*

The RSQ was developed as a tool to help assess adults with IDD who are having increased emotional or behavioral problems, or are “in crisis” due to suspected acute mental health concerns. The survey touches on a number of areas, and is meant to help clinicians gather a broad range of information about factors that are known to contribute to alterations in mood, behavior and mental status. The RSQ provides a “starting point” for the clinician to further explore the contribution of stressful events and factors to the current “presenting problem.” Research has shown that all people (with and without IDD or Autism Spectrum Disorder) are at greater risk of mental health disorders when experiencing stress. The events and occurrences we each experience as stressful is individual, but some aspects of having a neurodevelopmental disorder and being a person treated with psychoactive medications likely amplify such risk. This includes the presence of an abnormal or “fragile” neurological substrate (being born with cognitive and developmental challenges and atypical brains), often having restricted life experiences (being “sheltered” at times from usual experiences), having others be in control of where one lives and works, and having functional communication challenges.

At times, we have found that even very devoted providers or loved ones may inadvertently under-report certain potential sources of stress. This is not because people are not caring, but rather, because it is extremely challenging to recognize all of the varied influences on mood and behavior when helping individuals who cannot accurately or reliably self-report. We tend to focus on reporting about aggressive and self-injurious behavior because this is usually the reason help is sought.

Individuals with IDD or Autism Spectrum Disorder unlike many people, may appear more psychiatrically debilitated when they are actually experiencing a transient response to an intense stressor. It is important to follow – up to determine if a psychosocial or non-medical stressor is causing the person to be overwhelmed. This needs to be differentiated from an acute psychiatric condition like psychosis or mania. Because of “developmental effects” on psychiatric manifestations, it is also important to assess whether or not the person is engaging in stress induced behaviors that are typical for someone with a particular developmental profile. For example, a person who has lost a loved one might report seeing and talking to them after their death. A person with IDD might lack social awareness that this sounds unusual, report this during a mental health assessment, and be

deemed psychotic when they are really having a time-limited stress related response. Or, a person with ID under stress may become more restless and have more “tantrum” like behaviors, which might be viewed as evidence of a manic episode, if they are also not sleeping well. Stressful events may trigger an actual acute psychiatric episode. However, it is key to determine if the period of difficulty is more consistent with a psychiatric condition (has a clinical course and history that is consistent with this), or is a more transient reaction to recent highly stressful events. Making these distinctions is obviously important for a number of reasons. A key issue, however, is that medications will likely play a smaller role when there is a clear, known triggering event, and the person can be helped to get through a time-limited, difficult phase in their life.

Many individuals with IDD and Autism Spectrum Disorders have difficulty adjusting to changes in routines (evident across a number of RSQ items). The key, as with all stress, is the extent to which the change is meaningful to the individual. People with a clear history of problems managing even small changes are at greater risk when these events occur. Stress places us at risk for mental health challenges, but also for health problems, especially when stress becomes chronic.

Following is a brief discussion of each of the key areas addressed in the RSQ, with suggestions for follow-up on items for which informants have reported a “yes.” It is recommended that multiple informants participate in responding to the RSQ, and that these be people who know the individual well. It is helpful if respondents individually or collectively know the individual across settings and times of day. The clinician may then review the items that received a “yes” in a direct discussion with informants, to get more detailed information about these occurrences. Placing these reports into an overall timeline that covers key recent events can also provide clues to the sources of difficulty. It should be noted that the RSQ covers a wider range of potential stressful events than typical surveys, and includes items that would be seen as representing more “minor” events, such as staff changes. However, these occurrences have proven to be significant in many of our cases. Over time, clinicians and caregivers learn to be on alert for the types of factors/events found to have played a role in a person's struggles in the past, allowing more prevention planning and interventions. In many cases, individuals may be brought to an ER or hospital “suddenly,” as if their problems came on abruptly. Then, on further exploration, signs of the pending “crisis” were evident for a long time, often including having experienced recent stressful life events.

### **Items Addressing Changes in Settings**

Changes including moves into a new residential, school, vocational or day setting may provoke significant stress for individuals with ID/ASD.

Changes in small aspects of a setting can have a large effect on some people, especially individuals with an ASD, including things as simple as having a new bus driver, or a new seat in the classroom. Having new peers, peers who are agitated, new task demands and other aspects of change to our daily routines also cause stress. It is important to follow-up by assessing the specific nature and meaning of these changes to the individual, as each person is different in their response to these events, though most all people find this type of change stressful. Lacking cognitive concepts of time, and not being in control of one's own schedule, can cause people to escalate behaviorally. Sometimes, people are seen as "attention seeking," when anxiety about changes results in repeated reassurance seeking.

### **Items Addressing Changes in Caretakers-Teachers**

Changes in providers of care of all types can have a significant influence on our "stress level." In a number of cases, before using the RSQ, we would only learn of a key change of a familiar and valued caregiver until far into the evaluation process. In some cases, this type of change played an important role in the etiology of the presenting problem.

### **Items Addressing Family Concerns**

A range of family issues may cause stress, as we all know. However, even small changes in the nature and amount of family contact can be extremely stressful for people with ID/ASD. Loss or illness of a family member are obvious stressors. Changes in household make-up may also cause stress, such as when a sibling moves away or returns home. At times, the real stress is related to a sibling growing up and having opportunities the individual with ID/ASD is not experiencing but wishes to, such as going to college or getting married.

### **Items Addressing Non-Medical Treatment**

Changes in a therapist or in behavioral and other treatment interventions may cause stress, and are common in the lives of individuals with ID/ASD. In some cases, treatment teams pay more attention to changes in medications when changes in non-medical interventions also have the potential to exert a powerful influence over mood and behavior. Also, when people have an acute psychiatric problem, they may temporarily be unable to meet contingencies that were reasonable for them when more emotionally stable.

### **Items Addressing Health**

Some of the most frequently missed or under-appreciated sets of influences on mood, behavior and mental status are those related to health and physical wellbeing. Externalizing behaviors are the most common "presenting problems," and may act as a "final common pathway" for distress in individuals who have a limited behavioral

repertoire. Certain medical problems are commonly found to provoke agitation in patients with ID/ASD, and require more aggressive work-ups that may not have been pursued due to the challenges involved in gaining the patient's cooperation with invasive studies or procedures. Despite the challenges, it is important to advocate for a comprehensive medical assessment, even if the patient needs desensitization, other behavioral supports, second opinions (if the medical provider is dismissive of the need to evaluate for problems where there is reasonable suspicion) and where indicated, sedation to allow for the assessment to be completed. Medical problems are missed, not because all of the physicians who saw our patients were bad. Rather, our patients are poor at self-report, physicians may not even realize how much of what they diagnose depends on a clear complaint from the patient, and because some individuals with IDD are often uncooperative with examinations.

Changes in weight, eating habits, and sleep are all possible indicators of important sources or reflections of stress, or are indicators of health or mental health conditions emerging or worsening. Changes in vision, hearing and mobility are important and contribute to emotional and behavioral difficulties. For example, a recent patient referred for evaluation had developed very severe hearing problems, and was inadvertently viewed as being intentionally non-compliant.

#### **Common medical problems of adults with ID/ASD:**

Constipation

Acid Reflux

Seizure disorders

Urinary Tract infections

Ear Infections

Skin Infections

Orthostasis (Dizziness, BP Drops when moving from lying, sitting to standing)

Headaches

Sinus Infections and seasonal allergies

Dental Problems

Sleep Apnea

Osteoarthritis

Occult Fractures

Chronic pain from neuromotor problems

#### **Items Addressing Medications**

Many individuals viewed as suffering from an acute psychiatric or behavioral decompensation have medication side effects contributing to their level of distress. Also, having had multiple recent medication changes is significantly associated with having more medical problems, more

adverse drug events and longer hospital stays. Almost all of the patients sent for urgent care or hospital admission were treated with multiple

medications, placing them at high risk of medication side effects or Adverse Drug Events (ADEs). Most people with IDD are also poor reporters of side effects, and may suffer with painful symptoms for long periods of time before the source is accurately identified. In some cases, more medications are used to treat agitation from medications. Commonly missed adverse drug events or medication side effects may cause people to feel irritable, anxious, depressed, tired or may simply lower the threshold for problem behaviors. Some of the most common or most difficult to detect are listed below.

### **Common Psychiatric Medication Side Effects Associated with Distress**

Constipation

Intensive food drive (increased appetite)

- Increased weight/metabolic syndrome

Sedation/Fatigue

Drug induced movement disorders

- Extrapyramidal Syndromes (EPS) (Muscle rigidity, Parkinsonian symptoms)
- Acute dystonic events (i.e. torticollis, oculogyric crises or OCG, acute muscle spasms)
- Akathisia (Intense motor restlessness)
- Dysphagia (Swallowing problems)

Urinary retention – causing infections/incontinence

Sleep problems

Withdrawal and drug discontinuation syndromes/effects

### **Summary**

It is unclear if having many smaller stressors is as debilitating as having experienced a single but highly traumatic event. As noted, some people seem to cope with even large changes and challenges, while others may become emotionally dysregulated in response to what seem like minor issues. The key is using the findings from the to begin to explore the unique and individual concerns of the person being assessed, and to direct support to address and manipulate influences that can be affected to reduce their impact. A number of the RSQ items when endorsed, help identify what specific psychiatric problem is present when there is one, and whether or not stress is causing something more transient.

### **References:**

Charlot, L., Abend, S., Ravin, P., Mastis, K., Hunt, A., & Deutsch, C. (2011) Non-psychiatric health problems among psychiatric inpatients with Intellectual Disabilities. *Journal of Intellectual Disability Research*, 55, 199-209.

## **Brief Overview of the MEDS**

**(Matson Evaluation of Drug Side Effects, Matson & Baglio, 1998)**  
**Anne Desnoyers Hurley, Ph.D. Updated July 2013**

The MEDS (Matson Evaluation of Drug Side Effects) was developed by Matson and Baglio (1998). It is an instrument designed specifically to suggest the presence of a side effect or adverse event related to treatment with psychiatric medicine for people with intellectual disability. The MEDS has strong psychometric properties and has been widely used in clinical settings and research. Studies of the MEDS have shown that it can predict medication side effects related to the type of medication using single and multiple medication regimens. The MEDS is administered each time a person is admitted to the Resource Center.

Because people with IDD have the highest rate of psychiatric medication prescribing for antipsychotic medications world wide, the MEDS initiative is an important way to identify side effects/adverse events and influence decisions about treatment efficacy. Most importantly, with few exceptions, people with IDD cannot speak for themselves in giving true informed consent regarding the risks and benefits of medications. Therefore, we must take extra steps to insure the best and most appropriate treatment within the role of START. As a result, the MEDS will be administered when a person stays at a START Therapeutic Center.

### **Goals of the MEDS**

The MEDS was developed specifically to assess side effects/adverse adverse events that are the result of psychiatric medicine prescribed for people with intellectual disability. The side effects listed represent a sample of the most important and frequent side effects for all classes of psychiatric medicines.

### **Brief Review of MEDS**

The MEDS is a 90-item informant interview inventory. In other words, a trained professional interviews a person/caregiver who knows the guest well. The informant is asked to judge whether a potential side effects is severe (on a 3-point scale) and if present, then how long the problem has been noticed, on a 3-point scale. The interview can take as long as 90 minutes or more. Often the informant has little information or input, however, after administration, the staff/interviewer will use other medical information available to augment the interview information, in addition to any observations of the person while at the Center. Thus, the final scores are a combination of the interview and medical records.

### **Interpretation of the MEDS**

When interpreting the MEDS, It is important to appreciate that any “medical problem” identified (such as high blood pressure) may not be due to a side effect or adverse event. However, we want any possibility further explored by the guest’s medical team.

### **Sharing the MEDS**

After discharge from a START Center, a full copy of the MEDS completed for the guest is mailed to the involved medical providers, typically a general practitioner and psychiatrist. In addition, a letter explaining the MEDS accompanies this document and a sample is on our web site in the MEDS section.

### **Training**

All START personnel who will administer the MEDS should review the online MEDS training and complete it. Training and the START MEDS Initiative was developed by Dr. Hurley in 2012 for all START programs with Center-based Support Services, and is available on the Center for START Services’ Online Resource Center. Additional information is available on the website.

# SECTION IV:

## Conducting Comprehensive Service Evaluations

- Comprehensive Service Evaluation Overview
- Sample Procedures
- Components & Sample Forms
- Sample Completed CSEs
  - CSE Report Form
  - CSE Tool Form
  - CSE Action Plan Form
  - Sample Completed CSEs

# COMPREHENSIVE SERVICE EVALUATIONS OVERVIEW

Comprehensive Service Evaluations (CSEs) provide an in-depth review of an individual's history of services in order to identify opportunities to strengthen service outcomes for individuals with intellectual/developmental disabilities and their families in the community.

START Coordinators and Clinical Teams undergo intensive training to learn how to conduct effective Comprehensive Service Evaluations. Trainings that provide expertise on how to conduct key elements of Comprehensive Service Evaluations include:

- Initial assessment meetings with service providers, guardians, and family members
- Meeting with the individual in his or her typical setting
- Observation of the individual in a typical setting
- Comprehensive record review
- In-person meeting to review the Comprehensive Service Evaluation report, findings, and resulting recommendations and action plans
- Follow-up sessions to implement action plan

## Comprehensive Service Evaluation Process

The START teams identify individuals who will receive Comprehensive Service Evaluations. For developing START teams, members of the National START Team will provide supervision throughout the process, providing feedback, reviews and mentoring. All evaluations are co-signed and approved by your Clinical Director until the START Coordinator is certified. The CSE takes about 30 days to complete once key records are received and is an important tool to assist teams in improving their understanding of the client and of his or her service needs.

## CSE Guidelines

1. It is important to review all available records, and when records are not readily available to seek them out whenever possible.
2. Draft reports are reviewed with the START Clinical Director prior to sending them to the person's team.
3. Draft reports are sent to the team for review and discussion, and a final report, written after meeting with person's team, must include an action plan.
4. Summaries include "reported" information along with interpretation from the START team. Do not just copy what you find in records; explore their meaning and make connections between the various pieces of information.
5. Test scores must be reviewed with the Clinical Director, and interpretation or implications of the scores should be included in the report.
6. Recommendations/Action Plans often include other assessments or services that are needed. They can also include what has worked in the past that may be valuable to try again.
7. The START team assists the team in follow-up with recommendations/the action plan from the CSE.

## SAMPLE COMPREHENSIVE SERVICE EVALUATION TOOL AND REPORT

Please see sample Comprehensive Service Evaluation components and forms at the end of this section. The Center for START Services provides projects with access to an online toolkit that includes standardized forms.

**The Comprehensive Service Evaluation Tool** provides an outline of all relevant records and information to be collected to complete the CSE report.

**The Comprehensive Service Evaluation Report** provides a complete summary and analysis captured in the CSE tool, along with interviews and observations as part of the CSE process.



**Service History**

*Including hospitalizations and residential placements from referral form completed by team*

Date (begin with current and go backwards)	Name of hospital/service provider	Outcomes/results

**Medication History**

*Including all medications prescribed for chronic medical conditions along with mental health issues.*

Date (begin with current and go backwards)	Name and dosage of medication prescribed	Reason for medication (include changes/discontinuation if needed)

**Conclusions and recommendations:**

**Action Plan:** *(Developed with person's team)*

Respectfully Submitted,

## START Comprehensive Service Evaluation Tool

Individual's name:
D.O.B.:
Review date:
Person completing review:

### I. Sources of information

#### *Interviews*

Name(s)	Program (if any)	Relationship to Client	Date

#### *Records Reviewed*

Source	Description	Date



**IV. Developmental History (attach additional pages if needed)**

<i>Pregnancy and Delivery:</i>
<i>Newborn Development:</i>
<i>Achievement of Milestones:</i>
<i>Early Behavioral History:</i>
<i>Childhood Medical History:</i>
<i>Onset of Puberty:</i>

**V. Psychosocial History**

<i>Support/Placement History</i>
<i>Education</i>

**VI. Psychosocial –Neuropsychological Testing Reports:** Briefly record information and major results, report can be reviewed in detail if needed by START psychologist

Date of test	Tester	Test administered	Test results ( e.g., IQ, PIQ, VIQ)

*Adaptive Function Test Results*

Date of testing	Test administered	Results	Tester

*Basic Skills:*

LEVEL OF ASSISTANCE

<i>Skill</i>	<i>Ind.</i>	<i>Verbal Prompt</i>	<i>Gestured Prompt</i>	<i>Partial Physical</i>	<i>Full Assist</i>	<i>Description</i>
Mobility						
Eating						
Drinking						
Bathing __ bath -or- __ Shower						
Oral hygiene						
Dressing						
Toileting (urine)						
Toileting (feces)						
Menstruation						
Fire drill – Evacuation						
Street crossing						
Telephone use						
Money skills			NA	NA		

*Sexual activity/history:*

**VII. Medical History**

<i>Special Sensory Function</i>
Hearing
Vision
<i>Review of Systems</i>
<i>Neurological Status</i>
EEG Results:
Results of Imaging Studies:
<i>History of Illnesses (note illness and date):</i>
<i>Operations/procedures</i>

*Medical Hospitalizations*

Date	Description

*Current Medications as of \_\_\_/\_\_\_/\_\_\_*

Name of medication	Diagnosis	Dosage and administration schedule	Date first prescribed

*Drug allergies/sensitivities/side effects (include MOSES and AIMS when applicable):*

*Other Therapies and Special Diets*

**VIII. History of Behavioral/Mental Health Problems**

*Narrative*

*Admission to Psychiatric Inpatient and/or Behavioral Units*

Facility	Date of admission	Date of discharge	Discharge diagnosis

*Psychotropic Drug History (use back of page if needed)*

Name of medication	Diagnosis	Dosage and administration schedule	Date first prescribed

**IX. History of Criminal Activity**

*Narrative* (please attach risk assessment)

*History of criminal/court involvement:*

Date	Criminal charge	Outcome/disposition

X. **Diagnostic Impressions:** List DSM diagnoses Axis system or diagnoses as listed currently in any form and the name of the psychiatric clinician who gave the diagnosis and date.

*DSM-IV Diagnosis or DSM V Diagnoses (No Axis System)*

AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V	

*Current MH Treatment Plan (in addition to psychopharm)*

*Environmental/learned behavior factors to consider (based on ABA):*

*Psychological factors (coping skills, communication/language skills, social skills, traumatic events etc.)*

**Summary of assessment (impressions):**

**XI. Support services**

*Day Services- Education*

History	Date

Current Day Services – Education (dates/describe)

*Residential Services*

History	Date

Current Residential Services (dates/please describe)

**XII. Recommendations**

*Additional assessments needed:*

*Psychosocial/residential/day services modifications (describe recommended plan)*

# CSE ACTION PLAN

**Instructions:** Based on the list of recommendations in the service evaluation, list tasks and how they will be accomplished by members of the team. Schedule a follow up meeting to see if tasks are being completed and review the results of completing those tasks.

- List action to be taken, whom will do it, when expected to be completed, and when it is confirmed that the task was completed.

Client Name (first name, last initial): Date:			
Action to be Taken	Who	By When	Confirmed
Schedule a psychopharmacology evaluation	Case Manager	January 15, 2014	Confirmed completed during meeting on January 30, 2014

## Meeting Review Schedule

*(Receive updates and review the action plan)*

- January 30, 2014
- March 15, 2014
- May 20, 2014

## Comprehensive Service Evaluation

Client Name:

DOB:

Date of Intake:

Today's Date: 4/30/12

### **Purpose of Consultation:**

----- was referred to the NH START program by his service coordinator, \_\_\_\_\_, from Community Services in NH. After completing the initial intake meeting and later meeting with -----, it was determined that a comprehensive service evaluation was needed. This will allow for greater clarity and consensus regarding current presenting difficulties faced by ----- and his team as well as to seek some guidance with regard to future planning, treatment planning, and evaluating overall service needs.

### **Procedure:**

The initial intake meeting was held at Community Services in NH 12/28/11 with the following members of the team present:

---

When this writer met -----, he presented as friendly, articulate, and willing to freely discuss his interests. ----- is an individual who, despite having the challenges of a developmental disability and a psychotic illness, has demonstrated resiliency in his life and is actively engaged in treatment. It was clear in the meetings with -----'s care providers, that they enjoy working with him and care for him.

### **Background**

The most recent DSM diagnosis for ----- is based on a Psychological Evaluation from Dr., Smith, Ph.D. from testing done on 1/30/04 and 2/6/04.

Axis I: 295.70 Schizoaffective Disorder

299.80 Asperger's Disorder

295.90 R/O Schizophrenia, Undifferentiated Type

Axis II: 799.9 Deferred

Axis III: Mild obesity

Axis IV: out of district placement, family relational difficulties

Axis V: Current: 35; Past Year: 35

He received the following psychiatric diagnoses from Dr. Jones, MD; from a Hospital discharge summary on 2/14/02:

Axis I: 295.70 Schizoaffective Disorder (Primary)

299.80 Asperger's Disorder

Axis II: 301.22 R/O Schizotypal Personality Disorder

Axis III: Overweight

Axis IV: Predominant area of difficulty is with primary support group and social environment

Axis V: 50

Current medication: (as of 4/17/12)

1. Clozaril 150mg q AM and 250mg q PM (anti-psychotic)
2. Provigil 100mg q AM (for side effect of drowsiness)
3. Keppra 1000mg BID (anticonvulsant)
4. Clonazepam .5mg q AM and 1mg q PM (anti-anxiety)

The table below outlines the records reviewed for this evaluation:

Source	Description	Date	Recommendations/Results
Jane Doe. Ph.D., Clinical Neuropsychologist	Neuropsychological Consultation	8/26/96	-Asperger's Disorder diagnosis -constellation of emotional, social and cognitive deficits noted secondary to underlying neuropsychological factors -thought processes are well-organized but, at times, bizarre -needs academic interventions and will need familial therapy to provide structure and strategies to maintain progress
Mary Jones, MD	Dartmouth Hitchcock clinic	2/26/98	-continue Paxil and Clonidine -medications seem to help sleep, anxiety, temper tantrums, no significant side effects
Judy Doe, M.Ed., C.A.E. S., Certified School Psychologist	Adaptive Behavior Evaluation	9/24/98	Vineland Adaptive Behavior Scales yielded significant delays in socialization; Maladaptive Behavior Composite score was within significant range with parent concern about development of social and emotional skills; program needs are being met; parents

			and teachers view him as having successful year; ongoing good communication between home and school
Ronald Smith, M.Ed., CAGS	School District Evaluation Report	2/4/2000	Woodcock-Johnson Tests of Achievement, Revised administered: scores spanned average to high average ranges; math was relative strength especially his ability to apply math to practical situations; another strength was reading a list of words as noted in the Letter-Word identification sub score
Pat Miller, , M.S. CCC-SLP, Speech Language Pathologist	Speech and Language Evaluation	3/6/2000	-weakness in auditory comprehension and social problem solving skills; -difficulty recalling and using lengthy written information; -does best when in control of information and not challenged by linguistic or social constraints (This may be reflected in inability to shift social style to meet needs in social or conversational situation and thus difficulties with peers.)
Donald Smith, Ph.D., Licensed Psychologist	Neuropsychological Evaluation	1/12/02	-significant deficits in processing speed, executive functions, manual dexterity and most aspects of visual analysis and comprehension -limited insight into his behavior and odd affective reaction to past misbehavior; remains at risk for violence against animals and people; -vulnerable to exploitation by others; requires a supervised, structured, and protective living situation, daily structure, clearly defined rules and consequences for inappropriate behavior; therapy to enhance social skills and appropriate sexual outlets and behaviors -given Schizoaffective Disorder diagnosis
Mary Jones, MD, Psychiatrist	Hospital Discharge Summary	2/14/02	-discharge to Northeast Paces Dalton Station and remain until able to function without difficulty in home environment; maintain contact with parents and engage in family therapy; continue individual therapy and medication management; continue working on developing social skills and management of anxiety; -Medication: Clonidine discontinued; Paxil continued Zyprexa trial and then d/c'ed due to weight gain; Risperdal started; Lithium started- positive response, mood more stable
Larry Smith, MD, Consulting Psychiatrist	Psychiatric Evaluation	5/2/02	-behaviors childish and regressive; could represent serious risk to harm sister, threats to harm her should be taken very seriously; -seems to experience paranoid delusions with possible command auditory hallucinations, which have not been controlled by medication -Depakote started, lithium discontinued due to side effects; different type and/or higher doses of neuroleptics may be needed due to not responding adequately to current neuroleptic, Clozaril considered but not started
Lori Jones	Kaufman Test of Educational Achievement	4/28/03	Mathematics composite score-above average performance with Mathematics Applications well above average; Reading Composite score-average with significantly stronger decoding skills vs. comprehension skills; Spelling subtest score-average
Anne Jones, MS, CCC/SLP, Speech-Language Pathologist	Speech and Language Evaluation	4/03	-receptive language: average in word classes and semantic relationships, below average in concepts and directions -expressive language: average in formulating sentences, below average in recalling sentences and sentence assembly -overall language score falls in low average range; understands words and how they relate to each other but has problems using this knowledge when given more information to recall, process

			and produce -difficulty analyzing body language
Marie Black, OTR/L	Occupational Therapy Evaluation	4/18/03	-overall difficulty with fine motor tasks especially when required to use both hands simultaneously -delays in areas of visual perception: visual discrimination, form-constancy, sequential-memory, and closure -would benefit from OT service to improve fine motor skills, bilateral hand coordination, and visual-perceptual skills
Tim Jones, Ph.D., Certified Psychologist	Psychological Evaluation	4/9/04	-sensitive about peer relationships, does not feel he has positive peer interactions, feels left out and experiences high degree social isolation; negative feelings about self and believes others do not care for him -lacks effective coping mechanisms; difficulty regulating or controlling sexual thoughts -difficulty demonstrating effective perceptual and conceptual abilities; poor reality testing; evidence of a thought-disordered process with significant sexual preoccupation; becomes disorganized by this sexual preoccupation -difficulty dealing with aggressive impulses and therefore needs ongoing residential and mental health services -DSM dx: Schizoaffective D/O; Aspergers; R/O Schizotypal Personality Disorder -Recommendations: continued residential placement with consistent structure and behavior management specifically maintaining appropriate boundaries; individual therapy to learn stress management, anger management, assertiveness, strategies to manage inappropriate sexual verbalizations and sexual behaviors; group therapy for social skill development and sexual education; future family therapy; ongoing medication management by psychiatric medication provider; ophthalmological evaluation; continued communication between school, residence and therapy; re-evaluation of personality organization in next 3 years
John A. Jones, M.A., School Psychologist	Intellectual Assessment Report	1/26/06	-WAIS-II results best characterized by verbal and performance scores vs. full scale score; significant differences in VIQ=111 vs. PIQ=81, FSIQ = 98 -verbal comprehension skills and working memory much better developed than nonverbal reasoning and visual processing; more adept at using verbal reasoning skills than nonverbal reasoning -evaluation yielded higher intellectual functioning skills compared to previous testing and yielded average abstract reasoning ability compared to what was thought to be a deficit (thought to only have ability for rote memorization lacking abstract and comprehension skills)
Jerry Smith, M.A., School Psychologist	Adaptive Behavior Assessment Report	3/24/06	-significant behavioral functioning deficits in communication, daily living skills, and socialization with each area below the 1 <sup>st</sup> percentile; lacks skills for meal preparation, maintaining personal hygiene, and cleanliness of home -maladaptive behaviors "are of great concern"; avoids others, overly anxious, cries and laughs easily, says embarrassing things in public and behaves inappropriately at the urgings of others, unusual habits, speaks of hearing voices -difficult for him to be independently employed without assistance and on-the-job support, will need assisted living due to

			difficulties with basic daily living skills
Lorna Jones, MSW Clinician	Northeast Paces Annual Treatment Plan	2/13/07	Strengths: verbal comprehension, personable with adults, sense of humor; challenges: persistent and fixed delusions; difficulties with executive functioning, social awareness; high levels of anxiety Recommendations: continued residential placement in structured setting; structured educational program; case management; 24-hr a day supervision; weekly counseling with focus on stress management, anger management, and assertiveness training; weekly group therapy to improve social skills, peer interactions, and conflict resolution; medication management; family contact by case manager
Nick Jones, Case Manage	Court Report for Newbridge District Court	12/10/09	Recommendations: continued residential placement at Northeast Paces Boys Group Home; continued educational placement at Robert Jolicoeur School; continued individual and group therapy and case management; continued 24-hr a day supervision; continued medication management
Don Jones, Ph.D., Director of Clinical Services,	Risk Assessment and Management Consultation	7/30/08	-for mental health: ongoing psychiatric care with psychiatrist and psychotherapist addressing management of anxiety, stress, anger, interpersonal skill development, option-detection, and decision-making; use written vs. oral communication; use of journal or log and self report measure of feelings, mood, symptoms, may be more effective than therapeutic interview; provide ongoing monitoring of mental status noting psychotic symptoms, depression, and irritability -for residential options: enhanced care providers need to provide consistent support, supervision and monitoring of mental status; pair residential option with adequate day programming, vocational placement and social and recreational activities -for behavior plan: include gradual transition and acclimation to new home; identify how to communicate indicators of deteriorating mental status; identify coping strategies and ways to communicate them to care providers and integrating them into treatment; development of a crisis plan; process by which supervision can be reduced until an optimal level is achieved
Sharon Jones	† Individual Service Agreement	10/6/09	
Kathy Jones, MMHC- Behavior Specialist,	Behavior Support Plan	2/2/10	-key target behavior is verbal aggression; may escalate verbally when frustrated or anxious; verbal aggression defined as: swearing, yelling, noncompliance with safety protocols, threatening to harm to others or self as well as behaviors such as shaking fists, pointing, posturing and charging
Sharon Jones	Midpoint Individual Service Agreement	10/5/10	
Dan Smith	Midpoint Individual Service Agreement	10/3/11	

There is a positive family history of psychiatric and neurological disorders. With regard to -----'s immediate family, his mother has been diagnosed with bipolar disorder and his father is diagnosed with Asperger's Disorder. He has a sister who is 5 years younger than him. There was no information in his records or reports indicating that she has a psychiatric and/or neurological disorder. -----s' parents are married and continue to reside in his childhood home in NH.

----- was born in, NH. While pregnant with -----, his mother had no prenatal problems and it was a full-term pregnancy. However, shortly before birth his vital signs were suffering, which required an emergency C-section. His mother reported that there may have been a problem with the umbilical cord but was uncertain what caused the problems with his vital signs. He was able to recuperate quickly and was given an APGAR score of 10 after 5 minutes. The APGAR (Appearance, Pulse, Grimace, Activity, and Respiration) score is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two. These scores are then added to obtain a total score with a range of 0 to 10.

-----'s early developmental milestones were reported to be normal up to about the age of 3. Around this time, he began to demonstrate difficulty with language. He was reported to be echolalic and frequently spoke in codes that could only be understood if someone were familiar with the code. His parents report that he began to be able to spell at age 3 and was reading around age 4. Although he had significant problems with spoken language, his parents report that he had an amazing memory and could quote passages from books, movies and TV. His mother reported that he demonstrated poor social interactions. She explained that he has "no empathy or sympathy for others and is concrete". Around the age of seven, he began having sleep disturbances, night terrors, frequent anxiety symptoms, and temper tantrums. He saw a psychiatrist at a community mental health center in NH, who prescribed Paxil and Clonidine. He tolerated these medications with minimal side effects and they seemed effective in reducing sleep disturbances and anxiety.

When ----- was 8 years old, a neuropsychological consultation was performed.. From this record, Dr. \_\_\_\_\_ noted, "Reviewing his overall functioning through developmental history, as well as this current evaluation, this is a child who presents with moderate impairment in terms of reciprocal social interactions that are oftentimes seen in children with demonstrate Asperger's Syndrome." "He is going to continue to need to have academic interventions to provide the necessary structure and strategies to continue with his level of progression". In addition, the doctor explained that ----- "has responded positively to academic interventions and has shown an ability to interact in a school environment".

----- was able to be mainstreamed upon starting school but required specific education interventions including OT, speech therapy and a "part-time school room aid." He required a full-time paraprofessional from age 8 on. In one report from his grade school, it was noted: "He required assistance with assignments, behavior, peer interactions and organization. He required structure and was able to function appropriately when it is provided to him". During grade school he was unable to establish friendships with peers. He would "get upset quite easily", "speak loud and have a difficult time stopping himself from talking once he got going". "At times he would talk about sexual things inappropriately." However, throughout grade school he was seen as "making good progress in his ability to integrate interventions and tolerate change". He received speech and language therapy, occupational therapy, and adaptive physical education throughout grade school. He was able to achieve average academic performance with modifications.

At age 12, ----- had a speech and language evaluation performed by his Speech and Language Pathologist. She noted the following key findings: "weakness in auditory comprehension and social problem solving skills"; "difficulty recalling and using lengthy written information"; and "does best when in control of information and not challenged by linguistic or social constraints". She noted that his difficulty with peers could be linked to an "inability to shift social style to meet needs in social or conversational situations".

-----'s academic performance remained stable and his behavior improved to the degree that his full-time paraprofessional was removed toward the end of 7<sup>th</sup> grade. However, upon return to school in the 8<sup>th</sup> grade at age 13, his behavior and academic performance worsened significantly. At this time, he began to exhibit: explosive outbursts, mood swings, reduction in personal hygiene, physical and sexual assaults on the family cat, suicidal and homicidal threats, and assaults on both parents and younger sister. These behaviors led to multiple trips to the emergency room for psychiatric evaluations, calls to the local police department, and eventually to an arrest. He was charged with simple assault for striking his father and spitting and striking at two responding police officers. Initially, he was placed at the Youth Detention Services Unit until he was admitted to the Hospital in his town due to "fecal smearing, urination upon objects, self-report that other people inhabited his body and caused him to act against his will".

While there, he had a neuropsychological evaluation performed. From this report, it was noted that he has significant deficits in processing speed, executive functions, manual dexterity and most aspects of visual analysis and comprehension; he shows limited insight into his behavior and odd affective reaction to past misbehavior; remains at risk for violence against animals and people; is vulnerable to exploitation by others; requires a supervised, structured, and protective living situation, daily structure, clearly defined rules and consequences for inappropriate behavior, therapy to enhance social skills and appropriate sexual outlets and behaviors. This report gave him a diagnosis of Schizoaffective Disorder. He remained on Paxil, which he had been on since age 7, and began Risperdal and lithium. He showed a positive response to lithium with a noted stabilization of his mood. As was noted, ----- has a positive history of psychiatric and neurological problems in his family of origin. His family history is significant for Bipolar Disorder (mother, maternal grandfather, maternal uncle), Asperger's Disorder (father); paranoia (maternal grandfather), "severe autism" (maternal cousin, paternal uncle), Schizophrenia (maternal cousin), and depression (paternal uncle).

----- was involved in juvenile court prior to the hospital admission, which was related to the arrest for assaulting his father and 2 police officers. Due to his family's difficulty managing him at home, a recommendation was made to the court, with support of his parents, that he be placed in residential treatment. A referral was made for residential care and he was placed on juvenile probation through his 21<sup>st</sup> birthday. At age 13, ----- was discharged from the Hospital and placed at a residential facility.

At age 14, , he received a psychiatric evaluation which reported the following information: "His behaviors are extremely childish and regressive; he could represent a serious risk to harm his sister and threats to harm her should be taken very seriously; he seems to experience paranoid delusions with possible command auditory hallucinations, which has not been controlled by medication." The psychiatrist started him on Depakote and discontinued lithium due to side effects. Concerns were raised that he may require a different type and/or higher doses of neuroleptics due to not responding adequately to his current neuroleptic. Clozaril was considered, but not started.

An occupational therapy evaluation and another speech and language evaluation were conducted with ----- when he was 15. The OT evaluation reported that he has difficulty with fine motor tasks especially when required to use both hands simultaneously and that he has delays in areas of visual perception: visual discrimination, form-constancy, sequential-memory, and closure. She recommended OT service to improve fine motor skills, bilateral hand coordination, and visual-perceptual skills. She did note that he continues to demonstrate above average academic ability. The speech and language evaluation reported that he likes to read and enjoys obtaining information from encyclopedias. In terms of his receptive language, she noted that he is average in word classes and semantic relationships and below average in concepts and directions. For expressive language, he had average scores in formulating sentences, but had below average scores in recalling sentences and sentence assembly. "He understands words and

how they relate to each other but has problems using this knowledge when given more information to recall, process and produce". In addition, she noted that he has difficulty analyzing body language.

At age 16, he transitioned to a "Boys Group Home" in NH; where he remained until age 21. This transition was successful and it was approximately one year later, at age 17, he began Clozaril. He tolerated Clozaril fairly well. However, Provigil was added to help with a side effect of drowsiness. Also, around this time he was titrated off Depakote and began taking Keppra. The reason for the switch to Keppra was unclear from the records. He continued to experience psychotic symptoms including auditory hallucinations and delusions. However, he did begin to show "a reduction in behavioral volatility, demonstrated improved academics, and exhibited overall stabilization of functioning". Also, noted at this time were strengths such as "He takes pride in his intellectual abilities and he wishes to do well in his school subjects".

In addition to starting Clozaril at age 17, he had an "Intellectual Assessment Report" at this time. This report was conducted by a School Psychologist from his home school district. A key finding in results from the WAIS-II in that the scores were best characterized by comparing the verbal and performance scores vs. a focus on the full scale score. He explained that -----'s FSIQ (98) is not an appropriate indicator of his general ability due to the significant difference between VIQ (111) and PIQ (81). It was noted that his verbal comprehension skills and working memory are much better developed than his nonverbal reasoning and visual processing. It was also noted that weak visual spatial ability, as with -----, tends to be common among individuals with Asperger's Disorder. Difficulty with reading social cues and interpreting social situations, also a characteristic of individuals with Asperger's Disorder, was shown in his picture arrangement score which was the lowest in his Performance test profile. ----- had a previous IQ testing from a Neuropsychological Evaluation in January 2002: VIQ=104, PIQ=70, FSIQ = 86. Comparing these results shows a similar discrepancy between VIQ and PIQ. Of note also, was the fact that his most recent testing

yielded significantly higher intellectual functioning skills compared to previous testing. Strengths noted during this assessment included ----- being "pleasant and very cooperative", "maintained very good concentration and effort", "demonstrated a good sense of humor", "talked himself through problems as he solved them and he showed enthusiasm and enjoyment when he knew he got the correct answer."

At age 18, ----- had an Adaptive Behavior Assessment Report. Results from this assessment yielded overall significant functional deficits in communication, daily living skills, and socialization. Each area was at or below the 1<sup>st</sup> percentile. Specifics from the test included notations that he lacks skills for meal preparation, maintaining personal hygiene, and cleanliness of home. His maladaptive behaviors "are of great concern". "He avoids others, is overly anxious, cries and laughs easily, says embarrassing things in public and behaves inappropriately at the urgings of others; has unusual habits and speaks of hearing voices". The Adaptive Behavior Assessment Report also yielded information that it would be difficult for him to be independently employed without assistance and on-the-job support and he would need some form of assisted living due to difficulties with basic daily living skills. In addition, notated in this assessment were -----'s strengths of having "very solid cognitive abilities and academic achievement skills."

Near his 19<sup>th</sup> birthday, -----'s had an annual treatment plan. Strengths that were identified for him included academic skills, base of factual knowledge, desire to succeed, able to learn by discussing mistakes, responds well to clear expectations, personable with adults, initiates conversations, verbal comprehension, and a sense of humor. The key challenges that were identified were persistent and fixed delusions; difficulties with executive functioning, social awareness; and high levels of anxiety. For "Behavioral and Emotional Concerns" his current level of performance was described as: "continues to need prompting to refrain from instigating other peers...and is easily instigated by peers". "He has difficulty making choices about what is and is not appropriate to discuss in group sessions." Also on this treatment plan in the section on "Family Relations", it notes: "His parents are very

involved in his treatment, educational and discharge planning. They continue to visit him weekly, alternating between seeing him separately, with short visits home for the holidays."

A few months after ----- turned 20, he had a "Risk Assessment and Management Consultation" and this assessment was prompted by the fact that ----- was scheduled to leave at age 21. Concerns included such things as what would be an appropriate residential placement as well as the content and delivery of treatment in the community. Some of his key recommendations were the following: "He should receive ongoing psychiatric care with psychiatrist and psychotherapist."; "Treatment goals should address management of anxiety, stress, and anger; interpersonal skill development; option-detection; and decision-making."; and "Care providers should provide ongoing monitoring of his mental status noting psychotic symptoms, depression, and irritability."

In terms of residential options, enhanced family care was thought possible but "keeping into consideration his functioning and mental status as he nears time of transition, adequacy of a transition plan, enhanced care providers able to provide consistent support, supervision and monitoring of mental status; allowing for achievement of optimal independent living and opportunity to show he can use skills he has learned; adequacy of day programming, vocational placement and social and recreational activities."

Recommendations included considerations such as a gradual transition and acclimation to new home; identification of indicators of deteriorating mental status (psychosis and mood); and "communication of these indicators to persons providing community-based supports and services". A behavior plan was developed and the key target behavior identified was verbal aggression. It was noted that ----- may escalate verbally when he is frustrated or has anxiety. The verbal aggression was defined as: swearing, yelling, noncompliance with safety protocols, threatening to harm to others or self

as well as behaviors such as shaking fists, pointing, posturing and charging. She noted that despite having a history of physically aggressive behavior, there were no incidents for the past 5 years.

-----'s parents, Staff, and Community Services met and opted to pursue services through Preventative Services. At age 21, he left the Boys Group Home and began to receive services through the Preventative Services program. These services have continued up to the present and entail living in an enhanced family care setting and receiving 1:1 services from a direct care provider Monday through Friday for approximately 30 hours. The focus of his day activity has been to find and maintain employment. Community activities are included such as going to the YMCA and library. He has continued to see a Northeast Paces psychotherapist one time per week and was followed by a psychiatrist for medications. He now has a nurse practitioner he sees at the local Mental Health Center for psychiatric medications. Other staff services include a residential case manager who oversees his residential services and a day program coordinator who manages his day services.

Since leaving the residential program, ----- has transitioned fairly well into the community. He has been able to maintain employment at one job for nearly 4 years and recently has been assisted in finding and securing a second job where he is working 3 days a week. The behavior plan was implemented upon discharge from the residential program and then revised approximately 1 year later. ----- continued to have no incidents of physical aggression and no significant episodes of verbal aggression. Eventually, the behavior plan was terminated in 2/2011, due to no incidents of target behavior. It is now used as a "training tool" for new staff working with ----- . ----- continues to be "quite sociable and often witty." "He is doing very well at his employment site, and has established friendships in his day program." She went on to add that he "continued to use his coping tools and initiates conversation in areas that he questions, is uncomfortable with, or would simply like more knowledge about."

As noted, ----- moved into an enhanced family care setting after leaving the residential program. This original placement ended in July 2011 at his father's request. The reason for this was that the enhanced family care provider had additional family members move in including his daughter who was younger than ----- . -----'s father was concerned that ----- may act sexually inappropriate with her and/or may be physically aggressive toward her. He was placed in another enhanced family care setting, where he resides up to the present. This residence is provided by a married couple with no others in the home. The husband was -----'s direct care provider for about 3 years prior to ----- moving in with him and his wife. This move seems to have gone well. There continue to be no significant behavioral problems. Of note, is the positive relationship with the enhanced family care providers, who seem to be his key source of support. They seem to understand and care for him and are able to provide a helpful combination of structure, guidance, and support. ----- spends time with them on the weekends completing chores and going out into the community with them. They have assisted him to participate in a mainstreamed evening bowling league. He has been in this league for several months, which ends in spring 2012. However, he has been invited to return once it resumes in September. Also, he has been spending time with one of the enhanced family care provider's parents in learning how to repair and maintain cars. -----'s father and mother visit him at his residence on Saturdays. The parents come separately and alternate Saturdays. Unfortunately, he has minimal contact with his one sibling, a younger sister. This minimal contact seems due to -----'s history of threatening and then assaulting the sister when he was a young teenager.

In terms of current overall functioning, his care providers reiterated that he has transitioned quite well after living in a residential setting for nearly 8 years. His care providers report general problems with social interaction and restricted interests. He tends to misinterpret social situations; has difficulty understanding nonverbal communication; has difficulty with reciprocal communication; has good eye contact but may stare; seems to lack empathy; is very sensitive to loud noises such as sirens; and has narrowed interests , hallucinations and paranoia. These symptoms seem better controlled over the past several years with the introduction of Clozaril in his late teens. However, to some degree his psychotic symptoms are still present. His psychosis consists of believing there are 3 entities inside him, one good one and two bad ones. He believes these entities have some degree of control over him. Also, he believes that there are "conspirators" living in NH and that they are trying to find him. ----- says he is cautious to whom he speaks to avoid detection. On a daily basis, his current care providers see him talking to himself, smiling and/or laughing for no apparent reason. When ----- is asked who he is speaking to or what he is laughing and smiling about he will tend to minimize or deny his behavior.

Recently, he has had 2 episodes of reporting suicidal thoughts: late December 2011 and in mid March 2012. In both instances, he denied having a plan or intent. He has no known attempts. In December, his home care provider reported that he seemed “overwhelmed, overly anxious and couldn’t think straight”. He reported the suicidal thoughts to his therapist who then passed on the information to his team. In March, he witnesses another client assault a staff person. He began laughing and could not stop. Staff needed to intervene and escort him away from the situation. Upon returning to his residence, he reported vague suicidal thoughts to his enhanced family care provider. His verbalizations of suicidal thoughts are documented, reported to and reviewed with his therapist, residential support staff and home care providers. It would be helpful to generate more discussion about his suicidal thoughts and other problems such as his anxiety and psychosis and incorporate them into a Cross-Systems Crisis Plan.

From a review of all the records available to this writer and initial meetings with ----- and his care providers, there was no mention of him having any significant medical problems; however, at some point he was diagnosed as having a seizure disorder. The issue of him having a seizure disorder became known only after reviewing his medications and questioning why he was taking Keppra. Keppra is being prescribed by a neurologist in NH who he sees one time per year. ----- and his care providers report that the seizure disorder does not seem to be that significant and note they have never seen any overt signs of him experiencing a seizure. They do seem to be aware that there are different types of seizures. Seizures may entail more subtle manifestations versus falling and having uncontrollable body movements. This writer has sent a request to the neurologist for records to gain a better understanding of -----’s seizure disorder. No records were available at the time of this writing. One recommendation, once these records are obtained, will be to review them with ----- and his team.

### **Conclusion and Recommendations:**

----- is a 24-year-old white male who has demonstrated resiliency throughout his life. From an early age, he was faced with the social and communication problems associated with Asperger’s Disorder. Then at age 13, he experienced the onset of a psychotic illness, which added a new set of symptoms and complicated his functional deficits. After the onset of the psychotic illness, he was separated from his family for 8 years living in a residential placement. However, despite these events and circumstances, he has demonstrated a strong will to improve himself by using and continuing to use several strengths. These include a desire to succeed, motivation to learn, pride in his achievements, efforts to improve his social skills and physical health, drive to use his coping skills to manage stress, demonstration of solid academic abilities and achievement skills, displaying a good sense of humor, and

showing an awareness and interest in politics. He engages in regular exercise, is motivated to work and has maintained one job for nearly 4 years. He enjoys listening to music; watching TV game shows and animated sitcoms; swimming, walking, using his exercise bike; talking about cars, especially VW's; and going out to eat.

His most recent Axis I diagnoses are Asperger's Disorder and Schizoaffective Disorder. He has had difficulties consistent with Asperger's Disorder throughout childhood but his major behavioral problems did not emerge in a school setting until about age 8. From age 8 to 13, he received a full-time aide to remain mainstreamed in the school system. As noted, at age 13, his behavior and school performance worsened significantly. At this time, he began to exhibit explosive outbursts, mood swings, reduction in personal hygiene, suicidal and homicidal threats, and assaults on both parents and sister. There were multiple trips to the emergency room for psychiatric evaluations, calls to the local police department, psychiatric hospitalizations, an arrest, and an eventual long-term residential placement from age 14 to 21.

Since leaving the residential placement at age 21, he has successfully integrated into the community. He has had no significant behavioral problems, has complied with psychiatric treatment, has regular contact with his parents, and has maintained one job for nearly 4 years. However, there seems to be no set plan for fostering more independence such as allowing him unsupervised free time in the community or working toward living in a more independent residential setting. Given his history and struggles with mental illness and Asperger's Disorder, his family and care providers are exercising caution; however, it seems fair that a plan should be developed to give him the opportunity to become more independent. As noted, a behavior plan was implemented upon discharge from his residential program and eventually was terminated over one year ago due to no incidents of target behavior. Based on the results of an Adaptive Functioning Tests, ----- does need some form of assisted living due to difficulties with basic daily living skills and needs on-the-job support and a job coach to maintain employment. From a review of his service plans he has been working on these functional deficits and is demonstrating success.

### **Recommendations:**

1. It should be determined if ----- needs a risk management plan. He should be reviewed by Community Services' local risk management committee to determine if he meets the criteria for a risk management plan. If he does, an updated risk assessment will be obtained. This process will help to provide clarity on risk level. Also, it will help in developing a plan to assist ----- in become more independent. This writer will refer him to Midpoint Community Services' local risk management committee.
2. A referral to a new psychiatrist would help in gaining a better understanding of his diagnoses and how they impact his functioning. It would be helpful to get feedback on such things as treatment and support strategies, current medications, and his seizure disorder. Also, the psychiatrist will be asked if further assessment would be helpful such as neuropsychological evaluation. This writer will make the referral and set up a team meeting to review the results.
3. A Cross-Systems Crisis Plan will help to identify current problems or problems that may arise such as his recent verbalizations of suicide. A strategy can be developed for his care providers to assist in addressing these problems and preventing crises from occurring. This writer will set up a team meeting to develop the plan and then write the plan.
4. In terms of -----'s seizure disorder, once his records are obtained, they will be reviewed with ----- and his team. This review will help in ways such as gaining a better understanding of the seizure disorder, its type, how it may manifest itself, how it may impact functioning, and strategies for continued treatment and management. In addition, one of his care providers and/or this writer could participate in meeting with the neurologist at the next appointment. However, ----- should be approached about the reasons for doing this beforehand and his guardian should give his approval.
5. Based on -----'s OT assessment at age 14, he would benefit from OT service to improve fine motor skills, bilateral hand coordination, and visual-perceptual skills. It is unclear from the records if he received these specific services. Visual perception problems were also no

his IQ testing. It would be helpful to get an updated OT assessment to confirm and improve understanding of the identified problems. Also, OT services could be started to address the identified problems.

6. Group therapy should be considered. ----- currently has no group therapy and could benefit from treatment in a group setting. Helpful group therapy would be tailored toward such things as improving social skills, coping strategies, stress reduction, and psychiatric symptom management. It would be helpful for him to develop a sense of not being alone in experiencing social problems, stress, and psychosis and learning how his peers cope. Group therapy may be available at the Mental Health Center.

7. Family therapy should be considered. ----- has had minimal contact with his sister since he was 13 years old. If his sister is willing, it would be helpful to develop and implement a strategy to assist in improving his relationship with her. His current therapist may be willing to do this.

8. Based on Speech and Language evaluations, ----- has difficulty recalling and using lengthy information. When communicating with him, it is important to provide information in small and easy to understand portions or "chunks". For example, when he is learning a new task, his care providers may want to break the task down into small steps and then show him while explaining to him how to complete each step within the task.

9. -----'s team should continue to monitor his anxiety and how it may be impacted by such things as daily structure, routine, over-stimulating environments, and social settings/situations. His anxiety can be lessened by having structured activities and predictable routines. Also, if possible, overly-stimulating environments should be avoided especially those with loud noises. New or unpredictable social situations/setting may heighten his anxiety such as being around too many people or meeting too many new people. ----- should be

encouraged to use his stress-reduction techniques. It would be helpful to check in with him after he has experienced anxiety and have him explain how he was able to cope and provide feedback. Role modeling and engaging in stress-reduction strategies with him should be considered.

Respectfully Submitted,

START Coordinator

START Clinical Director



## Comprehensive Service Evaluation

**Name:** Nancy Smith

**Date of intake meeting:**

**Today's date:**

**Reason for Referral/Purpose of Consultation:** Nancy was referred to the START program by the service coordinator at the family's request for a comprehensive evaluation of her service needs.

**Procedure:** A referral meeting was held on \_\_\_\_\_ with the following members of the team present:

START Coordinator  
START  
Clinical Director  
START  
Program Manager  
Mrs. Smith, Nancy's mother

An intake meeting with Nancy and her mother was conducted on \_\_\_\_\_, at \_\_\_\_\_. During the visit, Mrs. Smith expressed her appreciation for receiving support through START and eager to assist in any way possible. Releases were signed and Mrs. Smith offered to obtain all requested documents.

Another meeting was set up by the referring START Coordinator for Nancy and approved by Nancy's mother, guardian, was held on \_\_\_\_\_. Nancy was interviewed in her respite setting, was eager to talk and answered rapport building questions by the START Coordinator.

**Background:** A request for START services was initiated by the referring agency, in an effort to gain clarity and consensus regarding current presenting difficulties faced by Nancy and her team as well as to seek some guidance with regard to future planning, treatment planning, and evaluating overall service needs.

At age 5, Nancy was involved in an all-terrain vehicle (ATV) accident. She was immediately sent to Regional Hospital and then transferred to Children's Hospital for stabilization. She was treated for a traumatic brain injury (TBI) consisting of a fracture along the left pterygoid plate and across the base of the sphenoid. She had an evacuation of a subdural hematoma and placement of an external ventricular drain. Tracheostomy and gastrostomy tubes were also placed. Her rehabilitation occurred from December 1997 to March 1998.

Up to December 1997, Nancy reached all developmental milestones at the appropriate stages if not early. At the time of the accident, Nancy's mother and father were in the process of getting

divorced. Her mother remarried but divorced again in 2001. She subsequently remarried. Nancy has had 2 step sisters and 2 half brothers. Her biological father reportedly has a history of abusing alcohol and her maternal grandmother reportedly had dementia.

According to the records that have been reviewed Nancy has been diagnosed with:

Axis I: Personality change due to head injury, aggressive type 310.1

Axis II: Mild Intellectual disability 317

Axis III: Type 2 Diabetes, Hx of closed head injury – December 1997, Obesity, hypothyroidism and Hyperlipidemia

Axis IV: Recent return to a highly restrictive and structured environment; limited family contact since move

Axis V: 20.

The table below outlines the records reviewed for this evaluation.

Source	Description	Date
<b>START Referral Form</b>	A brief presentation of the client, her needs, challenges, strengths and weaknesses. Also included are her diagnoses, current medications and brief social history.	<b>10-31-2011</b>
<b>Lab Reports (Hepatic Function Panel)</b>	<b>See attached documents.</b> Remarkable findings: Albumin – 4.9, AST – 59, ALT – 49	<b>10-26-2011</b>
<b>Psychiatric Evaluation</b>	Current findings of Psychiatric Evaluations include account of current need for placement, that psychological evaluation from 2004 seems to be appropriate according to Psychiatrist, and a list of current medications that are covered later in this report. He reports that Nancy likes dogs, is sleeping well, that before coming to a Human Development Center (HDC) she spent less than 24 hours at Behavioral Health Services facility until respite was secured. He addresses that her diet at home is not monitored to assist in controlling her Type 2 diabetes. Her labs from 10-12-2011 showed that her glucose was 171, hemoglobin ATc 7.5, LDL 99, HDL 33, triglycerides 360 AST 82, ALT 63 and a VPA of 60. Also provides previous placements which are discussed in more detail later in this report as well as family history, mental status exam and recommendations. Findings/Recommendations from Psychiatrist included: 1) diagnosis from 2004 is still accurate, because psychotropic medications are not given at the HDC, her PRN for Alprazolam would be discontinued, due to VPA levels a recheck would be necessary the following week along with a liver function test, a specific mention was made that after reviewing old records, in 2005, her tests showed an increase in liver function tests from	<b>10-18-2011</b>

	taking Seroquel and Depakote. Recommended length of stay was estimated at 4-6 weeks and that a formal behavior treatment program may be necessary if she were to stay for an undetermined amount of time after the above projection.	
<b>Free T4</b>	1.11	<b>10-17-2011</b>
<b>Micro albumin</b>	10.2	<b>10-14-2011</b>
<b>Medical Procedures Support</b>	Permission granted by mother to consent to dental, labs, e-rays, mammogram, EEG, MRI, CT, clinic exams, residence exams, off-campus exams and other treatments including procedures and scans to be administered. Remarkable records have been requested.	<b>10/13/2011</b>
<b>CHDC Memorandum</b>	An assessment written by Psychological Examiner. The assessment presents the emergent need for respite care and the event that led to current placement.	<b>10-12-2011</b>
<b>Vaccine Consent</b>	Consent for influenza vaccination	<b>10/12/2011</b>
<b>Mental Diagnostic Evaluation</b>	Mother denied any symptoms of depression and anxiety, only outpatient was in 1999 briefly. All other findings were consistent with other evaluations	<b>5/27/2010</b>
<b>Habilitation and Training Discharge Summary (HDC)</b>	Encouragement was given to Nancy to verbally express discontent/frustrations rather than with expressed aggression. Verbal counseling and redirection as well as separation to allow calming were also utilized by staff with Nancy. 1-1 staffing was also maintained when out of the home and visual supervision from staff when Nancy was in the home.	<b>5/10/2006</b>
<b>Occupational Therapy Discharge Summary (HDC)</b>	Upon discharge, Nancy was working to improve compliance with tasks for academic and self-care, improving visual-perceptual integration for academic and self-care performance and improving fine motor coordination for academic and self-care performance.	<b>5/10/2006</b>
<b>Speech/Language Pathology Discharge Summary (HDC)</b>	Nancy made progress in therapy and was encouraged to speak using a softer volume especially when excited.	<b>5/10/2006</b>
<b>Dietary Discharge Summary (HDC)</b>	Upon discharge her BMI was 35.5, she was on a 1500 calorie diet, receiving egg substitutes, unifiber for fiber and fluid were encouraged by using tea sweetened with	<b>5/10/2006</b>

	artificial sweetener.		
<b>Special Education Discharge Summary (HDC)</b>	Nancy progressed from 30 minutes per day to 45 minutes, 3 times daily for 5 days per week.		<b>5/10/2006</b>
<b>Physical Therapy Discharge Summary (HDC)</b>	She was independent with all gross motor activities and mobility skills. Reportedly she ambulates independently with fair balance. She does require some supervision outdoors or in new environments for safety due to decreased awareness of environment and potential hazards in her path.		<b>5/10/2006</b>
<b>Discharge Summary</b>	<b>Social Services Discharge Summary (HDC)</b>  Overall recommendation was for Nancy to continue receiving services in the areas of health/hygiene, social issues/appropriate problem solving, assistance accessing community services, planning for recreational/leisure activities as well as transportation needs.		<b>5/7/2006</b>
<b>Hospitalization History:</b>			
	Hospital	Admission dates	Reason for admission
	10/2011	Human Development Center	
			Respite Care
	10/2011	Behavioral Health Services	Acute Hospitalization
	6/2004-5/2006	Human Development Center	Residential Placement
	6/2004	Behavioral Health Services	Acute Hospitalization
	8/2001-6/2004	Behavioral Health	Residential Placement
	7/2000-2/2001	Behavioral Health	Residential Placement
	6/2000	Behavioral Health	Acute Hospitalization
	1998	Behavioral Health	Residential Placement
	1998-	Children's Hospital	Emergency/LTC/Surgical/Rehab.
	12/1997-	Regional Hospital	Emergency

**Findings:**

Nancy, a 19 year old, white female, currently receiving respite services at the Human Development Center, was referred by a START Coordinator. She has one half-brother and previously two stepsisters, and a second half-brother.

Nancy was delivered by cesarean section with no prenatal difficulties. Mother did report “blood contamination” during the delivery, however, there were no other problems noted. Reportedly, Nancy met all developmental milestones at or before the recommended ages leading up to the accident.

Nancy was involved in an All-Terrain Vehicle accident in December 1997, resulting in a fracture along the left ptergoid plate and across the base of the sphenoid. She had an evacuation of a subdural hematoma and placement of external ventricular drain as well as tracheotomy and gastrostomy tubes placements.

At the time of the accident, Nancy was transported to Regional Hospital until she was stabilized and transferred to Children’s Hospital (CH). She remained at CH until March 1998. It was there that she received therapy for services listed above. Nancy’s rehabilitation continued from December 1997 to March 1998.

Nancy’s developmental history shows an early behavioral history marked with intermittent aggressive behaviors including hitting, biting, kicking and spitting on self and others. Property destruction with the intent to cause harm to self, others or to destroy property out of anger was also present. Multiple inpatient psychiatric hospitalizations including admissions while in residential placement will be discussed later on in this report. Client’s childhood medical history is non-remarkable prior to the ATV accident. The onset of puberty however was remarkable as reported by mother. The onset of puberty occurred during her stay at Children’s Hospital and continued while in a residential placement. It was there that she was referred to an endocrinologist where she was at level 2 of 3 stages of pubescent development, at the age of 5. Nancy was put on Lupron to suppress the hormones. At age 11, the Lupron was discontinued. She regularly sees a gynecologist once a year; her hormone levels continue to fall in the low range and thus prevent menstruation from occurring.

Nancy received Special Education services from K-12<sup>th</sup> grade and last attended the local school district. It is unclear at the moment if she received a letter of completion, diploma or is considered as a “drop out.” Further investigation will be needed and it is the intention of the START coordinator to discover and report the findings of the Individualized Education Plan (IEP). Nancy’s education has primarily been served in and out of the school setting and hospitalizations.

On May 27, 2010, the WAIS-III was conducted and reports a Full Scale IQ of 59. A previous intelligence test (RIAS) scored Nancy as follows: VIX 68, NIX 66 and CIX of 62 in 2007. In July of 2007, a Vineland Adaptive Behavior Scale (VABS) was also conducted resulting in the following

scores: Communication 34, Daily Living 50, Socialization 44 and a composite of 39, indicating that she is functioning in the low range of adaptive behavior with moderate to severe deficits.

With regard to her level of assistance required for activities of daily living or ADLs, Nancy exhibits difficulty with mobility around uneven surfaces, her Type 2 Diabetes is not being monitored, and she needs encouragement from time to time to perform routine bathing or showering. Nancy requires verbal prompting in the area of fire drill evacuation, crossing a street, using a telephone, and managing money.

There is no history of sexual activity or abuse reported and not suspected.

Nancy tends to be very tactile as evidenced by wanting to hold various items, touching items within her immediate reach and engaging in a variety of fine motor activities. Her eyes do not track due to the rods that were implanted to lift her eye lids, and she typically will scan an environment and not focus on any one particular object for a measurable amount of time. Her review of systems showed little to no remarkable findings as well as her neurological evaluation, EEG results and imaging studies. Although no reports are available at this time, they have been requested. Nancy’s surgeries and procedures include the following: Feeding tube, wiring of mouth, tracheotomy, tonsillectomy, colonoscopy, C-diff, surgery to remove staph infection from right knee, surgery to stabilize broken right arm, surgery to repair her tongue after falling, and surgery to correct a broken right ankle. Her medical hospitalizations are shown below:

<b>Date</b>	<b>Hospital/Description</b>
December 1997	Regional Medical Center
December 1997-1998	Children’s Hospital
2001	Hospital– Staph infection
2006	Children’s Hospital– Tonsillectomy

Nancy is currently taking the following:

<b>Name of medication</b>	<b>Diagnosis</b>	<b>Dosage and administration Schedule</b>	<b>Date first prescribed</b>
Paroxetine (Paxil)	Psychiatric	40mg h.s	2004
Seroquel	Psychiatric	400mg p.o. b.i.d	2004
Zetia	Cholesterol	10mg p.o. b.i.d	2004
Levothyroxine	Hypothyroid	10mg p.o. b.i.d	2004
Ranitidine	GERD	150mg p.o. b.i.d	2004
Divalproex Sodium DR	Psychiatric	750mg p.o. h.s	2004
Alprazolam (Xanax )	Psychiatric	0.5mg p.o. b.i.d, prn (as needed)	2004
Metformin	Type 2 Diabetes	As prescribed Information will be available at a later date.	2004
Vitamin D	Supplement	As prescribed Information will be available at a later date.	2004
Calcium with vitamin D 2 tablets q.d	Supplement	As prescribed Information will be available at a later date.	2004

Mother reports that Nancy is allergic to Dilantin and Erythromycin. With both, Nancy has broken out in a rash.

Nancy is currently receiving occupational therapy. Therapy reports are being requested.

Nancy has a significant history of inpatient psychiatric hospitalizations beginning in 1998 and as recent as October of 2011. Reasons for admission have often been due to impulsive behaviors associated with ATV accident resulting in aggressive behaviors, causing Nancy to be a danger to

herself and others. Typically, Nancy will exhibit one to two aggressive episodes during a

month, resulting in destruction of property or aggressiveness towards others. Most often, her aggression is directed at staff, but occasionally towards her peers.

Subsequent to her injury, Nancy resided at a residential facility following her discharge from CH in March 1998 through January 1999. During that time, there was a decline in cognitive functioning. Nancy was admitted to HDC in June 2004 and remained there until May 2006 and returned home with waiver services in place. She remained at home until the recent respite placement at HDC.

Nancy’s current admission was the result of an incident in which Nancy became upset with her waiver worker, walked across the street to a neighbor’s home, and pulled a 3 year old out of a van, breaking his collar bone and being arrested by the police. She was taken to Behavioral Health for stabilization until respite services could be secured at HDC. Recommendations include current placement until appropriate support services are available to Nancy in her home and community setting. She has no previous history of criminal activity. Although she was arrested and court ordered to Behavioral Health, there are no pending charges at this time. Further discovery may be necessary at a later date.

Nancy’s current diagnosis is as follows:

AXIS I	Personality Change due to head injury, aggressive type
AXIS II	Intellectual Disability
AXIS III	Type 2 Diabetes, Hx of Closed head injury 12/1997, Obesity, Hypothyroidism and Hyperlipidemia
AXIS IV	Changes in living situation, social environment and limited family contact
AXIS V	GAF 20

Her current mental health treatment plan consists of a highly structured living environment at CHDC until appropriate Waiver placement is secured. Nancy and her mother have chosen Community Services as her Waiver provider. The Community Services Director is actively employing, training, and scheduling staff for Nancy. Nancy’s Waiver plan will be included in this report as it becomes available.

While most recent testing was in 2010, recommendations seem to be appropriate, with continued implementation of a behavior management program. Nancy responds best when she is encouraged to “help” someone, as though she is doing them a favor instead of being asked to do something she needs to do in general. She responds best with one-to-one supervision, enjoys being in the community, and loves the outdoors, playing card games, and playing with her dog.

In conclusion of the findings at this time, Nancy exhibits poor coping skills, limited communication skills with limited language skills. Social skills are below chronological age appropriateness. Traumatic events in Nancy’s life include the ATV accident, divorce of

biological parents, divorce of her mother and step father, and multiple highly restrictive and structured acute hospitalizations. Nancy's mother feels that she is a compulsive eater resulting in her obesity and her Type 2 Diabetes.

### **Recommendations:**

Nancy and her mother are motivated to participate in START and provide any information necessary to assist in Nancy's return to her home. While there is a strong desire for Nancy to return home by Christmas, many supports will need to be in place to provide appropriate social skills, tension reduction strategies, coping skills, dietary compliance, and impulse control skills. She would also benefit from a positive behavior support plan and outpatient therapy.

Throughout all the records and reports, we find that Nancy exhibits poor social skills with others, at times she displays an inability to cognitively follow basic requests, poor concentration, and easily becomes upset when she is told "no" or does not get what she wants.

It is evident by reports that when Nancy becomes upset, she becomes verbally and physically aggressive. At times she has shown that she can self-soothe, but other times, Nancy lashes out at her staff, family or anyone that she may see as a threat. She demonstrates intermittent aggressive behaviors including hitting, biting, kicking and spitting on self and others. Property destruction with the intent to cause harm to self, others or to destroy property may also be present. It is not recommended for Nancy to listen to sad songs as she will become sad and begin crying. There is little to no history of outpatient therapy in the reports, however further investigation will be made.

Following are recommendations for her team to consider:

1. It is recommended that the treatment team consider the implementation of a positive behavior support plan for Nancy. The plan would need to address environment and routines that set the stage for challenging behaviors, antecedent triggers of said behaviors, reduction of challenging behaviors through prevention strategies, and the teaching of alternative behaviors.
2. Provide Nancy with coping skills (e.g., relaxation) that she will be able to utilize in all settings involving staff, family, and community. These skills need to be specifically taught, practiced, and then prompted and supported in analogue and then real settings. The use of verbal de-escalation will be used to encourage appropriate responses to disappointing people, situations, and /or news. Family and staff will need to be trained in implementation of the verbal de-escalation programming.
3. Provide a routine/schedule for Nancy to follow daily. This schedule would allow Nancy to make controlled changes throughout the daily activities so as not to seem too restrictive, and will also allow for preparing her for changes that are coming. Nancy and her staff would begin each day discussing the schedule that will be followed and end each day with a discussion of how well she followed and responded to that day's schedule. Positive reinforcements will need to be in place throughout the day to encourage continuance. Client, family and staff will show unity in the implementation of a daily, weekly, monthly schedule and be consistent with

consequences and rewards.

4. Implement Occupational and Speech Therapies based on the most current evaluations. Therapists will be involved in making recommendations for staff and family to encourage at home or in the community.
5. Provide goals and objectives that will maximize independence in the home, community, and personal care areas.
6. In the event that Nancy becomes agitated/aggressive, she will need opportunities throughout the incident to recover from the emotional/physical outburst. She will benefit from individual/group therapy that can be implemented at home and in the community.
7. Develop Behavior Incident Reports (BIR) that will be filled out by family and staff in 30 minute increments throughout a 24 hour period. This will help identify and monitor any trends that may need further research. A code will be developed to indicate positive and challenging behaviors and a scale to determine the level of verbal/physical reactions. BIRs will also include a variety of settings to chart from.
8. Development of a START Cross-Systems Crisis Prevention and Intervention Plan to enhance the teams' ability to consistently observe and recognize the earliest signs/symptoms of behavioral escalation, provide the staff essential tools to assist Nancy to de-escalate, and provide essential information relative to Nancy's communication style and service needs.
9. Nancy's team should meet on a regular basis (monthly to begin) to discuss how things are going, any additional needs that may have emerged, and to enhance collaboration among all members of the team. The START Coordinator Intern can assist in facilitating these meetings.
10. Ensure that all support staff and family members are well-trained on traumatic brain injury and the resulting behavioral and emotional dysregulation and difficulty learning and responding to consequences. Keep this information in mind in all interactions and service planning for Nancy.

Respectfully Submitted,

START Coordinator

# SECTION V:

## Conducting Cross-Systems Crisis Intervention & Prevention Plans (CSCPIPs)

- Overview
- START CSCPIP Short Form
- Procedures
- Components and Instructions
- Sample Forms
  - CSCPIP Form
  - Sample CSCPIP (redacted)
  - CSCPIP Worksheet

## OVERVIEW

A **Cross-Systems Crisis Prevention & Intervention Plan (CSCPIP)** is an individualized, person-specific written plan of response that provides a clear, concrete, and realistic set of supportive interventions that prevents, de-escalates, and protects an individual from experiencing a mental health or behavioral health crisis. The goal of the CSCPIP is to identify problems that have or may arise and map out a strategy that offers the tools for the circle of support to assist the individual to address problems and prevent crises from occurring. Sample forms and other supporting materials can be found at the end of this section. For personnel involved in the emergent support of the individual, the CSCPIP provides a coherent plan that outlines a clear strategy to react and assist effectively in a coordinated manner with the person's on-site circle of support. The CSCPIP can also identify additional resources when necessary to prevent or de-escalate the acute circumstance and to assure the safety of the individual and others.

The need for an individualized CSCPIP arises out of the health and safety risk due to potential/known environmental, behavioral, or psychiatric difficulties. Providing this kind of support requires a clear understanding and competence from the responders. While the onset of a crisis is particular to an individual, the sense of an increasing loss of control that, if left unattended, could result in a mental health crisis, challenging behavioral episode, and/or an individual becoming a danger to self or others is a critical criteria for identifying a crisis to be addressed by a CSCPIP. Developing this prevention plan requires participation and assistance from the person's on-site circle of support and outside supports.

A CSCPIP's preventative, supportive, and protective intervention procedures are based on an understanding of systemic and environmental issues as well as an individual's bio-psycho-social vulnerabilities and behavioral indicators of increased difficulties. The escalation of difficulties often occurs over time or in "stages," based on a combination of individual vulnerabilities and/or environmental factors that may be influencing or contributing factors under conditions known as triggers or those conditions known to result in difficulties when they occur on the elicitation of external supports (including those found outside of the circle of support in the current environment) generally increases when the person's difficulties progress from one stage to another. The stages are outlined in accordance with the public health model of tertiary care, from least to most intensive, and will be outlined below.

The development of the CSCPIP is facilitated by the START Coordinator with the service recipient's circle of support in collaboration with other stakeholders that may be included in the planning and intervention process. For the service recipient's "on-site" circle of support (caregivers, family, others) the CSCPIP provides a coherent, coordinated, plan that assures their ability to react effectively and to provide and enlist the assistance of additional

supportive resources when necessary. The CSCPIP assists the circle of support in promoting positive coping strategies, preventing a problem from occurring, de-escalating a person, and assuring the safety of the individual and others.

Other stakeholders included in the planning and implementation of a CSCPIP typically include:

- Friends and family
- Direct support staff
- Case managers
- Psychologists
- Residential/vocational provider
- Supervisory staff
- Mental health crisis responders
- Emergency medical and law enforcement
- Psychiatric care
- Medical care
- START Resource Center
- Crisis diversion
- Hospitalization resource providers

## **START CSCPIP SHORT FORM**

Because the process of facilitating the development of a CSCPIP can take several weeks, a START Short Form is developed for the period of time between referral and the completion of the Long Form. Further, the CSCPIP Short Form is also used when service recipients live with their families, for ease of use. It is a brief plan designed to provide immediate relief and support to the circle of support while further information gathering and evaluation are completed.

The CSCPIP Short Form can be completed using data from the intake, family members, support staff, and the client. It is an abbreviated version of the Long Form and the instructions for completing overlapping sections of the Forms is outlined in the CSCPIP Procedure section that follows. Also, a sample CSCPIP Short Form is located in this section.

## **CSCPIP PROCEDURE**

The development of a viable CSCPIP is typically best accomplished in the context of a meeting facilitated by a START Coordinator. The meeting includes the active participation of the people who know the person well, other stakeholders, and representatives from each and all of the systems involved in supporting the individual to prevent or intervene in a crisis. It typically includes: family caregivers and friends, residential and vocational direct support staff, case managers, service coordinators, mental health and other health care providers as necessary.

The START Coordinator is responsible for scheduling the CSCPIP development meeting to gather input from all participants and for creating the CSCPIP document. The use of a "CSCPIP worksheet" to begin discussions allows for a free flowing process without overtly focusing on the CSCPIP form itself. The START Coordinator completes the CSCPIP draft after the initial CSCPIP development meeting and distributes the draft document to meeting participants and others. Once the plan has been finalized, all representatives of the team review and sign the plan. The final version of the plan is distributed to all persons and agencies that will be involved in supporting and/or treating the person.

Changes to the CSCPIP are made as appropriate. The CSCPIP is reviewed for efficacy by the support team each time it is utilized, and on at least an annual basis as part of the ISP review. The CSCPIP should also be reviewed whenever there are significant changes in the person's condition or circumstance, including admission to the Resource Center, hospitalization, or diversion bed admission.

## **PEER REVIEW**

It is important to note: *No START Coordinator writes a CSCPIP in isolation of the circle of support. Instead, the Coordinator facilitates its development and implementation in partnership with the circle of support.* Once the initial draft of the CSCPIP has been developed, it is important for START Coordinators to implement the peer review process with the Circle of Support. Steps are listed below.

1. E-mail the plan to circle of support members in advance so they can review it prior to the peer review meeting.
2. When you arrive at the meeting, assign all sections of the plan for review and provide feedback to the group. For example, you might ask the mother to review the first page of the plan and make sure it is clear and has accurate information. Each member of the team reviews a section and comments. Give them about 10 minutes to review.
3. Members of the circle of support who cannot attend the meeting should be invited to participate via conference call or speaker phone.
4. Comments are provided at the meeting and edits made.
5. Remind everyone that although you compiled the CSCPIP that it is a team authored plan. Any problems or issues that arise once the plan is in place should result in the START Coordinator facilitating either a conference call for face to face meeting depending on the complexity of the necessary modifications.

# COMPONENTS OF AND INSTRUCTIONS FOR THE CROSS-SYSTEMS CRISIS PREVENTION & INTERVENTION PLAN

## Part I: Face Sheet

A Face Sheet contains basic demographic information, support person and support agency identifying information, diagnoses, insurance information, and medications, as well as current medical and behavioral functioning. It serves as a quick reference to information that is important for on-site and/or responding support persons/agencies to have immediate access to.

### Demographics: Identifying Information

Complete all information as needed.

### Mental Health Diagnosis

Enter current Diagnoses from DSM IV or V as indicated. Be sure to include Axis I through V diagnoses and information if given or other diagnostic information from major areas (e.g., associated medical conditions). *This may require discussion with the current treatment team. Please only include most current diagnosis.*

### Insurance Information

Enter the full insurance information including the identification numbers as needed.

### Medication

Provide a list of medications, their doses and schedule as well as the purpose of the medications as of the date of the plan. It is important to be clear about what medications are prescribed for. List all known medication allergies in bolded type.

### Medical Concerns

Enter a brief description of medical concerns to consider. Include adverse medication reactions and side effects, if known. Highlight medical conditions that likely result in challenging behavior.

The next two sections contain a brief synopsis of the individual's baseline functional abilities and routines. It is a description of how the person typically presents and functions when not in crisis. This description serves as a source of useful person-centered information for support personnel who are engaged in assisting the person during times of difficulty or crisis, especially personnel who are not familiar with the individual. In addition, knowing the likes and dislikes of the individual is essential when attempting to avoid or diffuse a potential crisis.

### Communication Style

Enter the person's primary language, preferred mode(s) of communication, and a description of his or her expressive and receptive communication ability. Descriptions often also include reference to the person's emotional expressiveness and presence or absence of response latency. If the individual tends to understand language in a very literal or concrete manner, indicate that in this section.

Although having a hearing impairment would be identified as a medical issue it should be listed here as well since it directly influences what information may or may not be heard or understood by the individual, and highlights the need to speak at a slightly higher volume or augment with visual cues, written instructions, sign language, or other augmentations that are used.

In addition, this section should be a brief outline of ways in which to communicate with the individual during times of stress. This is especially important as some individuals' expressive and receptive communication abilities may become impaired when experiencing high levels of stress and may not respond the same to methods of communication that typically work for the person.

### **Strengths/Skills/Interests**

Enter information regarding the individual's skills and interests as well as their various strengths including personal, interpersonal, social, vocational, self-care, motor, and others.

### **Providers**

Please provide a comprehensive list of providers and contact information in this section.

## **Part II: General Guidelines**

- General patterns of behavior and personality traits: describe the person's typical demeanor, mood, interests, and strengths as well as challenges and stressors. It is important to describe the circumstances that promote the best success for the person and ways to develop rapport.
- Description of the home environment: enter information regarding individual's typical daily activities including performance of ADLs and home-related tasks, social relationships, family, personal interest, vocational activities, community contacts, and aspects of the physical space such as whether the person shares a room with others, etc.
- Factors that may increase stress for the individual: describe the person's capacity/ability to handle stress, particular types of stress that the person handles well versus types of stress the person handles poorly, and level of staff support the individual needs to handle stress.
- History of legal involvement should include information about

guardianship and any arrests or convictions and/or forensic issues that have resulted in legal action. If an individual has episodic issues which require police assistance (calling 911) these would not necessarily need to be articulated in this section.

- Situations that have historically lead to hospitalization: include the person's symptoms or behaviors that have led to hospitalization.
- Alternative supports/resources recommended for avoiding hospitalization; list what has worked in the past to keep the person out of the hospital or emergency services.

### **Part III: Multimodal Analysis of Behaviors**

This section serves as the blueprint of the agreed upon coordinated Tertiary Care plan to support the individual prior to and during crisis. It is a source of critically important and useful information to guide support personnel, both onsite and those called in as additional resources, who are engaged in supporting the person during crisis. It should be written as a set of instructions for exactly what to do in response to specific behavior or symptoms so that the support system can remain stable and calm. This section is divided into three stages, each representing a level of care (from the World Health Organization's public health three-stage prevention model):

1. Primary interventions focus on prevention of crises by responding early to signs that crisis may be impending. These are interventions that can be done in the person's current setting by typical supports.
2. Secondary interventions are those that require involving the support of outside systems and partners, such as getting the advice of specialists, or on-call personnel, or making appointments or team meetings to problem solve.
3. Tertiary interventions are crisis response and occur either in the current environment or the person is removed for some period of time. These can include emergency assessments, therapeutic supports, or hospitalizations, etc. as needed.

*It is important to focus on the primary issues that result in crisis service use for this individual in Section III (for example acute depression, panic, chronic pain) and identify these in the Chief Complaint to be Addressed section.*

*Challenging behaviors/mental health symptoms* are the most likely indicators of difficulty a person displays. They can range from problems / challenging behaviors that communicate distress or possible distress, to sudden and/or severe presentation of the need for immediate intervention. It is important that the earlier signs are addressed in an attempt to reduce the likelihood of the need for more crisis-focused interventions.

The person's symptoms of increased difficulty or distress are ranked in sequence from least to most intrusive with stage I behavior/signs and symptoms

being the least noticeable and most often missed during times of distress or crisis. Enter concrete, specific behavioral descriptions of how the individual presents at each stage of crisis.

*Vulnerabilities* are characteristics of the person that predispose him or her to experience stress, mental health problems, and/or challenging behavior. In the analysis of factors that set the stage for difficulty to occur, include vulnerabilities that are known about the individual (bio-psycho-social vulnerabilities). Vulnerabilities are identified through a person-centered understanding of the individual's history and life experiences that create conditions that make problems more likely arise. They establish the context under which the "trigger" results in a negative change within the person.

Enter working hypotheses of likely pre-existing bio-psycho-social vulnerabilities such as:

- Medical (conditions such as diabetes, gastrointestinal, thyroid, dental problems, mental illness, deafness, visual impairments, genetic disorders that may make individuals more susceptible to possible triggering events).
- Psychological (communication problems, cognitive or developmental limitations, self-esteem problems, history of trauma, exaggerated startle response, environmental factors changes in environment, loud noises, unwanted demands, stimulation, crowded spaces, going over bridges, etc.) that may be contributing to the crisis at that stage.

An example of a vulnerability analysis from a biopsychosocial perspective would be to note that an individual has trouble communicating pain, has difficulty with stimulating and noisy settings, and suffers from headaches.

*Triggers* are the issues that, on their own do not result in difficulty but under specific conditions (the vulnerabilities) can directly result in a problematic presentation. An example would be a request that, when the person is feeling ok, would result in a positive response; however, when the person is not feeling ok (associated with their vulnerabilities) the same request may result in a negative response.

In our example, if the person who ordinarily wants to go to work begins to scream and slap his head, this may be an indication of the conditions previously described (a headache and the inability to communicate this). We know this from previous knowledge about the person, that in the past, when he had a headache he refused activities and slapped his head.

*Interventions* are what the team members have agreed to do when each symptom is present. This section provides a "map" or list of instructions for families and/or support staff to follow to intervene effectively to prevent and assist in times of crisis. The section must be specific steps listed in the order of their

implementation for each stage of overall intervention. You must specify who is to perform the intervention and provide a list of specific names of support persons as well as their direct access telephone number within the intervention description.

Interventions should neutralize the triggers and address the vulnerabilities. Interventions should also incorporate the use of an individual's known strengths and interests whenever possible, to help cope with problems when they arise.

In the example of the person's poor response to a request (head slapping and refusal to go to work), the intervention might include assisting the person in communicating about the headache, modification of the request (can take the day off), Tylenol (to treat the headache), or taking the person to a quiet room and playing soothing music that the person enjoys (to reduce the stimulation) along with verbal reassurance (provided by staff or natural supports).

### **Crisis stages 1 to 3:**

**Stage 1 is when primary interventions are utilized** and is characterized by a noticeable change in the individual's demeanor, behavior, or attitude that may give rise to increased concern. The changes are considered subtle and the interventions needed should allow for ordinary caregivers and support people in the person's life to intervene.

At Stage 1 the person's presentation doesn't usually disturb others, but rather contains known indications of possible disturbance for the individual. They are often subtle indications of possible difficulty such as changes in degree of social engagement and/or isolation, sleep patterns, mood, or appetite. There may be unusual habits associated with a functional decline. It is vitally important during this stage that these subtle changes are recognized and interventions utilized. It is crucial to communicate among the team members when these early changes are manifesting.

The person may begin experiencing an internal feeling of losing control that leads to increased difficulties at these times. Typically, onsite support persons provide increased active/supportive intervention for the person. At Stage 1, the need is to explore vulnerabilities, including environmental factors that may be altered to reduce the person's discomfort and risk of further escalation. An intervention may include a medical intervention, change in schedule to address boredom, decreased stimuli to prevent over-stimulation, medication to improve sleep, etc.

**Stage 2 indicates that secondary intervention is needed** and is typically characterized by an escalation in the person's demeanor, behavior, or attitude that indicates to on-site support persons that Stage 1 intervention strategies have been unsuccessful and that the individual is experiencing increased difficulty. On-site support persons become concerned regarding their ability to

assure the safety of all and to successfully de-escalate the individual. This is when on-site support persons contact on-call supports and/or program supervisors and possibly others for consultation and additional supportive intervention. At this stage, an intervention may include a ruling-out any sudden onset of medical problems, a START team assessment, calling a specialist for help, or scheduling team meetings.

**Stage 3 is the crisis intervention stage** and the person has lost control and his/her behavior has escalated to the point of clearly posing an increased health and safety risk to self and/or others. On-site support persons are even more concerned regarding their ability to assure the safety of all and to successfully de-escalate the situation. During this stage, on-site persons seek additional immediate supportive resources from other identified systems and consider the advisability of alternate support settings such as the START Resource Center, crisis diversion, crisis triage, and psychiatric hospitalization.

#### **Part IV: Disposition Recommendations**

Emphasize interventions that work. Enter information regarding recommended ways of approaching, interacting, and communicating with the individual effectively. This information is helpful to support persons who are not familiar with the person and want to interact positively with him or her. Include interventions to avoid as well. Enter information regarding ways that do not work well when approaching, interacting, and communicating with the individual.

List hospitals, respite, or emergency service options that are recommended for this individual. Also list services that the individual has not benefited from in the past.

#### **Part V: Back-Up Protocol**

In this section it is essential to ensure that the system functions optimally to support the individual in need. There are times that the information in Part III should be bypassed when it is clear that immediate assistance is needed. This is the section where staff members will go to get immediate support from back-up systems. Please describe in detail, the person's emergency back-up system before the crisis team is contacted.

The next section describes in detail how and when to access crisis/emergency services.

## **Part VI: Cross-Systems Crisis Prevention & Intervention Plan Signature Page**

Once the CSCPIP has been finalized, the person (only when appropriate), family members, stakeholders, and all persons and designated representatives from all agencies involved in supporting the plan or services suggested in the plan sign the CSCPIP.

The final version of the CSCPIP is then distributed to all parties for use.

**INDIVIDUAL SUPPORT, CRISIS PREVENTION AND INTERVENTION PLAN**  
*Short Version*

**PART I – FACE Sheet**

**Demographics**

Name: \_\_\_\_\_ Region: \_\_\_\_\_  
 Date: \_\_\_\_\_ ID #: \_\_\_\_\_  
 D.O.B.: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Living Situation (check appropriate box):**

lives with parents/guardian                       lives alone  
 lives with spouse/partner                       other (please specify)  
 Describe: \_\_\_\_\_

	Diagnosis		Insurance
DSM V			
DSM IV			
Axis I		Medicaid #	
Axis II		Medicare #	
Axis III		Private Ins. #	
Axis IV		Other	
Axis V		Other	

**Current Medication (both prescription and over the counter)**

	<b>As of :</b>	
<b>Medication</b>	<b>dose</b>	<b>frequency</b>
medication	dose	frequency

Medical/Dental Conditions

Communication Style - Primary Language (note receptive and expressive language)

Strengths/Skills/Interests

**Circle of Support/Providers**

Type	Agency	Name	Address	Phone Number
Guardian				
Family/friend contact				
Residential Program				
Work Program				
Case manager				
Individual Clinician				
Primary Physician				
Psychiatrist				
Therapist				
Neurologist				
Mobile Crisis Management Team				

## PART II – General Guidelines

Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; skills, interests, does best when given "space," ways to develop rapport, etc.)

*These are things that we see on an ordinary day:*

Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):

Describe alternatives that have been effective in keeping the individual out of crisis. What can be tried in the current setting?

**PART III - Disposition Recommendations: When the person needs to leave home for help**

Specify what options have been most successful in the past; whether the individual has been to respite and did well there, which hospital is the hospital of choice if necessary, etc.

**PART IV - Back-Up Protocol**

**Outline specific protocols under which the START team, mental health crisis team or other first responders will be accessed. Who should be called in case of an emergency? How can they be reached? What will happen when family member/care giver contacts them? BE AS SPECIFIC AS POSSIBLE include contact names, phone numbers, hours of operation, etc. Protocol should be initiated to prevent crisis at *earliest signs of difficulty*.**

<b>What may happen</b>	<b>What to do</b>	<b>Who to call</b>	<b>Phone number</b>
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
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**PART V - Signatures/Approvals**

NAME:

CIRCLE OF SUPPORT SIGNATURES		
	<i>Signature</i>	<i>date</i>
Individual (OPTIONAL)		
Family member/friend		
Case Manager/Care Coordinator		
Psychologist		
Psychiatrist		
Primary medical provider		
Day/Voc Program rep.		
Advocate		
Neurologist		
Respite program rep.		
Mental Health Crisis Team representative		
Other		

**CENTER FOR START SERVICES**  
**INDIVIDUAL SUPPORT, CRISIS PREVENTION & INTERVENTION PLAN**

**PART I - FACE SHEET**

Demographics
Name:
START Program:
Date:
Medical Record .#:
D.O.B.:
Telephone #:
Address:

**Living Situation** (check appropriate box):

<input type="checkbox"/> lives with family	<input type="checkbox"/> lives alone
<input type="checkbox"/> lives alone with supports	<input type="checkbox"/> lives in enhanced family care
<input type="checkbox"/> lives in staffed community residence	<input type="checkbox"/> other
Describe:	

**Describe the environment (system) in which the individual lives:**

	<i>Diagnoses Psychiatric</i>		<i>Insurance</i>
<b>DSM-V</b>			
<b>DSM-IV</b>			
<b>Axis I</b>		<b>Medicaid #</b>	
<b>Axis II</b>		<b>Medicare #</b>	
<b>Axis III</b>		<b>Private Ins. #</b>	
<b>Axis IV</b>		<b>Other</b>	

Current Medication, as of (date):		
Medication	Dose/frequency	Purpose

Medical/Dental Conditions

Communication Style - Primary Language (note receptive and expressive language)

Strengths/Skills/Interests

Circle of Support/PROVIDERS

Type	Agency	Name	Address	Phone Number
<i>Guardian</i>				
<i>Family/friend contact</i>				
Residential Program				
Vocational/day Program				
Case manager/ Service Coordinator				
START Coordinator				
Primary Physician				
Psychiatrist				
Therapist				
Neurologist				
Mobile Crisis Management Team				
Other				

## **PART II – GENERAL GUIDELINES**

Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; skills, interests, does best when given “space,” ways to develop rapport, etc.):

Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):

Describe the nature of any legal involvement the individual has had. Is there or has there been any court involvement? Describe how (or if) this affects his/her supervision needs. Are there situations that care providers should be aware of in order to maintain safety for the individual and others?

Describe situations and/or behaviors that have historically led to crisis service use and/or hospitalization for this individual:

Describe alternatives that have been effective in keeping the individual out of crisis. Have alternative services i.e. respite and diversion to hospitalization been used effectively?

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### PART III: HIERARCHY OF BEHAVIORS

Chief Complaint to be Addressed:

Stage I - Primary Intervention: what you can do in the setting				
Behaviors/Signs/MH Symptoms	Biopsychosocial Personal Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #s

**Stage II – Secondary Intervention: when advice/ assistance from on-call help,  
specialists, or START coordinators is needed (make appts., team meetings, etc.)**

Behaviors/Signs/MH Symptoms	Biopsychosocial Personal Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #s

Stage III – Tertiary Intervention: acute level crisis intervention either				
Behaviors/Signs/MH Symptoms	Biopsychosocial Personal Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #s



## PART IV - DISPOSITION RECOMMENDATIONS

Specify what options have been most successful in the past; whether the individual has been to respite and did well there, which hospital is the hospital of choice if necessary, etc.

## PART V - BACK-UP PROTOCOL

Describe the systems emergency back-up protocols to support the individual:

Outline specific protocols under which the mental health crisis team or other emergency supports will be accessed.

## PART VI – SIGNATURES/APPROVALS

NAME:

CIRCLE OF SUPPORT SIGNATURES		
	<i>Signature</i>	<i>date</i>
Individual (OPTIONAL)		
Parent/guardian		
IDD Case Manager/ Service Coordinator		

Psychologist		
Psychiatrist		
Primary medical provider		
Day Program rep.		
Residential program rep.		
Neurologist		
Respite program rep.		
START Coordinator		
Other		

ADMINISTRATIVE APPROVAL		
	<i>Initials</i>	<i>date</i>
START Clinical Director		
START Director		
START Clinical Team Leader		

# CROSS-SYSTEMS CRISIS PREVENTION AND INTERVENTION PLAN - SAMPLE

## PART I - FACE SHEET

Demographics	
Name: Sam Jones	DMR Area: 12
Date: 7/15/12	Medical Record #: 048622941
D.O.B.: 1-12-73	Telephone #: (XXX) XXX-XXXX
Address: 12 Main Street, Anywhere, USA	

Living Situation (check appropriate box):
<input type="checkbox"/> lives with family <input type="checkbox"/> lives alone with supports <input checked="" type="checkbox"/> lives in XYZ residence
Describe: Sam lives in a home operated by XYZ - CT

	<i>Diagnosis</i>		<i>Insurance</i>
<b>Axis I</b>	Major Depression (296.34), w/psychotic features OCD (300.3), r/o Schizoaffective Disorder, r/o Panic Disorder	Medicaid #	XXXX
<b>Axis II</b>	Mild Intellectual Disability (317)	Medicare #	XXXXA
<b>Axis III</b>	H/o constipation, h/o NMS, generalized Dystonia	Private Ins. #	BC, BS XXXXX
	H/o hypercholestralidemia h/o heat stroke		
<b>Axis IV</b>	Change in primary supports	Other	
<b>Axis V</b>	GAF 60 at the present time	Other	

### Current Medication

*As of: 7/15/12*

<i>medication</i>	<i>dose</i>	<i>frequency</i>
<i>Klonopin</i>	<i>1.0 mg</i>	<i>tid</i>
<i>Celexa</i>	<i>60 mg</i>	<i>qd</i>
<i>Trazadone</i>	<i>200 mg</i>	<i>hs</i>
<i>Clozaril</i>	<i>150 mg</i>	<i>8:00 a.m.</i>
<i>Clozaril</i>	<i>150 mg</i>	<i>3:00 p.m.</i>
<i>Clozaril</i>	<i>325 mg</i>	<i>hs</i>
<i>H sulpher 6 C</i>	<i>1 pellet</i>	<i>4:00p</i>

### Medical Concerns

Neuroleptic malignant syndrome from the use of neuroleptic medications (NMS). No use of neuroleptic medications with exception of Clozaril. History of heat stroke.

### Communication Style - Primary Language

#### Expressive communication:

- speaks well with normal volume, some dysfluency and pressured at times.
- Silence may indicate an inability to communicate
- does not always report what he expects to have happen
- when stable speech is fluid
- will shut down when given unwanted demands

#### Receptive communication:

- always use simple language when communicating
- give one directive at a time

Sam's ability to communicate (both expressive and receptive) is greatly compromised when he is psychiatrically unstable. His thought process is slowed and his speech pattern is flat. This is not the way he ordinarily communicates and should be viewed as a sign of difficulty.

### Strengths/Skills/Interests

- Intellectually high functioning person with mental retardation
  - Interested in sports – especially basketball
  - Likes social contact
  - Has many interests
  - Good sense of humor
  - game system
  - Good eye-hand coordination
  - Likes to work
  - Likes to help
  - Likes being tall e.g. so he can help shorter people reach things
- Sam does very well at baseline and has many skills and abilities.

## PROVIDERS

<i>Type</i>	<i>Agency</i>	<i>Name</i>	<i>address</i>	<i>phone #</i>
<i>Guardian</i>		Susan A. Jones	Anywhere	Home: XXX XXX-XXXX Work: XXX XXX-XXXX Cell: XXX XXX- XXXX
<i>Nurse Consultant</i>	XYZ	Karen Smith		Page: XXX XXX-XXXX
<i>Residential program</i>	XYZ	XYZ House: Michael Johnson	Anywhere	Phone: xxx-xxx-xxxx
	Program Coord.	Pat Gardner		XXXX
<i>Work program</i>	ARC of The World	Kim James Joan Giles	Anywhere	XXXX
<i>Crisis team</i>	Mobile Outreach	On-duty clinician	Anywhere	XXXX
<i>primary physician</i>	Private Practice	Dr. Medicine	Anywhere	XXXX
<i>psychiatrist</i>	UState Health Center	Olga Doc, M.D.	Anywhere	XXXX
<i>Behavior therapist</i>	XYZ	Sheryll Psychology	Anywhere	XXXX
<i>DMR case manager</i>	DMR	Liz Manager	Anywhere	XXXX
<i>neurologist</i>	Neurology Associates	Dr. Brain	Anywhere	XXXX
<i>Clinical service consultant</i> <i>START</i>	XYZ consultant  USTATE coord.	Dr. Joan Consult  Dr. Lauren Hospital	Anywhere	XXXX

## PART II - GENERAL GUIDELINES

**Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; does best when given "space", etc.):**

- Good sense of humor
- Likes to play and watch sports, especially basketball
- Does best when in a calm setting with low noise, but tolerates noisier, more congested settings if he is comfortable with the people and/or activity, and is not unusually anxious
- Engaging but anxious
- When troubled, his left shoulder may droop and he carries his left arm stiffly indicating anxiety
- Works well with routine /consistency
- Responds well to concrete planning (i.e., calendars for daily routine and for weekly events)

**Describe the environment (system) in which the individual lives:**

- Sam lives in a 24 hour staffed home operated by XYZ with one other individual
- XYZ provides most services along with ARC

**Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, etc.):**

- Loss of relationships
- Birthdays
- Change
- Too many choices
- Too many demands
- People violating his personal space
- Feeling lonely
- Christmas; anniversaries
- Loud noises

**Describe the nature of any legal involvement the individual has had. Is there or has there been any court involvement? Describe how (or if) this affects his/her supervision needs. Are there situations that care providers should be aware of in order to maintain safety for the individual and others?**

Mother is legal guardian. All incidences of aggression and irritability must be reported to her and to the team.

**Describe situations and/or behaviors that have historically led to hospitalization for this individual:**

- Changes in routine
- Days of sleep deprivation
- Agitation and/or irritability; confused or disoriented cognition
- Intense assaultiveness or repeated incidents of brief aggressive behavior
- Packing his bags—attempting to leave
- Disappointment
- Pressured speech
- Slurred speech, excessive drooling
- Unable to separate what is happening to himself and what is happening to others
- Unable to think ahead—confusion about coming and going

**Describe alternatives that have been effective in keeping the individual out of the hospital:**

- Increases in dose of Clozaril
- Get him to sleep 7 or more hours per night
- Increase engagement direct away from perseverations
- Increase activities that build self-esteem

Stage I - Primary Intervention: what you can do in the setting				
Behaviors/Signs/MH Symptoms	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
<p>Tense facial expression, pacing, appearing flushed, increased perspirations (especially about girlfriend and/or his age)</p> <p>- change in thought process – confused/ agitated/irritable/ unable to separate what is happening to himself and what is happening to others. <b>(look for clusters in behaviors—this is what is the sign of psychiatric instability)</b></p> <p>Wandering, glazed eyes and dilated pupils.</p> <p>- starts to complain about how miserable his life is.</p>	<p><b>Medical concerns:</b> mild dehydration: decreased fluid intake leading to dehydration: thirst, dry lips, slightly dry mouth and/or membranes</p> <p><b>psychiatric vulnerabilities:</b> - Lack of sleep (2 consecutive nights)</p>	<p>Ordinary demands in his daily routine may result in confusion.</p> <p>Change in routine may result in his becoming agitated and stuck.</p>	<ul style="list-style-type: none"> <li>- <b>medical concerns:</b> contact Karen Smith: XXXX</li> <li>- <b>Review standing orders-</b></li> <li>- <b>Inquire about bowel status</b></li> <li>- <b>Encourage fluid intake</b></li> <li>- Engage him in an activity that he finds interesting</li> <li>- Be supportive, don't confront with reality, move to a reality based topic</li> <li>- Encourage him to do something he is good at and enjoys</li> <li>- Physical exercise (basketball)—</li> <li>- Utilize ABC tracking and report to IDT</li> <li>- Contact team members to determine medical of mh intervention (Dr. Psychiatry, Sheryl, Pat, Joni BB, Mrs Jones and Nurse Karen)</li> </ul>	<ul style="list-style-type: none"> <li>- <b>shift staff/house manager;</b> <b>Michael XXXX</b></li> <li>- <b>Karen Smith: XXXX</b></li> <li>- <b>Mrs. Jones: XXXX</b></li> <li>-</li> <li>- <b>Sheryll</b></li> <li>- <b>W: XXXX</b></li> <li>- <b>H: XXXX</b></li> <li>-</li> <li>- <b>Pat G: XXXX</b></li> <li>-</li> <li>- <b>Joni BB: XXXX</b></li> <li>- <b>Liz: XXXX</b></li> <li>- <b>Dr. Psychiatry XXX</b></li> </ul> <p>**** if Joan cannot be contacted Michael Stanley should be contacted at XXXX</p>

**Stage II – Secondary Intervention: when advice/ assistance from on-call help, specialists, or START coordinators is needed (make appts., team meetings, etc.)**

Behaviors/Signs/MH Symptoms	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
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<p>Lethargic, constipated, confused</p> <p>Psychiatrically:</p> <p>*****look for clusters in behaviors – this is a sign of decompensation*****</p> <ul style="list-style-type: none"> <li>- Difficulty processing</li> <li>- Slight smile and answering “yes” to most questions</li> <li>- Not able to carry on a conversation</li> <li>- Not following/ completing daily routines</li> <li>- Responding “ok” to everything</li> <li>- Resists/refuses to complete routines i.e will refuse to change clothes, wears clothes inside out.</li> <li>- lethargic</li> <li>- Irritable in hot weather</li> </ul>	<ul style="list-style-type: none"> <li>- Medical difficulties including dehydration and constipation.</li> <li>- Increase in mental health symptoms associated with acute episode of psychosis.</li> </ul>	<ul style="list-style-type: none"> <li>- Medication effects, problems with heat</li> <li>- Noisy or distracting environment</li> <li>- Too many choices</li> <li>- Being teased or feeling incompetent</li> <li>- Staff being authoritative and/or directive</li> <li>- Unwanted demands/ (unnecessary phone calls)</li> <li>- Lack of sleep (more than 2 consecutive days)</li> </ul>	<p>stage 2 or 3 of dehydration; needs to go to the hospital</p> <p>Psychiatric:</p> <ul style="list-style-type: none"> <li>-Simplify schedule</li> <li>-reduce or change any demands on him</li> <li>- contact START on-call to prescreen for emergency respite admission</li> <li>-Call Pat who will call Mrs. Jones</li> </ul> <p>call Emergency meeting to address:</p> <ul style="list-style-type: none"> <li>- Assess sleep and possible medication adjustment.</li> <li>- Assess for anxiety related to anticipation of an event causing increased symptoms</li> <li>- Assess psychotic thinking</li> <li>- Switch off staff</li> <li>- Be aware of the environment – remove all potentially harmful objects</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Nurse number XXXX</b></li> <li>Shift Staff</li> <li>- Inform House manager Michael : cell XXX, beeper: XXX</li> <li>- Call Karen Smith nurse for medical support: XXX</li> <li>- Inform Mrs. Jones</li> <li>- Dr. Psychiatry</li> <li>- Joni BB ( START)— XXX</li> <li>- cell: XXX</li> </ul>
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**Stage III – Tertiary Intervention: acute level crisis intervention either  
in the current environment or removal from the environment**

Behaviors/Signs/MH Symptoms	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
<ul style="list-style-type: none"> <li>- Highly aggressive toward males.</li> <li>- Yelling and pounding on walls</li> <li>- Unable to hear others</li> <li>- Ruminates on birthday and upcoming events</li> <li>- Inconsolable</li> <li>- Unable to express self effectively</li> <li>- Highly confused cannot dress self</li> <li>- No sleep in a number of days ( 3 or more)</li> </ul>	<p>acute medical issue that has resulted in delirium</p> <p>psychotic episode</p>	<p>Sun stroke</p> <p>Period of decompensation of mental health condition unresponsive to previous interventions</p>	<p>Call 911 It is important to explain that this individual has a history of NMS and sun stroke. Connect the ER with Dr. Psych and START asap</p> <ul style="list-style-type: none"> <li>- Go to Hospital name ER</li> <li>- Call Sheryll to coordinate with ER Emergency Room Physician and/or psychiatric clinicians, STASRT team call to assist to assess for possible admission into Ustate or START respite</li> </ul>	<p>Michael : House Manager Cell: XXX beeper: XXX Dr. Psych. XXXX Karen Smith: XXX Mrs. Jones: XXX Pat : XXX / cell phone XXX h: XXX</p> <ul style="list-style-type: none"> <li>- Sheryll w: XXX cell XXX</li> <li>-</li> <li>- Dr. Michael Stanley XXX or XXX</li> <li>- Dr. Joni BB : XXX</li> <li>- cell: XXXX</li> <li>- Liz Manager: XXXX</li> </ul>

#### PART IV - DISPOSITION RECOMMENDATIONS

**Specify what options have been most successful in the past; whether the individual has been to respite and does well there, which hospital is the hospital of choice, if necessary, etc.**

Will usually go to START respite after hospitalization to help transition home

Has been treated with success at the University of State Medical Center, Neuropsychiatric Disabilities Unit.

It is anticipated that Sam will utilize Local Hospital ER only for medical examination followed by his return, if possible. If Sam requires psychiatric hospitalization he will be admitted to UState— Director of unit is Lori Hospital XXX or pager XXX START Dr. Joni BB will prescreen.

#### PART V - BACK-UP PROTOCOL

**Describe the individual's emergency back-up system:**

When in a pre-crisis situation, Sam mother will be called, along with the rest of his treatment team and START early on to evaluate the situation and determine if crisis respite or hospitalization is necessary. The two criteria for include 1) intense assaultive behavior and/or 2) persistent deterioration/disorganization in Sam thinking and contact with reality.

**How and when would START team be accessed?**

START team will be contacted asap. In a crisis situation, Sam will be transported the Hospital ER by the ambulance (call 911) for stabilization. Mobile Outreach will be called when he is taken to the ER and notified that there is a crisis that DMR is attempting to handle within its program staff. If Sam cannot be stabilized at the ER, or if he is acutely ill, he will be hospitalized at UState or Name Hospital, depending upon medical recommendations, and availability of a bed, etc. After medically stable in that setting if Sam does not improve so that he can be returned to the house, he can transition back home for two to four weeks through START emergency respite.

**PART VI - SIGNATURES/APPROVALS**

NAME: Sam Jones

SIGNATURES		
	<i>signature</i>	<i>date</i>
XYZ Behavioral Specialist	<i>Signed</i>	<i>dated</i>
Parent/Guardian	<i>Signed</i>	<i>dated</i>
DMR Case Manager	<i>Signed</i>	<i>dated</i>
Nurse Consultant	<i>Signed</i>	<i>dated</i>
Clinical Services Consultant	<i>Signed</i>	<i>dated</i>
UState Medical Center	<i>Signed</i>	<i>dated</i>
Mental Health Crisis Team Representative	<i>Signed</i>	<i>dated</i>
Other	<i>Signed</i>	<i>dated</i>

APPROVAL		
		<i>date</i>
Residential Administrator	<i>Signed</i>	<i>dated</i>
DMR administrator	<i>signed</i>	<i>dated</i>
Day/Voc. Administrator	<i>signed</i>	<i>dated</i>
Mental Health Crisis Team Administrator	<i>signed</i>	<i>dated</i>

SENT TO			
	<i>name</i>	<i>date</i>	<i>check off</i>
Psychiatrist			
Guardian			
DMR Regional Office			
Mental Health Crisis/ Screening Team			
Other			

**START Coordinator Cross-Systems Crisis Prevention & Intervention Plan  
Brainstorming Worksheet**

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As members of the team discuss the individual, list information in the appropriate box below. Reach consensus on chief complaint; then organize behaviors, biopsychosocial vulnerabilities, triggering events and interventions in the hierarchical order to be entered into the crisis plan form.

Chief complaint/issue to be addressed
Overview/History  Expressive Language Skills:  Receptive Language Skills:  Medical and Dental:
Strengths/Skills/Interests  Strengths 1. 2. 3. 4.  Skills 1. 2. 3. 4.  Interests 1. 2. 3. 4.

Biopsychosocial vulnerabilities: what makes the person vulnerable to triggering events?

Triggering events: When do you begin to worry that problems will most likely occur (e.g., what types of environmental, physical or situational stressors may trigger behavior/signs/symptoms)?

Describe general patterns of behavior, personality, and traits (e.g., things that make up who the individual is)

Interventions: What was your response/what works/what doesn't work?

# SECTION VI:

## Conducting Emergency Assessments

- Role of the START Coordinator
- Safety First
- Assessments
- Disposition Recommendations
- Sample Forms
  - Emergency Screening Form
  - Emergency Assessment Form

# **THE ROLE OF THE START COORDINATOR IN CONDUCTING EMERGENCY ASSESSMENTS**

One of the essential roles of the START Coordinator is to assist in the evaluation of individuals with emergent needs and/or who are in crisis. It is essential that our services are timely. Start Coordinators who provided emergency back-up are on call 24 hours a day, 7 days a week. Telephone access is immediate, and face-to-face supports are required to occur within two hours of the contact in rural communities and within one hour of contact in urban centers. In larger regions, this may mean that two Coordinators are always on-call in order to cover the geographic size of the region.

Our primary role is to enhance the abilities of the current mental health emergency service system. Each member of the START team has on call responsibilities, including the Director, Clinical Team Leader, and Clinical Director of the program. While START Coordinators provide mobile on-call supports, the Director, Clinical Team Leader, and Clinical Director provide back-up clinical and administrative support to assist the START Coordinators.

The START team collaborates closely with the local mental health entity responsible for the provision of emergency services, and assists with crisis stabilization and/or prescreening for mental health inpatient admissions. The START Coordinator may also initiate follow-up of additional clinical consultation and support, in-home respite, emergency admission to the Resource Center, and other services available through linkages with the START team.

As described in the START Overview, all Clinical Team members participate in daily triage meetings which occur each morning to insure that all members of the team are aware of any issues that need to be addressed or potential needs for any individuals. This includes activating the Cross-Systems Crisis Prevention and Intervention Plan to assist individuals and their systems of support. The plan will assist the START Coordinator in determining whether a face-to-face evaluation is needed. For new referrals that are not known to the program, face-to-face evaluations are always needed.

*Important information to effectively provide crisis supports:*

1. A crisis is a problem without the tools to address it. It is never acceptable to leave people languishing in emergency rooms for extended periods of time, and it is important that the team do all it can to assist in the assessment and resolution of the presenting problem.
2. The job of the on-call START Coordinator is to let people know that help is on the way.
3. The information we need to effectively help is typically already available in the Cross-Systems Crisis Prevention and Intervention Plan (CSCPIP).

### **The Presenting Problem**

The presenting problem is the reason for the emergency/crisis contact, and it is often described as an “incident.” An “incident” description often does not contain needed information and more exploration is needed. For example, you cannot decide what to do based on an incident of aggression. It is important to remember that the problem presented by the referring source may not be the true presenting problem (for example, self-injury may be caused by extreme pain from appendicitis). Therefore, more in-depth evaluation is necessary.

Key aspects of working within the emergency evaluation process are below:

- It is important to connect with the individual's system of support and informants. The first step is to identify the most accurate informant(s). They are not always the people in the room with you at the time of the emergency assessment.
- It is important to connect with the individual by making he or she as comfortable and calm as possible. This often requires information from CSCPIP and/or informants.
- It is essential to review both the incident that lead to the crisis contact along with recent life events that contributed to the incident.
- Recent life events may not be in the immediate past. There is often a cumulative impact of interpersonal stressors that result in an incident. This requires exploration on the part of the START Coordinator as part of the interview process.
- Take the time needed to get as much information as possible prior to making your recommendations.

Sample documents related to emergency assessments are located at the end of this section

## **SAFETY FIRST**

Many incidents include aggression, but the individual is often calm by the time the START Coordinator is involved. However if this is not the case, the first thing to always insure is *safety for the individual and those around her/him*. If the person is in the emergency room, please note suggestions to defuse the problem in pages that follow. If in the community, work with informants to decide the best way to create safety. Discuss the possible ramifications of each option with informants if no CSCPIP is in place. The goal is to reduce or eliminate the use of police involvement whenever possible and safe.

## **ASSESSMENTS**

START Coordinators conduct face-to-face emergency assessments within one hour of the crisis contact in urban settings and within 2 hours of the contact in more remote settings. An assessment usually occurs with a member of a mental health mobile crisis team and can be in the individual's home or work setting or elsewhere in the community. It is key that the situation be well controlled so the START Coordinator can evaluate the presenting issues in a safe setting. Emergency assessments can also occur as part of the CSCPIP and this does not always include a member of the mental health mobile crisis team.

An emergency assessment is the process of collecting relevant information to both determine the likely contributors to the presenting problem and the interventions that may be employed to intervene quickly and effectively. This guide will lead the START Coordinator through steps needed to assess an individual who does not have a current Cross-Systems Crisis Prevention & Intervention Plan. If one is in place, it will guide you through the process in a person-specific manner that will include all of the steps outlined below.

Information gathered should include a history (medical/psychiatric), psychological profile (vulnerabilities associated with the person's life experiences and personal characteristics), and social (environmental) factors.

## **The Telephonic Assessment should include the following:**

The purpose of a telephone contact is to ensure the safety of person in crisis and letting all know that help is on the way, either from a START Coordinator or other local emergency services. The second purpose is to gather essential information to help guide the face-to-face assessment. An informant who knows the person well should provide the information.

*The information should include:*

1. An objective description of the challenging behavior or presenting problem
2. The context/circumstances under which this has occurred and when the problem began
3. The frequency and intensity of difficulty (e.g., has it occurred previously?)
4. Issues about the person to consider/know during the assessment process:
  - a. Psychiatric diagnosis
  - b. Sensory issues
  - c. Communication style
  - d. Ability to express needs
  - e. Range of disabilities (e.g., Autism Spectrum Disorder (ASD), level of cognitive abilities, etc.)
5. Recent and or chronic medical problems
6. Setting in which the person lives/works (any recent changes?)
7. What has been tried to manage the problem so far?
8. What is the desired goal of the assessment?
9. What are thoughts about what is needed?

If the phone assessment indicates that a possible intervention may include in-home support (for families only) or an emergency admission to the START Resource Center, the START Coordinator should call the Center Director to determine if these resources are available. However, until the face-to-face assessment occurs, this option should not be discussed with the individual or his

team. This is to insure that appropriate services and supports are provided and that decisions are not based on access alone, rather, the needs of the individual and system.

Should the face-to-face assessment determine the potential need and services are not available, the START Coordinator should contact the on-call supervisor who will assist in finding alternative services, such as services in a neighboring region. Obtaining access to psychiatric inpatient care is not the role of the START Coordinator, however he/she will assist the Mental Health Crisis team or Emergency Room staff in sharing relevant information and support to access this service when needed.

**The function of the face-to-face assessment is to:**

1. Collect enough information to lead to a coherent understanding of the presenting problem; this is mutually understood by the system as a whole so that a common understanding of what lead to the presenting problem is reached. This will result in agreement for interventions proposed.

*Practical tips for conducting the interview:*

- a) Make the person (and their caregiver) as comfortable as possible
- b) Work with the caregiver present
- c) Encourage bringing things that comfort the person
- d) Use a quiet area for evaluation
- e) Engage the individual in positive interaction(s)

*Effective communication is essential:*

- a) Use simple language but do not be condescending
- b) Speak slowly
- c) Have a neutral voice tone
- d) Allow the person adequate time to respond (may take longer than you expect)

- e) Be aware and sensitive to nonverbal communication as indicators of how things are going
  - f) Use gestures if needed
2. Use the list provided for telephonic assessment to guide the face-to-face assessment, verify information and include observation and interview with individual.

With the individual and caregiver (or team members present) review and enhance:

- 1. The objective description of the challenging behavior or presenting problem
  - 2. An understanding of the context/circumstances under which this has occurred
  - 3. Knowledge of the frequency and intensity of difficulty (e.g., has it occurred previously?)
  - 4. Issues about the person to consider/know in the assessment process: psychiatric diagnosis, sensory, communication style, and ability to express needs, additional neurodevelopmental disabilities (Autism Spectrum Disorder (ASD) level of cognitive ability, etc.)
  - 5. Recent and or chronic medical problems (request needed assessments if in Emergency Room or request medical review if needed)
  - 6. Setting in which the person lives/works (recent changes?)
  - 7. What have they tried to manage the problem so far?
  - 8. What would they like from this assessment?
  - 9. What do they think is needed?
3. Request information about possible medical issues. Following is a list of common medical conditions to consider:
- A) Headaches and migraines
  - B) Seizures
  - C) Earaches
  - D) Eyesight disorders

- E) Stomach related issues, GERD, colic, ulcers, constipation
- F) Urinary tract infections
- G) Joint pain, muscle aches and any tremors or stiffness
- H) Neoplasms (tumors)
- I) Wounds and fractures
- J) Dental issues

4. Mental Health/Psychiatric Disorders to consider:

- a) Use the symptoms guides found in the *DM-ID / DSM V*
- b) Remember that behavior may also be a secondary feature of a mental illness; for example, sleep disturbance and appetite changes are often associated with depression. Other behavioral issues may include: lack of interest in activities usually enjoyable to the person, crying, a withdrawn attitude, and/or aggression
- c) For people with Autism Spectrum Disorder (ASD), anxiety and mood disorders are often expressed through aggression and self-injurious behavior
- d) It is important to know the medication history and current or recent changes in medication. Medication side effects should be considered and can cause difficulties in many ways (e.g., stiffness, insomnia, gastric upset, etc. )

5. Recent psychosocial problems and many types stressors are a major focus of this assessment. These factors are addressed and will be covered in the completion of the *Recent Stressors Questionnaire (RSQ)*, which should be completed at this time.

6. Evaluate changes in baseline or previous everyday functioning, for example:

- a) cognitive functioning (focus, attention)
- b) adaptive functioning (skills)
- c) communication (speech problems)
- d) living situation (isolative/intrusive)
- e) Daily activities (toileting, eating, dressing, bathing sleeping, swallowing, ambulating)
- f) Ask about the last time the person was doing well:

- a. When?
  - b. What were they like?
  - c. How did they handle a stressor? Was it different from now?
  - d. What interventions were used? What worked? What did not work?
7. Interventions proposed for the person and their system of care should consider:
- a) Degree of potential harm to self or others
  - b) Level of distress of the person
  - c) Level of distress in the system of care
  - d) Ability of the home system of care to make the proposed modifications
  - e) Ability/willingness of the person to respond to strategies being considered
  - f) Capacity to consent of the person or guardian to receive services
  - g) Be mindful of the individual's skills, aspirations, and wishes as part of the interview and note them in the CSCPIP. The goal is always to build on the person's skills, abilities, and preferences. This will reduce risk and the likelihood of an intervention that is overly restrictive.

## **DISPOSITION RECOMMENDATIONS**

*Never tell a system in crisis that there is nothing you can do.* Do not argue against a request; instead explain your recommendations based on the assessment you have just conducted. Have a back-up safety plan when sending someone home. Include what can be done at home, and how to contact you if a crisis should occur. Schedule a follow-up visit and/or meeting for the next day to check in.

An admissions meeting is scheduled for the next business day if an individual is admitted to an inpatient mental health facility or receives START in-home or site-based emergency care at the Resource Center. During that

meeting, the goals of the admission, along with discharge and follow-up plans, are discussed.

The following are guidelines to assist in disposition decision-making. The team will need to know: **Please be as specific as possible!**

1. What is the current presentation of the individual being assessed?  
Are their problems significant and/or is consent and issue so that would need to be committed. If so, the person should be hospitalized (e.g., is a danger to him or herself or others; functioning is so impaired they cannot return to their home.
2. Can you determine if the incident that resulted in the prior acute presentation has been addressed or can be neutralized?
3. What are the individual's assessment and treatment needs?
4. Where is the best place to address the his or her needs?
5. If the person is returning home, what needs to occur to improve the conditions there?
6. If the person is going to the Resource Center, what needs to be in place to adequately support her or him there?
7. If the person is being admitted to the hospital, what is the treatment request? How long do you expect her/him to need hospitalization?
8. Is there any history of the person benefiting from a medication augmentation (increase in dose, PRN, etc. ) during a time of crisis?
9. What preferred activities should be in place to assist with positive supports to help stabilize the individual?

Once a disposition plan is in place, the development of a provisional crisis prevention plan or contract for safety is needed. (Use Provisional Crisis Prevention Plan form). This requires the involvement of the caregiver, the START team, and the other parties involved in the assessment and disposition process. Whenever possible and appropriate, please include the individual being assessed. What ever decision is reached, a safety net must be established to help prevent further crises and to effectively address issues as they occur. As a result of the emergency/crisis, the CSCPIP (if one has been completed) must be reviewed and revised if as needed

# START Emergency Challenging Behavioral/Medical Screening Tool for Admission to Resource Center

To be completed for new START individual prior to emergency admission to the START Center. Complete information below and review with START team for disposition for admission into the Resource Center.

## CHALLENGING BEHAVIORAL INFORMATION (if any box is checked, request additional information)

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Aggression in the last 4 to 6 hours | <input type="checkbox"/> Threats of Physical Aggression |
| <input type="checkbox"/> Verbal Aggression                            | <input type="checkbox"/> Property Destruction           |
| <input type="checkbox"/> Suicidal Ideation/Threats                    | <input type="checkbox"/> Hallucinations or Delusions    |
| <input type="checkbox"/> Self-Injury                                  | <input type="checkbox"/> Change in Mood                 |
| <input type="checkbox"/> History of Running When Upset                | <input type="checkbox"/> History of Setting Fires       |
| <input type="checkbox"/> History of Inappropriate Sexual Behavior     | <input type="checkbox"/> Other:                         |

Provide additional information for any checked items:

## MEDICAL HISTORY

1. Does the person use any of the following medical equipment?

- Oxygen     CPAP machine     Feeding tube     Insulin Injections  
 Intramuscular Injections     Colostomy     Other

2. Medication, Food, Environmental, or Other Allergies:

- No Known Allergies     No Known Drug Allergies     Latex Allergy  
 Food Allergy    Please list allergy: \_\_\_\_\_

3. Does the person have Diabetes?  Yes     No

How long has the person been a diabetic? \_\_\_\_\_

Is the person compliant with diet?  Yes     No

Does the person take insulin injections?  Yes     No

If yes, what type of insulin? \_\_\_\_\_

Does the person self-administer his/her insulin?  Yes     No

4. Does the person have a Seizure Disorder?  Yes     No

Date of Last Seizure: \_\_\_\_\_

If yes, are the seizures controlled with medication?  Yes     No

Does the person receive a PRN medication for seizures?  Yes  No

5. History of MRSA infection?  Yes  No

Date of MRSA infection: \_\_\_\_\_

Location of MRSA infection: \_\_\_\_\_

6. Tuberculin Skin Test: \_\_\_\_\_ (date)  Negative  Positive

If positive history, must have a negative chest x-ray or screening by the health department.

7. Does the person have any signs or symptoms of the flu?  Yes  No

8. Has the person been exposed to someone with the flu within the last 48 hours?

Yes  No

9. Does the person have any type of diet restrictions?  Yes  No

# START Emergency Assessment

An emergency assessment is the processes of collecting relevant information to both determine the likely contributors of the presenting problem and the interventions that may be employed to intervene effectively.

\*Be sure to gain relevant information before going to do assessment-location, participants and team members

Date: \_\_\_\_\_ Time of Contact: \_\_\_\_\_  Business Hours  After Hours  
 Weekend  
Individual's Name: \_\_\_\_\_ Gender:  M  F  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ MID#: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ County: \_\_\_\_\_

## Current Living Situation:

- Community ICF/MR  Supervised Group Living  Supported living  Homeless, Sheltered  
 Homeless, Unsheltered  Foster care home  AFL, Asst. Family Living  ALF, Asst. Living Fac.  
 Independent  Other \_\_\_\_\_  Family, list with whom: \_\_\_\_\_

Emergency Contact (name/relationship) : \_\_\_\_\_

Legal Guardian:  Yes  No If yes – Legally Responsible Person: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred By: \_\_\_\_\_ Relationship to Individual: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Reason for Assessment: (check all that apply)

- Physical Aggression  Threats of Physical Aggression  Verbal Aggression  
 Sexual Issues  Suicidal  Property Destruction  Leaving Unexpectedly  
 Homicidal  Change in Mood  Self Injurious  Hallucinations or Delusions (MH symptoms)  
 Other: \_\_\_\_\_

Describe:

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**Multi-Axial Diagnosis**

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V \_\_\_\_\_

**RISK ASSESSMENT**

**Risk to Self**

Suicidal Ideation:  Yes  No      Suicidal Intent:  Yes  No

Suicide Plan:  Yes  No    If Yes,  
Specify: \_\_\_\_\_

Access to Means:  Yes  No    If Yes, Specify:  
\_\_\_\_\_

Previous Attempts/Gestures:  Yes  No    If Yes, How Many Times: \_\_\_\_\_  
If Yes, Triggers: \_\_\_\_\_

**Risk to Others**

Homicidal Ideation:  Yes  No      Homicidal Intent:  Yes  No

Homicidal Plan:  Yes  No    If Yes, Specify:  
\_\_\_\_\_

Access to Means:  Yes  No    If Yes, Specify:  
\_\_\_\_\_

Identified Person Targeted: \_\_\_\_\_

Hx of Harm to Others:  Yes  No    If Yes, Specify: \_\_\_\_\_  
\_\_\_\_\_

Aggression has Occurred:  On Admission to ED     In past 6-12 month     In distant past     None noted

If yes, what was observed  
\_\_\_\_\_

\_\_\_\_\_

Does person have access to weapons:  Yes  No If Yes, Specify:

\_\_\_\_\_

**Bio/Psycho/Social Stressors**

Recent stressful life event:  Yes  No If Yes, Specify: \_\_\_\_\_

\_\_\_\_\_

Recent bereavement or loss of relationship:  Yes  No If Yes, Specify: \_\_\_\_\_

Chronic Medical Issues:  None noted  Pain  GI Issues (constipation, etc)  Dental

Seizure disorder  Other (diabetes, hypothyroidism, etc): \_\_\_\_\_

Intellectual/Developmental Disability:  None noted  Autism Spectrum  Cerebral Palsy  TBI  Fetal Alcohol Syndrome  Genetic DO  Undetermined  Intellectual Disability: Level \_\_\_\_\_

Sensory Limitations:  None noted  Limited communication  Visual  Hearing  Sensory Integration

Safety Awareness:  Good  Limited: *(concern(s))*: \_\_\_\_\_

\_\_\_\_\_

**Other Risk**  None/Not applicable

<input type="checkbox"/> Leaving	
<input type="checkbox"/> Verbal Aggression	
<input type="checkbox"/> Physical	
<input type="checkbox"/> Property Destruction	
<input type="checkbox"/> Self-Injury	
<input type="checkbox"/> Other	

**MENTAL STATUS**

<b>Physical / Hygiene</b>	<input type="checkbox"/> Appropriate <input type="checkbox"/> Neat <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <b>Hygiene:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>Eye Contact</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Minimal <input type="checkbox"/> Absent
<b>Motor Behavior</b>	<input type="checkbox"/> Calm <input type="checkbox"/> Hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Stereotypic <input type="checkbox"/> Tics <input type="checkbox"/> Hypoactive <input type="checkbox"/> Tremors
<b>Communication</b>	<input type="checkbox"/> no impairment <input type="checkbox"/> gestures and/or vocalizations <input type="checkbox"/> single words <input type="checkbox"/> phrases <input type="checkbox"/> Aug Comm. Device <input type="checkbox"/> limited sentences or conversation ability <input type="checkbox"/> symbol/picture <input type="checkbox"/> signing

<b>Speech</b>	<input type="checkbox"/> Appropriate <input type="checkbox"/> Coherent <input type="checkbox"/> Slurred <input type="checkbox"/> Pressured <input type="checkbox"/> Garbled
<b>Ambulation</b>	<input type="checkbox"/> uses wheelchair <input type="checkbox"/> walks with adaptive device full time <input type="checkbox"/> walks with partial assistance <input type="checkbox"/> walks unaided
<b>Mood</b>	<input type="checkbox"/> Sad/Tearful <input type="checkbox"/> Happy <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Withdrawn <input type="checkbox"/> Attentive <input type="checkbox"/> Aggressive <input type="checkbox"/> Agitated <input type="checkbox"/> Irritable <input type="checkbox"/> Cooperative <input type="checkbox"/> Frightened <input type="checkbox"/> Anxious  <input type="checkbox"/> Elevated mood <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Euphoric <input type="checkbox"/> Hopelessness <input type="checkbox"/> Loss of interest
<b>Affect</b>	<input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Constricted <input type="checkbox"/> Flat <input type="checkbox"/> Guarded
<b>Thought Processes</b>	<input type="checkbox"/> Coherent <input type="checkbox"/> Relevant <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential <input type="checkbox"/> Concrete <input type="checkbox"/> Perseveration
<b>Executive Functioning</b>	<b>Orientation:</b> <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation <input type="checkbox"/> Not Oriented  <b>Attn/Concentration:</b> <input type="checkbox"/> Good <input type="checkbox"/> Impaired <input type="checkbox"/> Distracted  <b>Memory:</b> <input type="checkbox"/> Recent Intact <input type="checkbox"/> Remote Intact <input type="checkbox"/> Recent Impaired <input type="checkbox"/> Remote Impaired  <b>Judgment:</b> <input type="checkbox"/> Good <input type="checkbox"/> Impaired (mild, moderate, severe)
<b>Anxiety</b>	<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Panic Attacks
<b>Impulse Control</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>Hallucinations / Delusions</b>	<b>Hallucinations:</b> <input type="checkbox"/> Not present <input type="checkbox"/> Auditory <input type="checkbox"/> Auditory(with command) <input type="checkbox"/> Visual  <b>Delusions:</b> <input type="checkbox"/> Not present <input type="checkbox"/> Persecutory <input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Somatic
<b>Appetite</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Overeating <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain
<b>Sleep</b>	<input type="checkbox"/> No change <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep
<b>Incontinence Issues</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constipation <input type="checkbox"/> G/I issues
<b>Alcohol/Drug Use</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <b>Type/Frequency:</b>

**CURRENT SERVICES**     None

Type of Service: \_\_\_\_\_

Current Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Type of Service: \_\_\_\_\_

Current Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Treating Psychiatrist: \_\_\_\_\_

Phone number: \_\_\_\_\_

Has the psychiatrist been contacted: \_\_\_\_\_

Hospitalization  None

Dates	Facility/Provider(s)	In-Patient or Out-Patient	Reason for Treatment

HEALTH/ MEDICATIONS  None/Not applicable

All Current Medications	Dose and Frequency:	Prescribed By	Last Use:	Taken as Prescribed
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

**RECOMMENDATION FOR IMMEDIATE CARE:**

Is acute in-patient treatment needed at this time?  No, see Additional Recommendations  Yes

Summary of Disposition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL RECOMMENDATIONS (check all that apply):**

- Return to community setting
- Additional supports at home (1:1 supports)
- Increase community activities
- Day Supports/Day Program
- Schedule team meeting
- Follow up with Primary Care Dr
- Follow up with Psychiatrist
- Other \_\_\_\_\_

**RECOMMENDATIONS TO ADDRESS SAFETY/ENVIRONMENT RISKS:**

In a Crisis Contact:

- 
- 
- 
- 
- *START Crisis Line:*

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START Coordinator Signature

Date

Shared with: \_\_\_\_\_

\_\_\_\_\_

Title

Contact #

If START Therapeutic Supports are being considered:

\* If person is returning to residence following assessment, the START Coordinator should assist the team with development of a safety plan. Some of the questions below should be used to guide the development of this plan.

1. What is the presenting problem?

\_\_\_\_\_  
\_\_\_\_\_

2. What is the purpose of START Therapeutic Support Services?

\_\_\_\_\_  
\_\_\_\_\_

3. What is the proposed length of stay?

\_\_\_\_\_

4. What is the plan for discharge? (Where will this person be discharged to?) Plan should be clear and include details re: date, location, team involvement.

\_\_\_\_\_  
\_\_\_\_\_

5. To avoid or when experiencing behavioral challenges what does this person need?

- A. A quiet place away from others?

- B. \_\_\_\_\_  
\_\_\_\_\_

C. Removal of others from the area?

D. Other? \_\_\_\_\_  
\_\_\_\_\_

6. Can this person be supported with the current staffing pattern?  
\_\_\_\_\_

A. If not, what enhanced staffing pattern is needed?  
\_\_\_\_\_  
\_\_\_\_\_

B. If enhanced staffing is need, what will occur?  
\_\_\_\_\_  
\_\_\_\_\_

C. How will we evaluate the need for continued enhanced staffing? (should be evaluated every 72 hours)  
\_\_\_\_\_  
\_\_\_\_\_

D. How will we know when it is no longer needed?  
\_\_\_\_\_  
\_\_\_\_\_

7. Can this person contract for safety?  
\_\_\_\_\_

A. Can safety plan/terms be negotiated? \_\_\_\_\_

B. What will the person do to remain safe? What can the support system do to help keep the person safe? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Has this person responded to medication augmentation?  
\_\_\_\_\_

A. If so, what? When? \_\_\_\_\_

B. Who is the person's treating psychiatrist/contact information?  
\_\_\_\_\_  
\_\_\_\_\_

C. Can plans be made for augmentation while this person is at The START Center?  
\_\_\_\_\_  
\_\_\_\_\_

9. Can the interventions above be provided at NC START Respite for this individual? What is needed in order to provide this?

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**START Coordinator**

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**Date**

# SECTION VII:

## Systemic Consultation

- Overview & Understanding Systems
- Using Eco-maps to inform Systemic Consultation
- Live Supervision & Video Exercises

# OVERVIEW OF SYSTEMIC CONSULTATION

More traditional behavioral and mental health interventions focus on the individual and his/her immediate surroundings, and use these to change the individual's behavior or functioning. The START model is unique because it conceptualizes all behavioral challenges or presenting problems within the context of the system in which the person lives, works, and interacts with his/her environment. In this section, the START team can find the following information:

- A definition and description of a system
- An overview of homeostasis, boundaries, and communication as it relates to understanding systems
- The role of the START Coordinator in systemic consultation
- Using ecomaps when conducting a systemic analysis
- Interventions and methods to promote system shifts and changes

## OVERVIEW OF SYSTEMS

A **system** is defined as: any group of individuals living or working together. There are both traditional (families) and non-traditional (group home) **systems**, each of which are equally important. It is necessary to recognize **subsystems** within systems since subsystems function in the same capacity as the larger system. By understanding the ways in which subsystems communicate and exchange resources with the larger system, the clinician will be most effective when intervening. As mentioned, subsystems can be traditional or non-traditional. Examples of subsystems include parent or sibling subsystems, direct support or administration subsystems.

We all work and live in systems created by people. A system is considered most **functional** when boundaries are flexible and clear, and communication is open. Attaining this level of functioning is the goal for START Coordinators in working with identified service recipients and their systems

START uses a model of "systems change" pioneered by Salvador Minuchin, M.D. who worked in Family Therapy. He helped a patient referred, for example a child, but called them the "identified patient" because he found that complex problems in the functioning of the whole family system were at the root of the problems, and that changing the complex relationships in the system as a whole were the key to helping everyone. START is a model developed by Joan B. Beasley, Ph.D. in 1989 in which she applied this Family Systems Therapy model to

changing systems that helped people with intellectual disability. Based on the family systems work of Dr. Salvador Minuchin, START Coordinators are trained on systemic consultation activities to enhance service outcomes by training and influencing the way the systems work together to help people with intellectual disability. As in family systems work, the “identified patient” is the member of a system who expresses the difficulties/concerns/ anger of the system.

When designing individualized supports, it is critical to evaluate and formulate hypotheses based on the functioning of the person's entire system of support. It is equally important to understand that each individual's **role** in the system is defined by that system. When each person follows his/her role, the system continues to function the way it always has. This does not imply that the way the system has been functioning is the best for all members of the system, nor that it is beneficial for any. In fact, it is most likely that the ways in which the current system is functioning are not helpful or the START program would not be contacted for help. In determining how to best support systems to function at their optimal capacity, there are several things START Coordinators need to keep in mind in order to maximize effectiveness.

# HOMEOSTASIS

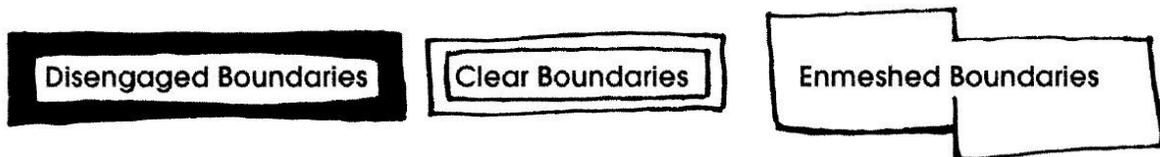
Homeostasis is defined as the “equilibrium” in the system. It is human nature to strive for equilibrium and resist change, because it often causes discomfort. One way in which a system attempts to maintain homeostasis is by developing rules governing how communication amongst members of the system occurs and in what contexts. The communication may not be effective, causing challenges within the system, but still maintaining homeostasis.

Each system has its own dynamic force that maintains the status quo of current functioning. In a closed system, that force strongly resists any change. When homeostasis is compromised, the system engages in communication and behavior with the ultimate goal of returning to the status quo.

One example demonstrating homeostasis is when a person who has schizophrenia returns home after a hospitalization. The person’s symptoms may cause an imbalance in the family’s status quo and the symptoms may actually worsen in response to the upset in the homeostatic balance of the family system. Shifts and change in the entire system needs to occur in order to accept the symptoms of mental illness and maintain homeostasis.

# BOUNDARIES

Boundaries define how individuals relate to each other in the system. There are three major types of boundaries:



A “boundary” is defined as the rules and regulations that separate the system from its environment. The characteristics of the boundary determine how interchanges occur and boundaries define the system’s “structural” framework.

Boundaries exist both within the system and between the system and its external environment. They are the result of the system’s rules and regulations. Boundaries can be fixed and rigid, moveable and flexible, or scattered and unpredictable. When a system is open, it functions at its optimal capacity, with clear, yet flexible boundaries and negotiable rules and expectations.

*To understand why systems function as they do, it is important to identify the types of stressors on the system. These stressors stem from the type of boundaries between subsystems and between the system and the environment. Below are the types of stressors a system can experience and an example of each stressor:*

1. **Stressful contact of one member with outside forces:** difficulty with a day program causes the individual to stay home influencing the day-to-day activities of the group home.
2. **Stressful contact of the whole system with outside forces:** the way in which changes in types of services available affects coping mechanisms.
3. **Stress at transition points:** someone leaving, moving in, etc.
4. **Stress around characteristic problems:** coping with the stress of mental illness and/or challenging behavior.

# SYSTEMIC DESCRIPTORS

It is important to understand how the members of a system might use one another to maintain homeostasis. In **triangulation**, the "identified patient" is the go-between for other members of the system in order to keep the system functioning smoothly based on its current needs. The individual is "triangulated" when two members would have difficulty interacting in a functional way without him/her. This can occur in a group home as well as in a "traditional" family setting.

## COMMUNICATION

Communication in a system is determined by its structure, which includes hierarchy, boundaries, and subsystems. A core aspect of systemic consultation is understanding the communication methods of systems and subsystems. If the communication amongst a system is closed, then a START Coordinator should employ interventions to open lines of communication amongst members.

There is no superior communication structure that a system should follow at all times. Rather, the communication structure and approach is contingent on the nature of the environment and the system at any given time. Continued evaluation and analysis of the system and its needs are necessary since the way in which information and resources are shared may shift depending on the environmental stressors or circumstances.

The following are basic assumptions from systems theorists about the function of behavior, communication, and boundaries within a system.

1. All behavior is communicative. Human beings communicate both verbally and non-verbally.
2. Communication provides the flow of information amongst subsystems
3. Communication must take place in order for the system to exchange relevant information with the environment.
4. When boundaries are closed: there is an inability of the system to use feedback appropriately; The system is overly focused on internal functions and behavior; communication is also closed and rigid and flow of information and resources is stifled.
5. When boundaries are open: the system is focused on the "big picture"; there is a sense of dynamic homeostasis (the system takes feedback and turns it into positive energy); materials, resources, and information can pass through the system unhindered; communication is reciprocal and consistent.
6. When boundaries and communication are open and expectations are clear and consistent, there is a synergy among the system. The system recognizes that the "whole is greater than the sum of its parts."

# FUNCTIONAL HYPOTHESIS

START Coordinators working with a system develop a working hypothesis that explains how and why the system works the way it does – how individuals' roles are defined, what boundaries and subsystems exist, and how members of the system maintain homeostasis.

In developing functional hypotheses the following concepts must be kept in mind:

1. The primary need of the individuals within a relationship is to form and maintain the relationship.
2. There are two major tasks involved in this process:
  - a. Deciding *what* the rules of the relationship are, and
  - b. Negotiating *who* actually makes decisions regarding the rules
3. The tasks of setting rules and negotiating who has control over rules are accomplished through the exchange of messages.
4. Messages form the substance of the communications between people in the relationship and as such are the *basic element* of the interactional process.
5. Messages have two major aspects: the content itself and the message about the message. The latter defines the nature of the relationship and is central in formulating a functional hypothesis.

## **JOINING, SHIFTING, REFRAMING & HOMEWORK**

START Coordinators working with a system must “join” (develop rapport and empathy) with that system in order to understand how the system works. The goal of the START Coordinator is to create a shift (or change) in the system that will enable the system to move toward reaching its optimal functioning level.

It is often helpful to “reframe” what is happening so that individuals understand how behavior has become functional in the system. Reframing involves describing a particular behavior or action in a new way that demonstrates empathy and the likelihood that the behavior was done without ill intention regardless of the outcome. It can assist a system to make a change by helping that system see and understand itself differently. By reframing the “problem behavior,” the team begins to identify a helpful and workable hypothesis about why the problem is occurring and also creates a sense of shared responsibility in solving it. The START Coordinator models this throughout meetings to help other members of the system better understand and communicate with one another. Reframing the problems of the “identified patient” for example, would assist the members of the family/team to see that his/her stubbornness may be viewed more positively as persistence or that “attention-seeking” may be reframed as reaching out.

Changing the individual’s behavior within the system is often subtly and creatively accomplished through giving “homework.” The homework assignment must necessitate the system working together in a way that the desired shift is occurring. The homework should be something easy and fun that

requires system members to interact in a new or different way; it should not focus on directly changing the identified patient's behavior. This moves the system toward becoming more functional, and eventually better able to support the identified patient.

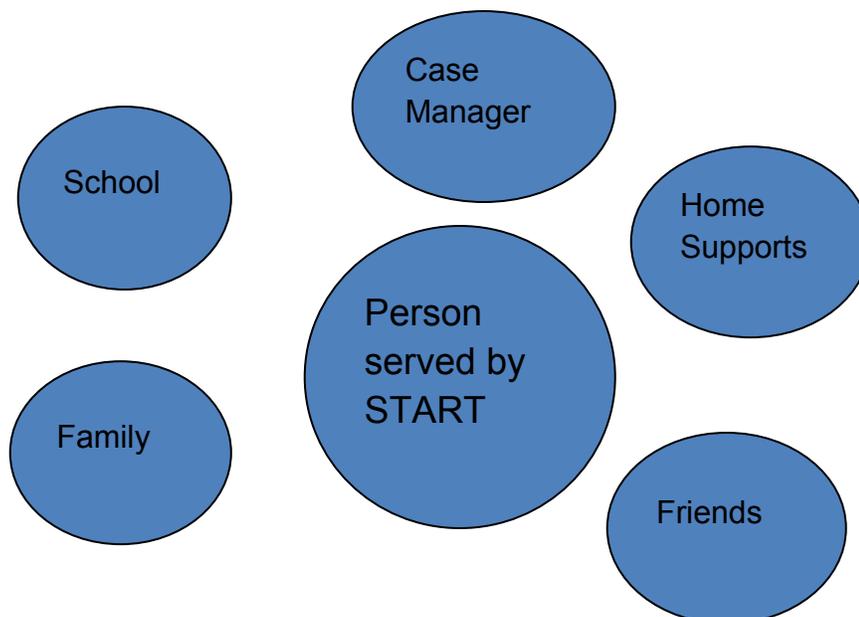
## Eco-MAPS-TOOLS TO INFORM SYSTEMIC CONSULTATION

Ecomaps are important and needed tools when trying to understand how or why a particular system functions the way that it does. The ecomap is a graphic representation of the person's connectedness to others (subsystems) in his/her life. It allows for identification of how reciprocal interaction exists between the person and the system. Ecomaps express the strength and effect of each relationship. They serve as a tool to highlight different relationships and human resources in a person's life, which serve as a starting point when addressing the person's needs.

By highlighting the strength and openness of the relationships a person has with his/her system, a START Coordinator is more successful in identifying barriers and developing a working hypothesis as to how to affect change in the individual's system.

### Ecomap Construction:

The Ecomap is constructed with the individual served by START as the center of the system. Subsystems or "domains" are represented surrounding the individual.



Domains can include natural or paid supports. Some examples are outlined in the table below:

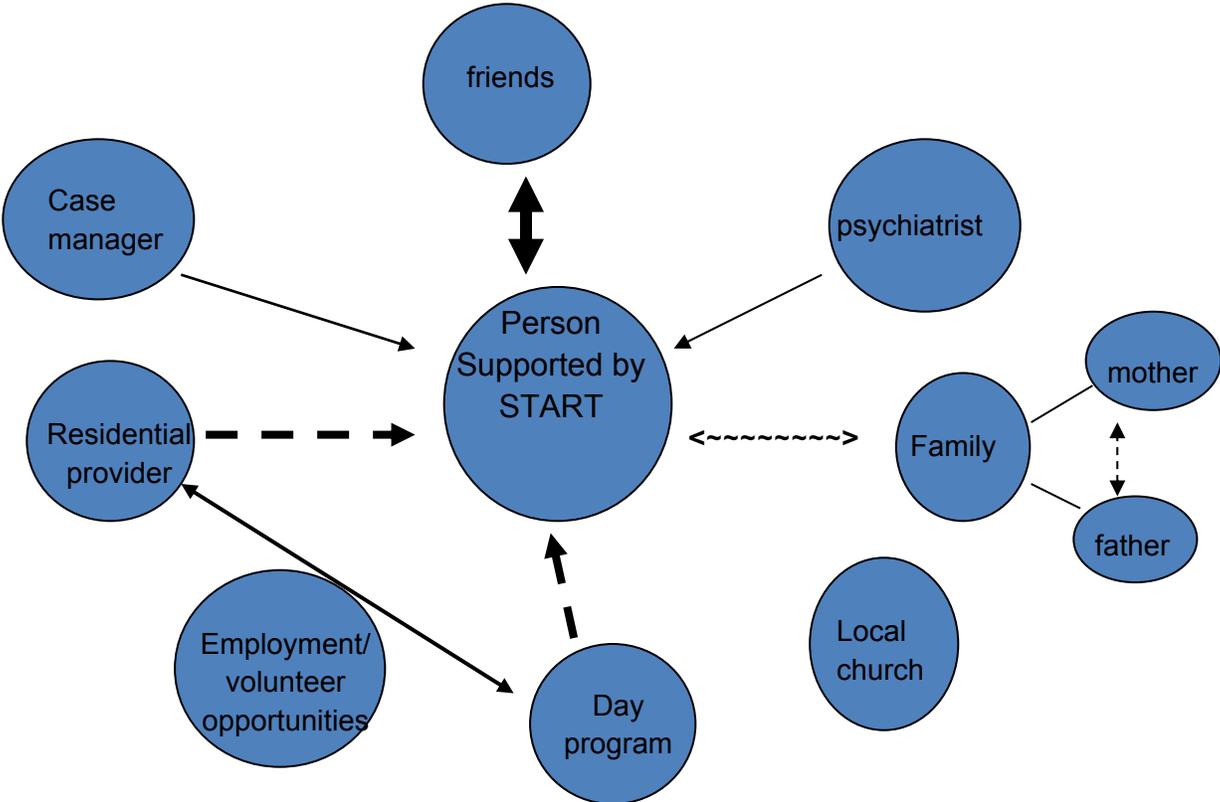
Natural Supports	Community Supports	Paid Supports
Friends	Department of Social Services	Case Manager
Family	Local emergency services	Residential Provider
Neighbors	Fire Department	School
Cultural outlets	Community Recreation activities	Job coach
Church/spiritual organizations		Mental health professionals
Volunteer positions		Residential provider

The list above is not all-inclusive; rather it gives a few examples of the types of supports/subsystems that may be included in a person's ecomap. When developing an ecomap to inform systemic analysis, it is particularly important to highlight natural supports in a person's environment. Natural supports are not paid and remain in the person's life regardless of funding availability and/or determined need. Natural supports are reciprocal relationships, which allow for non-contingent flow of resources and communication between the person and the support. This is different from paid supports, which always has a one-way flow of resources from the support to the person. A major issue often identified through the use of an ecomap is the need to build on and promote the use of natural supports and reduce the need and dependence on paid supports.

Once the domains are identified, it is then necessary to determine the way in which communication and resources (whether material or human resources) are exchanged. When identifying the flow of resources amongst subsystems, the key below is used.

Symbol	Meaning
—————	Strong/positive relationship
—————	Very strong relationship
≈≈≈≈≈≈≈≈≈≈	Strained relationship
- - - - -	Negative relationship
←—————	Primarily influences the individual
—————→	Primarily influences the subsystem
←—————→	Two direction flow of influence
No line	No connection to the individual at this time (has in the past, or is an opportunity to create a new relationship)

Example:



An example of an ecomap and the template to create one can be found in the appendix of this manual and additional resources regarding systemic analysis and the use of ecomaps can be found on the Center for START Services website ([www.centerforstartservices.com](http://www.centerforstartservices.com)).

## LIVE SUPERVISION & VIDEO RECORDING

Video recording has been utilized by START as a training technique called live supervision since 1989. It is used to teach the supervisee the steps outlined above. The **initial goal** during live supervision is to assist the supervisee to **join** with the system by actively listening, engaging all members of the team, and by establishing a non-judgmental, non-threatening posture. Sensitivity to body language and group dynamics (who sits where, how people introduce themselves, who has eye contact with whom, etc.) is essential to the supervisee figuring out how the particular system works. When appropriate, meetings are video recorded with the consent of the participants so that it can be reviewed following the meeting or training session.

The trained eye of the supervisor is very helpful in assisting the supervisee to figure out the system. It is also easy from a video recording to notice when a member of the team may be getting “lost.”

A **working hypothesis** is then formulated regarding how and why that particular team or system works the way it does and how the system might function differently in order for a more mutually desirable result to occur. Participants are obviously meeting because there is a mutual problem and a desire to see that change (though most people initially think it's someone else who needs to do the changing). It is often helpful to point out that commonality to the group in order to set the stage for working together. And it is always helpful to be positive. It is a positive sign that people are meeting and communicating even if they protest that they do not want to be there. The live supervision tool is helpful in assisting the supervisee to remain positive within a potentially resistant group. The next step is for the supervisee to empower that system to actually make a small shift in its “normal” way of relating so that movement in the direction of change is possible.

Live supervision, which incorporates the principles of systemic theory, has become a valuable training component at the Center for START Services to assist clinicians and coordinators to work effectively with consumers and their providers.



# EXERCISE # 1

Six participants (hopefully volunteers) will be chosen to enact the following situation. It works best if the roles are assigned to coincide with the participants' real/actual roles in their own family structures (the mother is a mother, the middle child is a middle child, etc.).

**The Situation:** a family consisting of two parents and three siblings has been directed by DSS to see a therapist due to excessive absenteeism of the youngest child at school.

## Roles

Therapist -	<ul style="list-style-type: none"><li>* Skilled in family therapy and systems theory</li><li>* Will be supervised by clinical director</li></ul>
Father -	<ul style="list-style-type: none"><li>* Hard working, blue collar</li><li>* Believes it is the wife's job to make sure the youngest daughter goes to school</li><li>* Enjoys a few brews with the boys before heading home at night</li></ul>
Mother -	<ul style="list-style-type: none"><li>* No career interests outside the home</li><li>* Protective of the youngest daughter</li></ul>
Oldest Son -	<ul style="list-style-type: none"><li>* Graduating from high school – barely</li><li>* Rides a Harley</li><li>* Eager to leave the nest</li></ul>
Middle Daughter -	<ul style="list-style-type: none"><li>* Straight-A student</li><li>* Daddy's little girl</li><li>* Perfect in all she does</li></ul>
Youngest Daughter -	<ul style="list-style-type: none"><li>* Refuses to go to school</li><li>* Very attached to mother</li></ul>

Five of the six participants (the family) will be filled in privately regarding their role and what the underlying issues are. Audience participants should ask themselves the following questions:

1. What is the youngest daughter trying to communicate by not going to school and creating the current situation?
2. What does each of the other family members "get out" of the situation?
3. What subsystems exist in this family?
4. What shift could take place to assist the family in communicating differently?

## EXERCISE #2

Apply the definition of a system to the organizational structure of the group today.

Discuss the following questions:

1. What are the parts and processes of your organization?
2. How many different types of subsystems exist?
3. Which subsystems are significant to the operation of the organization?
4. How is feedback handled in the system and within subsystems?
5. Do subsystems change when all members are not present? How?

## EXERCISE #3

Seven happy participants will be selected to enact the following situation.

**The Situation:** An individual has been admitted to a respite program due to difficulties in his staffed residence; the team is meeting to discuss his return back to the home. There is much anger and resistance to his return.

### Roles

Consultant -	<ul style="list-style-type: none"><li>* Skilled in family therapy and systems theory</li><li>* Will be supervised by the clinical director</li></ul>
Home Manager -	<ul style="list-style-type: none"><li>* Eager to please supervisor</li><li>* Good administratively</li><li>* Won't share opinion regarding individual's return</li></ul>
Home Supervisor -	<ul style="list-style-type: none"><li>* Eager to please department heads</li><li>* Authoritarian style of supervision</li><li>* Thinks individual should return home</li></ul>
Service Coordinator -	<ul style="list-style-type: none"><li>* Worried about money (believes respite is too costly)</li><li>* Thinks individual should return home</li></ul>
Evening Shift Coordinator -	<ul style="list-style-type: none"><li>* Has been assaulted by individual</li><li>* Adamant individual should not return home</li><li>* Angry</li></ul>
Home Counselor -	<ul style="list-style-type: none"><li>* Has been assaulted by the individual</li><li>* Feels individual should not return home but is reluctant to speak up</li></ul>
Work Site Case Manager -	<ul style="list-style-type: none"><li>* Reports that the individual has no difficulties at the workshop</li><li>* Feels the home is mismanaged and they should get their act together</li></ul>

All but the consultant will be provided with more detail privately regarding issues and personality traits of their character. Audience participants should ask themselves the following questions:

1. What is the individual trying to communicate when having difficulties?
2. What are the subsystems within the larger system?
3. How does the current situation perpetuate the role of each of the members in his/her subsystem?
4. What shift could take place to assist the team in communicating differently?

## EXERCISE #4

After discussing homeostasis, divide up into small groups of individuals (preferably 5-6 people) who normally work together.

The group will discuss how to maintain someone in the community who is extremely assaultive. It would be most helpful to discuss an individual who is known to all in the group, but not essential.

One person will act as the leader but will try to facilitate the discussion in the reverse style to which he/she is accustomed (i.e., if the leader is usually directive, he/she would become more process oriented).

In the process of the exercise, consider the following:

1. By the end of the exercise, was the leader back to his/her original role or behavior?
2. Were there observable behaviors on the part of the group that encouraged the leader to move back to the original behavior, whether or not the reversal actually occurred?
3. Did the members of the team feel the need to move the leader back into the role they were used to?

## EXERCISE #5

### Living with Mental Health Problems and/or Challenging Behavior

This exercise is intended to help us experience what it is like to live with chronic disabilities in a world which has difficulty accepting you and your disabilities. It can be very intense, so the group needs to be prepared to feel their feelings.

Each person needs a pen or pencil and 20 small pieces of paper. One separate pieces of paper write down:

- The four most important people in your life
- Four roles you have which are most important to you (i.e., sister, mother, clinician, etc.)
- Four things that mean a lot to you
- Four things you enjoy doing the most
- Four dreams/goals

The leader will then arbitrarily take away pieces of paper from the participants. What are the feelings that are evoked?

Many of the people we support have had to live with these types of losses and the loss of control that was experienced in this exercise. It is important to advocate from their point of view within the systemic context whenever possible in insuring that the quality of his/her life does not become impoverished.

# SECTION VIII:

## Clinical Education Teams (CET)

Introduction

Clinical Education Team (CET) Confidentiality Guidelines

Preparing the CET Presentation and Ecomap

Day of the CET and Agenda

Order of CET

After the CET: CET Note; CET Team Meeting: CET Follow-Up Note

Forms and Sample Forms

CET Presentation

CET Presentation Sample

CET Note

CET Note Sample

CET Follow-Up Note

CET Follow-Up Note Sample

Sample Evaluation form

Sample CEU form

# CLINICAL EDUCATION TEAM (CET) INTRODUCTION

## Introduction

Clinical Education Teams (CETs) are a forum designed to improve the capacity of the local community to provide supports to individuals with ID/DD and behavioral health needs through discussion of a case. The CET typically lasts 2 hours and includes presentation of a brief follow-up from the previous month, and presentation of a new case.

The CET team consists of START Coordinators/Interns, members of local Center for START Services or local START programs (typically a psychiatrist, a psychologist, the systems specialist/START Director) and the professionals in the community who support the person. START Coordinators/Interns may invite members from the local community who provide services to individuals. Please include local mental health centers, emergency services, and inpatient providers if possible.

The goal of the CET is to help service system providers learn how to best support people while improving the capacity of the system as a whole through information sharing, learning, and collaboration among team members.

Because this is an educational forum, each individual presented will have his or her identity hidden to protect confidentiality. The training is not so much about the person presented, but rather descriptions of the problems faced, strengths and resources, as well as diagnosis and treatment information so that the individual serves as an example for discussion and further examination. However, it is expected that the discussion will generate ideas about possible remedies to improve services and clinical outcomes to explore for the individual presented.

Coordinators/Interns will initially select individuals for review but later reviews can be suggested from community partners to project/team leaders who help coordinate the CETs.

After the CET, START Coordinators will discuss recommendations from the CET with the team and guardians. In addition, START Coordinators provide follow-up information to the team at subsequent meetings so that all can learn from the process.

**These trainings will not involve parents or the individual or any type of legal guardian.** This is training rather than consultation. Most present will not have

permission to read documents or have anything to do with this person. Because it is training, difficulties and feedback for START staff may occur. In addition, many ideas proposed for the person's life might not be helpful. It is after the CET that the person's team, family and guardians meet to review the recommendations of the CET, decide if they made sense, and then make a list of actions and timelines.

At each CET, a formal didactic training related to the case being presented will be organized by the START Clinical Director or one of the consultants. This typically is a short power point but may also be in the form of discussing an article distributed to the group, video, or role-play. Samples of power points are on the web site as well as the *Guide for Creating CET PowerPoints*. It is important that the didactic training is planned to last about 15 minutes to not limit discussion of the case by all present.

## **Clinical Education Team (CET) Confidentiality Guidelines**

Clinical Education Teams (CETs) are an educational forum designed to improve the capacity of the local community to provide supports to individuals with ID and behavioral health needs by teaching through discussion of a case. The CET presentation uses the “case” method of teaching mental health professionals. Briefly, trainees and professionals in mental health disciplines acquire their diagnostic and treatment skills through discussing a case history example. A case is presented to all trainees and clinical staff using this clinical teaching model: those present ask questions, propose diagnoses and treatment options, and they discuss and learn together. The format is a “seminar” so that all present are encouraged to contribute and/or question. The case presentation is always led by a senior clinician supervisor and/or invited consultants.

The START CET is a case-based training event. **Confidentiality or anonymity of the case is always paramount.** The identity of the person must be completely guarded and disguised. Many people present will not know the individual. General information is what is important. For example, a 45-year-old man would be described as “middle-aged” and names of vendors, provider agencies, and hospitals should be omitted. It is important that specific names of providers, medical and psychological professionals, names of hospitals and vendors, community clubs associated with the individual, and specific dates are not included. Instead say: “He was admitted to a psychiatric unit at age 23 and the psychiatrist diagnosed him with PTSD.” The best rule to follow when checking on the confidentiality of a CET Presentation is this: If the person presented was living next door to me, or was the child of my 2<sup>nd</sup> cousin who I see at summer parties, would I be able to identify him or her?

Each START CET presentation is developed in concert with the START clinical supervisor in charge of the CET. The START Coordinator must receive permission of the person/guardians to share the records with the Clinical Director and Consultants for the case.

The CET presentation information is only shared at the CET itself. Any written material is collected and shredded by the START Coordinator at the end of the meeting. It is never distributed to a group again. However, the CET Presentation can be retained in a record. It may be useful to give to, for example, a psychiatrist who never had any real background on the individual. In this case, the START Coordinator must clearly explain that the CET Case Presentation was prepared for a teaching conference and also get permission of the guardian to share the CET Presentation.

The CET note written after the presentation is part of the individual's record. It serves as a record of the meeting and as billing documentation. This also must be developed with the START Clinical Director. During review, some recommendations made at the CET may be deemed as not in the best interest of the individual. The START Coordinator must gain approval of all recommendations from the Clinical Director prior to placement in the record.

The CET note is not distributed to team members of the person who was presented. It is the role of the START Coordinator to discuss recommendations from the CET note with others collaboratively at a special meeting after the CET: only recommendations that are recognized as relevant to the person are important. At these special meetings, recommendations will be discussed and a final list will be developed collaboratively. It is important that the group have a sense of time lines for the different recommendations and also assigned responsibilities with regard to various tasks. The CET Follow-Up Note records information from this meeting and will be briefly presented typically 2 months after the CET prior to the main presentation.

## **Preparing the CET Presentation**

The CET Presentation is done in collaboration with the Clinical Director. It is important that the case be selected well ahead of time, and 2 months is recommended. The START Coordinator must then get permission to present, and permissions to distribute background information to the Clinical Consultants on the case. In addition, several drafts and discussions are typically necessary. Lastly, the START Clinical Director will have the responsibility of developing a didactic training for the CET.

When the case is selected, the START Coordinator should invite the team members as soon as possible to encourage a good attendance. Because this is training, the guardians, family, and others personally involved are not invited.

An outline for the CET is available on this web site. The majority of the CET Presentation follows the model of mental health presentations using the Psychiatric Diagnostic Interview formulation.

## **Day of the CET and Agenda**

So that the event goes well, it is important to keep in mind the following suggestions and procedures:

1. It is important that everyone be on time as everyone is busy and there is a 2-hour limit.
2. It is useful to have some light refreshment and a large enough room to accommodate everyone.
3. Technical equipment should be tested and set up early (e.g. power point equipment and presentation) so that there are no delays.
4. The START Coordinator presenting the case is responsible to bring copies of (unless changed for local convenience):

CET Presentation

Ecomap

Sign-in Sheet

CET Evaluation Form

CET Training Documentation Form

PowerPoint outline and any other training documents selected

The START Coordinator presenting the Follow-Up is responsible to bring that document after review by the Clinical Director

## **Order of CET**

Before the CET begins technical equipment is checked including:

Video for remote access

PowerPoint related equipment

## Telephone for participation and back-up

1. Clinical Director chairs and calls the CET to order
2. Brief explanation of START for those new to START
3. Brief explanation of CET- that it is training, need for confidentiality, and that everyone present has something to add, question, or disagree, e.g., "We are not relying solely on the Consultants. Although they have expertise, none know the case personally, and they have only reviewed selected records." Emphasize that this is not a consultation, rather an educational event. Explain that after the CET, the team will meet and review the CET discussion, decide which recommendations made sense, prioritize them, and develop action plans and timelines.
4. Explanation of agenda (follow-up case, new case, no break, 2 hours ending time, those present will have about 5 minutes to read the CET after the Follow-up, and that START Coordinator will call special meeting after the CET, reminder to try to use the "anonymous name" assigned to the case.
5. Introductions of those present
6. Ask START Coordinator for the Follow-Up to briefly summarize the new perspective and report on recommendations and progress
7. Ask everyone to take 5 minutes to read the CET Presentation
8. Ask START Coordinator for the new case to briefly summarize the reason this case was selected, the importance of the issues, and what is hoped to be learned from the CET discussion. Be sure to have a discussion of the **Ecomap** with explanation to the invited guests of what this instrument assesses. Leave at least 15 minutes for this discussion.
9. Close the meeting 10 minutes before the 2 hours, and ask the START Coordinator to try to capture the "new perspective" learned today; then ask him or her to list the recommendations
10. End the meeting, thank everyone, and remind everyone to fill out the evaluations
11. START Coordinator and Clinical Director make sure that all clinical documents are shredded.
12. Prepare to write the CET Note as soon as possible that day at least in draft to recall the discussion as much as possible.

## **After the CET:**

### **The CET Note**

After the CET, as soon as possible, complete the CET Note. In the section titled, *Discussion/New Perspectives on Individual*, write a brief overview of the major concepts discussed at the CET. Typically, this includes new information leading to new perspectives. In addition, the CET didactic training piece may also cause attendees to see the person differently. As a result, recommendations for changing supports are generated.

The CET Note also serves as a recording of the training and as documentation for billing.

### **CET Follow-Up Team Meeting**

The START Coordinator calls a meeting of the team after the CET. It is wise to schedule this prior to the CET so that this can happen as soon as possible. At this meeting, the new perspectives will be discussed. The Service Coordinator brings a list of all the potential recommendations and reviews any new perspectives regarding the person presented. All the recommendations will be reviewed, discarded, or altered. New recommendations can be made. Then, a timeline for implementation and assignments will be agreed upon. The CET Note is not distributed to the team but it is placed in the person's record.

### **CET Follow-Up Note**

The CET Follow-up note records the meeting of the team after the CET. If you are to present a follow-up of progress on the CET case presented, a *CET Follow-up Note* is prepared and distributed at that CET. This note is identical to the CET Note, except that this records the discussion with the team after the CET. In addition, it lists the recommendations that the team decided to pursue and progress on those changes in supports. The Note serves as documentation of follow-up and also serves as billing documentation

## CET Individual Presentation (add date)

**Name** (not their name, e.g., "Carla")      **Age Range**      **M/F**      **ID Level**  
**(name of person who prepared report with degree and START status)**

**Living situation:** (short)

**Day situation:** (short)

**Describe Person:** (height, weight, social abilities, conversation etc.)

**Strengths:**

**Describe the Person at his or her best in the past:**

**Goals:** Differentiate goals of the team and the person's goals

**1: Reason for presenting individual:** (key current challenges)

**2: History of these challenges recently:** Include events, changes in supports, medical problems—anything that seems relevant to #1 within the last 90 days

**3. History of any emotional, psychiatric, neurological, special education problems throughout life from birth including diagnosis of intellectual disability:**

***TIP:** When documenting this information, be sure to go in chronological order*

Include diagnosis of ID, developmental-cognitive-mental health problems in childhood, and any neurology problems, e.g. seizures or movement disorders

Include psychological-and educational testing. If there is a great deal of testing, choose perhaps the earliest testing, and most recent. Always consult your Clinical Director with regard to this.

Also include age that person entered special education and any relevant IEP information.

*\*\*Include IQ testing scores & educational achievement testing scores and age at time of testing*

Include Axis 1-5 psychiatric diagnoses if available or DSM V diagnoses.

Include at least intake ABC Scores:

ABC scores administered at intake (month and year)

ABC Area Scores	Total possible	Informant type	Informant type
Irritability	45		
Lethargy	48		
Stereotypy	21		
Hyperactivity-Noncompliance	48		
Inappropriate Speech	12		

**4. History of neurological or psychiatric problems in biological family and/or family of origin:**

Include any psychiatric issues and neurological diagnoses, do not mention specific family member. say e.g., "There is a history of schizophrenia and epilepsy in the family."

**5. Medical history:** Include medical diagnoses, current medications, including any known side effects or allergies. If the cause of ID is known, this should be discussed first, e.g., Down syndrome.

**6. Life history from birth to present:** This is the most important section and should be the longest. It should start with situation at birth, early childhood, and schooling, up to the present. Relationships are important to include as well as general descriptions of placements.

**7. Service interventions:** Supports and results, e.g., respite, behavioral supports, residence supports, changes in placements, hours of supports

**8. Family and community supports:** Family, friends, community groups. Describe verbally and attach an **Ecomap** to the presentation.

**9. Current community mental health providers and treatment:** psychiatry prescribers and mental health- psychotherapy, no specific names, frequency of contact, type of psychotherapy if known

**ATTACH ECO MAP**

## “Example”

### CET Individual Presentation

Laura                      Age: Young Adult                      Female                      ID Level: Mild

**Presented by:** Charlotte Laferrier, B.A., START Coordinator                      **Date:** January 2, 2013

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**Living situation:** Laura lives with her parents. She has a warm and supportive family.

**Day/service situation:** Laura attends a community-based day program five days a week. She also has a part-time job in a pet store through the program.

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**Describe Person:** Laura takes great pride in her appearance and her fashion statement. She is average height and a bit overweight. Laura is often pleasant and is interested in others. She can converse well. She enjoys independence.

**Strengths:** Laura can be charming, funny, and talkative. She can be considerate of others and how they are feeling, helping them to feel better. She can be very kind and generous.

**Describe the person at his or her best in the past:** Laura is motivated, positive, and socially connected. She enjoys leadership roles and can oversee activities with supervision.

**Goals:** Laura enjoys independence, for example, taking a local bus by herself. She wants a puppy. She and her team would like to work on helping her to regulate her emotions and anger outbursts.

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**1: Reason for presenting individual & challenges:** One year ago, Laura lost a part-time job due to her emotional and behavioral challenges, resulting in her entering a day service. She has difficulty managing her emotions and functioning within the social setting of work (and at home). Laura can be extremely happy and cooperative, and then change to angry and hostile with only slight provocation. Laura will frequently target a peer whom she views as less capable/more vulnerable than herself and uses insults, and verbal aggression (sometimes physical) toward them. Over the past 2 months, the frequency of verbal and physical aggression toward peers, and occasionally staff, has increased.

**2: History of these challenges recently:** Over the past two months, Laura's difficulties are increasing in frequency. There are no particular known reasons for this increase.

**3. History of any emotional, psychiatric, or neurological problems:** Since her earliest years, Laura has always had difficulty regulating her emotions and behavior. She entered regular kindergarten and then entered special education services for 1<sup>st</sup> grade. She was seen by speech therapy and was in a separate classroom for most classes.

Psychological Evaluation, Age 6: WISC-R: VIQ=84, PIQ=74, FSIQ=79

Laura was difficult to manage due to being hyperactive and volatile. In contrast, she was described as likable and fun to be with. Her IEPs had consistent behavioral and emotional goals. Psychological Evaluation, Age 10: psychological evaluation for IEP: WISC-R: VIQ=77, PIQ=64, FSIQ=70. Educational testing noted that word reading is a strength.

Laura's primary diagnosis in childhood was ADHD and was treated with 10 mg. Adderall slow release in the morning until she was 13 years old. A psychiatric evaluation at the age of 11 occurred due to difficulty managing her at school. She would cry easily, blame others for difficulties, and be physically aggressive to other children. The psychiatrist noted scatter in cognitive abilities. He thought she might be depressed and/or anxious. A mood disorder was considered possible.

Diagnoses during early school years: Dyslexia, ADHD combined type; r/o bipolar dx nos, r/o depression, r/o intermittent explosive disorder

Laura also has difficulties at home. She will frequently become upset over a particular situation and will cry, yell, blame others, refuse to accept responsibility for her actions, and occasionally be aggressive if she does not get her way. In service settings or work, Laura nearly always blames staff for her outbursts, believing that she is justified in her behavior because someone else has wronged her. Laura is intrusive and inserts herself into other people's business. Staff is continuously reminding her to only take care of herself.

**An adult psychiatrist is following Laura presently: DSM Diagnoses:**

Axis I: mood disorder nos, r/o bipolar dx, r/o MDD recurrent, ADHD (nos) by history

Axis II: mild intellectual disability

Axis III: seizure disorder

Axis IV: problems in community and in work

Axis V: 55

**The psychiatrist currently prescribes:**

aripiprazol (Abilify) 5 mg po qd (antipsychotic)

fluoxetine (Prozac) 60 mg po qd (antidepressant)

clonazepam (Klonopin) 0.5 mg bid (anxiolytic)

depakote 500 mg bid for seizures prescribed by neurologist\*

**ABC scores administered at intake June 2013**

ABC Area Scores	Total possible	Parent	Work Supervisor
Irritability	45	23	28
Lethargy	48	5	10
Stereotypy	21	3	1
Hyperactivity-Noncompliance	48	35	38
Inappropriate Speech	12	3	2

**4. History of neurological or psychiatric problems in family of origin:** Her grandfather and his 2 brothers died of Alzheimer's disease. Grandfather lived with her family until he died recently.

**5. Medical history:** In her early years, she had a seizure and is diagnosed with epilepsy. She is treated with Depakote 500 mg bid. Currently she is seizure free.

**6. Life history from birth to present:** Laura was the third child born to her parents and has 2 twin brothers who are 8 years older. Laura was the product of a complicated birth and delivery and was in the ICU for 8 days. Thereafter, she appeared to develop within normal limits but appeared to be a bit "delayed." The pediatrician did not refer but preferred to wait. Laura entered special education after kindergarten. She graduated at age 21.

Her education plan focused on teaching basic academic skills and prevocational work. Equally as important were efforts to help her manage her emotional state. She spent some time in mainstream classes, such as music, but most time was in special classes and interventions such as speech therapy and reading. When school ended, she remained in a part-time job arranged through school until she had multiple interpersonal problems and outbursts; this ended 1 year ago.

Laura lives with her mother and father in a 2-family home. Parents both work. Laura participates in household chores. She has no friends of her own due to her emotional and behavioral difficulties. She does not complain about this, however, as she has a full family life. Laura is very capable but has many behavioral difficulties at her day program. As part of this program, Laura works 4 afternoons a week at pet store. In contrast to other settings, staff report that she works well

operating within the boundaries laid out by the facility. She would like her own puppy and this has become a focal point of numerous behaviors while at home.

**7. Service supports and results:** Laura entered Adult Services 2 years ago. She did not attend a day program until 10 months ago.

**8. Family and community supports:** Laura's parents are frequently involved in service planning. Laura values the time spent with her two brothers and their families. She enjoys playing with her many nieces and nephews. The family is involved in the community including a local church and the town council.

**9. Current community mental health providers and treatment:** A local psychiatrist follows Laura and she is seen quarterly. Laura sees a psychotherapist weekly and she reports little progress.

## START CET Note

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**Name:** (of Individual and official identification #)

**Date of CET Presentation:**

**START Coordinator/Intern:**

**Consultants Present:**

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**Discussion/New Perspectives:**

(Two to three paragraphs to focus new conceptualization from what was learned/discussed at the CET and may use the same discussion in the CET Note Including formal didactic PowerPoint and what was learned, related to person presented)

**Recommendations: (from CET Note)**

(Use bulleted format)

## **“Example”**

### **START CET Note**

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**Name Dave Tramontatta (Anonymous)**

**identification #: 1102445**

**Date of CET Presentation: January 23, 2013**

**START Coordinator/Intern: Jill Lamontagne, M.A., START Coordinator Intern**

**Consultants Present: Anne Desnoyers Hurley, Ph.D.; Joan Beasley, Ph.D., Bob Scholz, M.S.**

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**Discussion/New Perspectives:** Dave is a young man in his 30s, currently living in a supported apartment with 2 other men and working 20 hours a week at a recycle facility. He has trouble with attending to the job, leaving the job site, and he also becomes difficult and upset, sometimes having a “temper tantrum” and throwing objects. He is in danger of losing his job and the men he lives with are often afraid of him.

It was known that Dave probably had fetal alcohol syndrome (FAS), but the difficulties experienced, needs for supports, and future directions had not been integrated into his supports. A PowerPoint on FAS helped focus this discussion. In addition, as with most people who have FAS, he was taken from his family of origin at an early age. He had several foster families before finally living with his current family who adopted him at age 7. His school history was extensively reviewed, and one major point was important, that being that he has superficially good verbal skills so that others expect much more of him than is possible, and others are then disappointed or frustrated when he fails to succeed with current supports. A presentation on FAS, symptoms and supports was very informative and helped the team to think differently in how to conceptualize his strengths and need areas. In addition his “nonverbal learning disability” was discussed to help the team appreciate how we think of people who have good superficial verbal skills. An ecomap showed that he mainly had paid relationships. He has potential to develop friendships but needs help with social skills and being impulsive and demanding.

As with many people who have aggressive behavior, he is being treated with several antipsychotics. As a result he is now morbidly obese and has sleep apnea, high blood pressure, and high cholesterol. Consultants recommended changing treatment to that recommended for people with FAS/ADHD. This may include stimulants during the day and perhaps a medicine such as clonidine to help with sleep and late hours. Slow reduction of antipsychotics may also help his medical conditions, in combination with exercise and diet.

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#### **Recommendations:**

-Hold a team meeting and focus on review of FAS, symptoms and supports, bring FAS training materials to aid in team discussion. Also discuss nonverbal LD. Make

sure support system understands his strengths and difficulties so that appropriate supports and responses can be developed and followed.

-Offer more education to family and engage them in supports.

-Explore any trauma that may have been experienced due to early placements.

-Meet with psychiatrist to discuss FAS and changes in medicines to d/c antipsychotics slowly and then introduce medicines known to help people with FAS.

-Discuss diagnosis with psychotherapist and consider more structured therapy, such as CBT, and engage with team in follow-through for CBT assignments.

-Consider a community support job that involves a lot of activity and moving about and/or alter his present job so that he can be more successful and/or consider trying CBT supports appropriate to a work site.

-Have discussion with home support staff exploring ways to help him remain calm, increase activities, ways to help his apartment mates cope better with him and feel more secure there; also consider a different placement if that seems appropriate.

-Celebrate his many strengths and do not lose site of the need for slow change and slowly being successful.

## CET Follow Up Note

---

Name: (Anonymous of Individual and official identification #)

Date of CET Presentation:

Date of Follow-up:

START Coordinator/Intern:

Consultants Present:

---

Discussion/New Perspectives:

(Two to three paragraphs to focus new conceptualization from what was learned/discussed at the CET and may use the same discussion in the CET Note. Discuss didactic-PowerPoint and how it related to the case presented)

Recommendations: (from CET Note)

(Use bulleted format)

Current Progress:

(Use bulleted format)

*“Example”*

## CET Follow-Up Note

---

**Name:** Sara

**Date of CET Presentation:** January, 2013

**Date of Follow-up:** February, 2013

**START Coordinator/Intern:** Jerry Smith, B.S., START Coordinator, West Collaborative

**Consultants Present:** Anne Desnoyers Hurley, Ph.D.; Joan Beasley, Ph.D., Van Silka, M.D.

---

### **Discussion/New Perspectives:**

Sara is currently residing in a specialized developmental center on an emergency basis. She was moved to the facility recently after an altercation with a roommate in her staffed apartment. She has a history of impulsive and serious suicide attempts. At her home, she became aggressive, which resulted in injuries to support staff. She has been at the center for a few weeks, and has been receiving some evaluation while there. There is a possibility that Sara may move in with her mother. She mainly has professional relationships, but has some friendships from the past (shown on Ecomap) and these can be reinstated possibly.

Sara is currently diagnosed with mood disorder NOS, mild ID, personality disorder NOS with borderline and histrionic features, high cholesterol and high blood pressure. At the CET, the consultants discussed the possibility of early onset bipolar disorder due to the review of her historical clinical records. A training on early onset bipolar disorder was presented. Treatment of early onset is difficult; lithium is often ineffective. Her history did seem consistent with early onset bipolar disorder and this would lead to a discussion with her psychiatrist and consideration of new expectations and needed supports. Her history also documented many placements and moves from an early age and as a result she may have experienced some trauma.

### **Recommendations:**

- Due to extensive history, look at the possibility of loss, grief, and/or trauma counseling. Modified CBT would be helpful.
- Contact between the team and Sara's mother would be beneficial
- Explore the possibility of early onset bipolar with the team
- Moving in with her mother is not a good option; she would most likely engage in another suicide attempt due to a lack of clinical oversight
- Ask her psychiatrist to consider the diagnosis change, and possibly, lithium should be titrated down slowly.
- A mood stabilizer, such as Tegretol or Lamictal, may be beneficial. If neither of those work, Clozaril would be another option to consider, but should only be used as a last resort due to the extensive side effects.

- A monthly bipolar chart, which documents daily moods, should be utilized to collect data. The START Coordinator will provide to the case manager.
- Change supervision requirements and increase access to activities

**Current Progress:**

- Discussion has been initiated with developmental center staff about early onset bipolar disorder, psychiatrist was not sure and we will arrange a telephone call with one of the consultants
- Contact with Sara's mother is being attempted to engage her regularly
- The team is looking for a more appropriate placement.
- The team is looking for opportunities to engage Sara in preferred activities.
- The bipolar chart was provided to the staff.

---

## Evaluation of Training

**Topic:** Clinical Education Team

**Date:**

**Site:**

<b>Areas to be evaluated for this presentation</b>	<b>Very good</b>	<b>Satisfactory</b>	<b>Unsatisfied</b>
Relevance to my work			
Handouts/Power Point materials			
Comfort of physical setting			
Team interaction			

**Please add any comments to help us plan our next trainings:**

**“Example”**

---

Behavioral Healthcare & Intellectual Disability  
Clinical Education Team Seminar Series

**Perspectives on Mental Health Treatment & Community Supports  
for People with Developmental Disabilities**

**Faculty:** Anne. Desnoyers Hurley, Ph.D., Joan B. Beasley, Ph.D.,  
Jennifer McLaren, M.D., & Robert Scholz, M.S.

2 Contact Hours/CEUs

---

*name of attendee*

**Concord, NH Institute on Disability/UCED, University of New  
Hampshire**

**DATE:**

Anne Desnoyers Hurley, Ph.D.  
Research Associate Professor  
University of New Hampshire

# SECTION IX:

## Data Collection & Reporting

- Overview
- SIRS: START Information Reporting System
  - SIRS Demonstration Link
  - User Guide
  - Data Dictionary

## OVERVIEW

The START model relies on data to provide feedback to stakeholders and funders to assess the effectiveness and efficiency of START services. The START Information and Reporting System (SIRS) database captures de-identified health information about START clients across the country and has the ability to provide stakeholders with customized reporting by case load, region or state. SIRS also allows for the analysis of service outcomes for START users and provides valuable information on service effectiveness over time for decision makers

The START model relies on data to drive decision-making in the system and to develop a better understanding of clinical and treatment needs required to improve service outcomes.

As a result, START requires the active participation of coordinators in the collection of data related to START services.

## SIRS – THE START INFORMATION REPORTING SYSTEM

In order to provide an effective service delivery system, assess program goals and monitor fidelity to the model, the Center for START Services and the University of New Hampshire maintain the START Information Reporting System (SIRS). SIRS was developed in 2012 in conjunction with the VA START Project. The first phase of the data collection and reporting process for the SIRS was completed in FY12 with a pilot process conducted in VA-START Region III.

All START programs are required to contribute data to SIRS.

SIRS includes a number of standardized reports that summarize data collected by caseload, region, and state. The reports allow for the identification of trends in a variety of areas including service use and effectiveness of START services. The SIRS also provides users with the capacity to download current data at any time to address internal needs/questions.

In addition to reporting and quality improvement activities, SIRS provides an evidence-informed data set to help enhance systems as we work to increase effective person-centered outcomes for individuals with IDD, their families, and their communities and can be used to enhance our knowledge about the populations served

## REPORTING

In collaboration with their Advisory Council, START Programs develop and

disseminate annual reports that provide important information to stakeholders and the community, as well as to other projects across the nation. These reports rely heavily on the analysis of programmatic and clinical data that is found in the SIRS database. The Center for START Services assists each START Program with the analysis of this data and implications for future services. Reports are posted on the Center for START Services website and shared among projects.

Reports typically follow an organization's fiscal year (e.g., NH-START produces an annual report during late summer/early fall that covers the period of July 1 through June 30 of the preceding year). Because of their size and scope, statewide projects produce quarterly reports, which provide the key data needed to develop a comprehensive annual report in an efficient manner.

Please check the "[Community Resources](#)" section of the Center for START Services website for sample reports.

## **CONTACT INFORMATION FOR SIRS**

For information regarding SIRS, please contact the SIRS Manager, Ann Klein, at [ann.klein@unh.edu](mailto:ann.klein@unh.edu).

## **SIRS DEMONSTRATION VIDEO**

**LINK GOES HERE**

## **SIRS USER'S GUIDE AND DATA DICTIONARY**

# User's Guide for START Information Reporting System (SIRS)

Version 2.0.1

July 2014

Center for START Services

Institute on Disability, University of New Hampshire

Institute for Health Policy and Practice, University of New Hampshire



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## **I. Overview of SIRS**

### **Introduction**

The START Information Reporting System (SIRS) is a web-based platform created to assist regional START teams in electronically reporting information and service outcomes for individuals served by START.

### **Background**

The Center for START Services is a national initiative that strengthens efficiencies and service outcomes for individuals with intellectual and/or developmental disabilities and behavioral health needs in the community. START is a service linkage coordinated system of care that involves stakeholders on multiple levels of service delivery along with the individual and their family. Community education and access to services along with the development of affiliations and linkages with existing services is a primary mission in filling the gaps in the service delivery system. The underlying philosophy of START is that services will be most effective when everyone involved in support and treatment is allowed to participate actively in treatment planning and service decisions.

In order to improve consistent data collection of these services, the Institute on Disability (IOD) and the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH), have developed the START Information Reporting System (SIRS) to assist START team members capture information related to service outcomes.

For more information on the Center for START Services, please visit the website at <http://www.centerforstartservices.com/>.

### **Data Collection**

One way in which START is accountable to stake-holders for services provided is through the collection of relevant information and maintenance of a database (SIRS). Analysis of service outcomes provides the information needed to ensure that START is effective and efficient. The data also provides important feedback regarding the utility of particular services and where services may need modification to improve outcomes. The SIRS database has the capacity to track START services provided to each individual, both by region and by state. Analysis of service outcomes provides valuable information regarding service effectiveness over time and provides a management tool for decision makers.

### **Confidentiality**

UNH staff who will have contact with SIRS have signed confidentiality agreements. Confidentiality of individual information within SIRS is protected both through the use of firewalls and the programming of the system.

## Security

Strong passwords on user accounts are required, and you will be prompted to choose a new password every six months. If you need a SIRS account or are having issues accessing SIRS, please contact the START Regional Program Manager in your state or region.

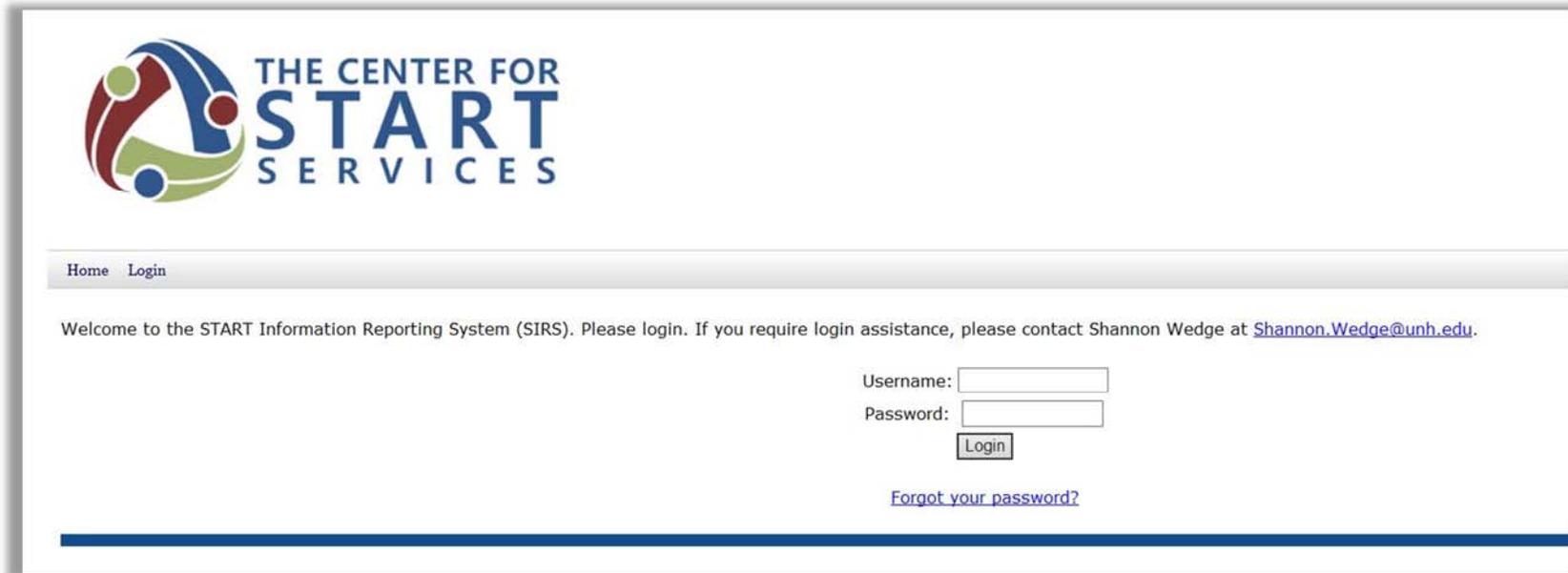
## II. Using SIRS

### Introduction to SIRS

This section of the SIRS User's Guide provides step-by-step instruction on how to access the system, how to enter individual information, and how to view and edit individual records.

### Accessing SIRS

To access the SIRS website, please visit <https://www.SIRSdata.org/>. Note: SIRS runs best using Internet Explorer 6 or higher. Before entering any individual information, START Coordinators must log into the system using their assigned username and password from SIRS administrators; both username and password are case-sensitive. You will be required to change your password when you first log into the system. If for some reason you do not have your username and password, please contact your Regional START Program Manager.



The screenshot shows the login page for The Center for START Services. At the top left is the logo, which consists of three stylized human figures in red, blue, and green, with the text "THE CENTER FOR START SERVICES" to its right. Below the logo is a navigation bar with "Home" and "Login" links. The main content area contains a welcome message: "Welcome to the START Information Reporting System (SIRS). Please login. If you require login assistance, please contact Shannon Wedge at [Shannon.Wedge@unh.edu](mailto:Shannon.Wedge@unh.edu)." Below this message are two input fields: "Username:" and "Password:". A "Login" button is positioned below the password field. At the bottom of the form area is a blue hyperlink that reads "Forgot your password?".

- If you need to reset your password, you can click on the "**Forgot your password?**" link to reset it yourself – the system will e-mail you instructions, so please check your spam folder if you don't see it within an hour

## Main Menu

The main menu of SIRS will assist you in navigating the site. Each section has a specific purpose which is detailed below.



**Home:** This menu item brings a user to the homepage from anywhere on the website

**Individuals:** This menu item directs users to the list of individuals assigned to that user

**Time:** This menu item provides users with a comprehensive list of the time they've spent providing services related to the START program

**Intake/Triage Information:** This menu item directs users to the intake form to create a new individual record. More information about this item is detailed in the next section of the user's guide

**Service Outcomes:** This menu item directs users to a list of services provided to individuals assigned to that user

**Assessment Tools:** This menu item directs users to the scores for any assessment tools (ABC, RSQ, and Meds) entered for individuals assigned to them

**Help:** This menu item directs users to contact information for the SIRS technical assistance

**Logout:** This menu item logs a user out of SIRS

### III. Entering Individual Information

START Coordinators have the ability to enter information for new or existing individuals. Instructions are detailed below.

#### A. New Individuals

1. To enter a new individual into SIRS and create a new record, click on **Intake/Triage Information** from the main menu.



2. Enter as much information as available for the individual and click **Submit** at the bottom of the page

Submit

Some fields require a response in order to save a record.

These fields are:

- Local ID
- Date referred to START
- Suitability
- Date of birth (month/year)
- Gender

### Intake/Triage Information

Region:	<input type="text" value="--- Select ---"/>
County:	Please select a region
START coordinator: <a href="#">Add</a>	
Local ID:	<input type="text"/> M
Date referred to START: MM/DD/YYYY	<input type="text"/> <input type="button" value=""/>
Time referred to START:	<input type="text" value="--- Select ---"/>
Purpose referred to START:	<input type="text" value="--- Select ---"/> M
Source of referral to START:	<input type="text" value="--- Select ---"/> M
Suitability of referral to START:	<input type="text" value="--- Select ---"/>
Outcome of referral to START:	<input type="text" value="--- Select ---"/> M
Presenting problems at time of referral:	<input type="checkbox"/> Aggression (physical, verbal, property destruction, threat) <input type="checkbox"/> At risk of losing placement <input type="checkbox"/> Decrease in ability to participate in daily functions <input type="checkbox"/> Diagnosis and treatment plan assistance <input type="checkbox"/> Family needs assistance <input type="checkbox"/> Leaving Unexpectedly <input type="checkbox"/> Self-injurious <input type="checkbox"/> Sexualized behavior <input type="checkbox"/> Transition from hospital <input type="checkbox"/> Other <input type="checkbox"/> Mental health symptoms <input type="checkbox"/> Suicidal ideation/behavior Other: <input type="text"/>
Month and year of birth: MM/YYYY	<input type="text"/> M
Gender:	<input type="text" value="--- Select ---"/> M

**NOTE: For all pages, if you do not click the Submit button the information will not be saved!**

3. An individual record is created when an intake form is submitted for an individual. The individual record also contains additional sections which capture supplementary information related to an individual. These additional sections can be filled out immediately or at a later date. Instruction for each additional section is detailed in the Existing Individuals section of this user's guide.

Individual Local ID: 77777

---

**Individual Information** view open

---

**START Time Tracking** add open

---

**Intake/Triage Information** view open

---

**Individual Services and Outcomes Data** add open

---

**Medication List** add open

---

**Assessment Tools** open

---

**Individual START Plans and Evaluations** edit open

---

---

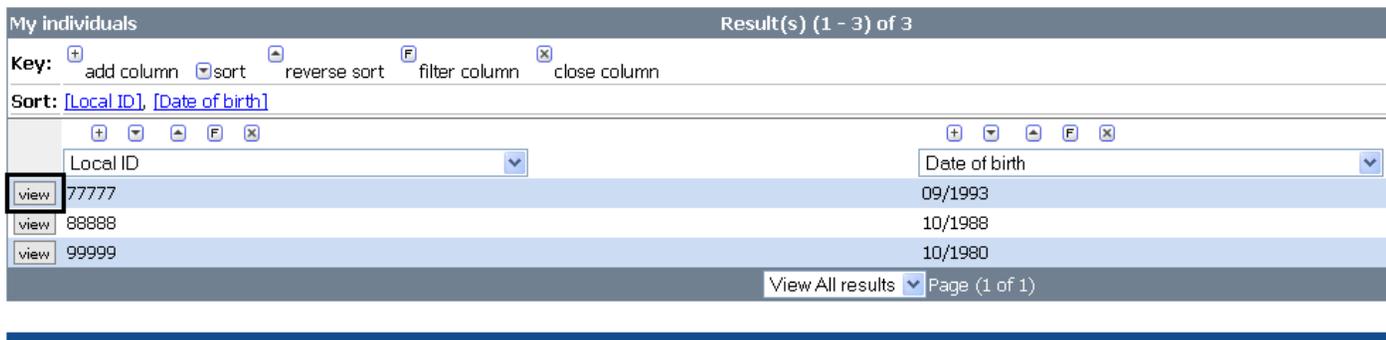
## B. Existing Individuals

A START Coordinator can add information to an existing individual record via the SIRS homepage by clicking on "View individuals" after logging in and may be able to view all individual records in their state, territory or region.

**Note: only those given Regional Administrator privileges will be able to edit information for individuals. If you, as a START Team member, need to make a change due to an error, please alert your supervisor.**



1. Find the individual record you wish to view or edit and click **view**. Please note that an individual record will open in a new window or tab depending on your browser settings.



The screenshot shows a table titled 'My individuals' with 'Result(s) (1 - 3) of 3'. The table has columns for 'Local ID' and 'Date of birth'. Each row has a 'view' button next to the 'Local ID' value. The table is sorted by 'Local ID' and 'Date of birth'.

Local ID	Date of birth
77777	09/1993
88888	10/1988
99999	10/1980

2. In the individual record view, additional sections of the record are available.
- START Coordinators (designated Case Managers within SIRS) have the option of **viewing** sections of the individual record, and **adding** individual information
  - Supervisors with Regional Administrator privileges can also **edit** individual information
- b. To view individual information within a section, click the **open** button.

Individual Local ID: 77777

Individual Information	view	open
START Time Tracking	add	open
Intake/Triage Information	view	open
Individual Services and Outcomes Data	add	open
Medication List	add	open
Assessment Tools		open
Individual START Plans and Evaluations	edit	open

The screenshot displays a user interface for an individual record. At the top, it shows the 'Individual Local ID: 77777'. Below this, there are seven sections, each with a title and a set of action buttons. The sections are: 'Individual Information' (view, open), 'START Time Tracking' (add, open), 'Intake/Triage Information' (view, open), 'Individual Services and Outcomes Data' (add, open), 'Medication List' (add, open), 'Assessment Tools' (open), and 'Individual START Plans and Evaluations' (edit, open). The 'open' button for the 'Individual Services and Outcomes Data' section is highlighted with a black border.

c. To **add** individual information to a section, click the **add** button.

Individual Local ID: 77777

Individual Information	view	open
START Time Tracking	add	open
Intake/Triage Information	view	open
Individual Services and Outcomes Data	add	open
Medication List	add	open
Assessment Tools		open
Individual START Plans and Evaluations	edit	open

#### IV. START Time Tracking

There are two ways to track time: A) specific to an individual and B) general, not individual specific time.

- A. To add **START Time Tracking** information to an **individual's record**:
- Click the **add** button in the **START Time Tracking** section of the individual's record

- Select the type of time that you would like to add, and a drop-down menu will appear.

**Add Time**

Please enter time related to services you've provided to this specific individual ONLY.

Client local ID: 77777

Section:

- Clinical Education Team
- Clinical Tools
- Comprehensive Service Evaluations
- Crisis Contacts
- Cross-Systems Crisis Prevention and Intervention Planning
- General Administrative work
- Outreach, Specialized Training and System Linkages
- Therapeutic Respite

- Select date (month, day and year), and the amount of time spent on the activity (in hours and minutes) and click **Submit**. Please note that time should be entered in 15 minute intervals.

**Add Time**

Please enter time related to services you've provided to this specific individual ONLY.

Client local ID: 77777

Section:

	Date	Hours	Minutes
Follow-up/communication with teams, etc.	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preparing and/or reviewing CET case	<input type="text"/>	<input type="text"/>	<input type="text"/>
Travel time related to CET	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Once you click **Submit**, the individual record will reappear. You will notice that the **START Time Tracking** section of the individual record now contains the information that you just entered. View your additions by clicking **open**

B. To add **START Time Tracking** information that is **general - not individual specific** (i.e. attending START training):

- Click the **Time** button in the menu bar at the top of the Home page

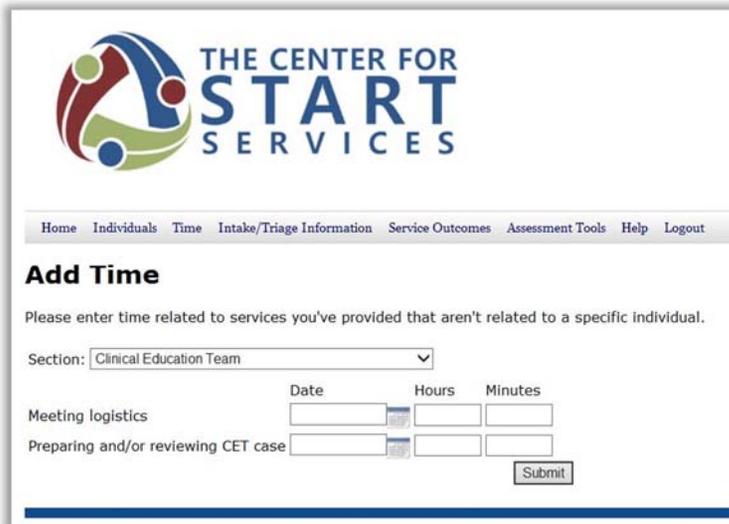


- Click the **New** button on the right (next to "refresh" and "export")



- Select the type of time that you would like to add, and a drop-down menu will appear

- Select date (month, day and year), and the amount of time spent on the activity (in hours and minutes) and click **Submit**. Please note that time should be entered in 15 minute intervals



The screenshot shows a web application interface for 'THE CENTER FOR START SERVICES'. At the top left is the logo, which consists of three stylized human figures in red, blue, and green. To the right of the logo, the text 'THE CENTER FOR START SERVICES' is displayed in a blue, sans-serif font. Below the logo and text is a horizontal navigation menu with the following items: Home, Individuals, Time, Intake/Triage Information, Service Outcomes, Assessment Tools, Help, and Logout. The main content area is titled 'Add Time' in bold black text. Below the title is a paragraph of instructions: 'Please enter time related to services you've provided that aren't related to a specific individual.' Underneath this is a dropdown menu labeled 'Section:' with 'Clinical Education Team' selected. Below the dropdown is a table with three columns: 'Date', 'Hours', and 'Minutes'. There are two rows of data entry. The first row is labeled 'Meeting logistics' and the second row is labeled 'Preparing and/or reviewing CET case'. Each row has a date input field, an hours input field, and a minutes input field. A 'Submit' button is located at the bottom right of the form area.

**THE CENTER FOR START SERVICES**

Home Individuals Time Intake/Triage Information Service Outcomes Assessment Tools Help Logout

### Add Time

Please enter time related to services you've provided that aren't related to a specific individual.

Section: Clinical Education Team

	Date	Hours	Minutes
Meeting logistics	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preparing and/or reviewing CET case	<input type="text"/>	<input type="text"/>	<input type="text"/>

Submit

## V. Adding Individual Services and Outcomes Data

To add **Individual Services and Outcomes Data** information to an individual's record:

- Click the **add** button in the **Individual Services and Outcomes Data** section of the individual's record
- Choose a service type
- Enter information and click **Submit**

Home Individuals Time Intake/Triage Information Service Outcomes Reports Users Regions Admin Help Logout

### Individual Services and Outcomes Data

Service type:  M

Date/Time of contact or admission:

S

- Select ---
- Emergency/Crisis services
- Respite - Emergency
- Respite In-home planned services
- Respite - Planned
- Respite In-home emergency services
- Emergency Room/Department Use
- Law Enforcement Involvement
- Psychiatric In-patient admission

- Once you click **Submit**, the individual record will appear. You will notice that the **Individual Services and Outcomes Data** section of the individual record will now include the information that you just entered. View your addition by clicking **open**

## VI. Medication List

To add **Medication List** information (numbers of types of medication) to an individual's record:

- Click the **add** button in the **Medication List** section
- Enter psychiatric medication information and click **Submit**

### Medication List

Date Administered:   
MM/YYYY

Type of service:

Individual is on medications:

Type of prescriber:

Number of antipsychotic-typicals:

Number of antipsychotic-atypicals:

Number of mood stabilizing/anticonvulsant:

Number of antidepressant:

Number of antianxiety:

Number of sedative/hypnotics:

Number of ADHD/stimulants:

Number of other:

- Once you click **Submit**, the individual record will appear. You will notice that the **Medication List** section of the individual record will include the information that you just entered. View your addition by clicking **open**

## VII. Assessment Tools

### A. To add **Matson Evaluation of Drug Side Effects (MEDS) Checklist** information

- Click the **open** button in the **Assessment Tools** section of the individual's record
- Click the **add** button in the **Matson Evaluation of Drug Side Effects (MEDS) Checklist** section of the individual's record
- Enter information and click **Submit**

The screenshot shows a web form titled "Matson Evaluation of Drug Side Effects (MEDS) Checklist". The form contains the following fields and options:

- Date Administered: MM/YYYY (text input)
- Type of service: --- Select --- (dropdown menu)
- MEDS-Cardio: SV #/0-18: (checkbox)
- MEDS-Cardio: DU #/0-18: (checkbox)
- MEDS-Gastro: SV #/0-20: (checkbox)
- MEDS-Gastro: DU #/0-20: (checkbox)
- MEDS-Endo: SV #/0-16: (checkbox)
- MEDS-Endo: DU #/0-16: (checkbox)
- MEDS-EarNose: SV #/0-22: (checkbox)
- MEDS-EarNose: DU #/0-22: (checkbox)
- MEDS-Skin: SV #/0-22: (checkbox)
- MEDS-Skin: DU #/0-22: (checkbox)
- MEDS-CNS-G: SV #/0-28: (checkbox)
- MEDS-CNS-G: DU #/0-28: (checkbox)
- MEDS-CNS-D: SV #/0-10: (checkbox)
- MEDS-CNS-D: DU #/0-10: (checkbox)
- MEDS-CNS-PD: SV #/0-28: (checkbox)
- MEDS-CNS-PD: DU #/0-28: (checkbox)
- MEDS-CNS-BA: SV #/0-16: (checkbox)
- MEDS-CNS-BA: DU #/0-16: (checkbox)
- MEDS-TOTAL: SV #/0-180: (checkbox)
- MEDS-TOTAL: DU #/0-180: (checkbox)

At the bottom right of the form are two buttons: "Submit" and "Close".

- Once you click **Submit**, the individual record will appear. You will notice that the **Matson Evaluation of Drug Side Effects (MEDS) Checklist** section of the individual record will include the information that you just entered. View your addition by clicking **open**

### B. To add **Aberrant Behavior Checklist (ABC)** information

- Click the **open** button in the **Assessment Tools** section of the individual's record

- Click the **add** button in the **Aberrant Behavior Checklist (ABC)** section of the individual's record
- Enter **Aberrant Behavior Checklist (ABC)** information and click **Submit**

### Aberrant Behavior Checklist (ABC)

Date Administered:   
MM/YYYY

Type of service:

ABC\_IrritabilityAgitation: #/0-45:

ABC\_LethargySocialWithdrawal: #/0-48:

ABC\_StereotypicBehavior: #/0-21:

ABC\_HyperactivityNoncompliance: #/0-48:

ABC\_InappropriateSpeech: #/0-12:

ABC\_Total: #/0-174:

C. To add **Recent Stressors Questionnaire (RSQ)** information

- Click the **open** button in the **Assessment Tools** section of the individual's record
- Click the **add** button to the right of Recent Stressors Questionnaire

<b>Individual Information</b>	edit	open
<b>START Time Tracking</b>	add	open
<b>Intake/Triage Information</b>	edit	open
<b>Individual Services and Outcomes Data</b>	add	open
<b>Medication List</b>	add	open
<b>Assessment Tools</b>		hide
<b>Matson Evaluation of Drug Side Effects (MEDS) Checklist</b>	add	open
<b>Aberrant Behavior Checklist (ABC)</b>	add	open
<b>Recent Stressors Questionnaire</b>	add	open

- Fill in the date administered in MM/YYYY format

### Recent Stressors Questionnaire

M

Date administered:  
MM/YYYY

11/2013 M

Type of service:

--- Select --- M

- Use the pull-down menu to select Intake, Review, or Crisis related

Type of service:

--- Select ---

Which of the following have occurred in the past six months?

--- Select ---  
Intake  
Review  
Crisis related

Changes in residential staff:

NOTE: The questions will be familiar to people who have kept track of cumulative recent stressor data in Excel in 2012 and/or 2013. The wording of each question is the same as before, but there is one new question: "death of a loved one, caretaker, friend or peer."

As before, each question needs a yes or no response, and every question must be answered. Also as before, consider the past six months of the client's life. You will be evaluating these answers at intake, at the time of a review, or when there is a crisis.

- To answer the question, click on the drop-down menus to the right of each and choose yes or no as appropriate

Changes in residential staff:	---
Changes in school or day/vocational staff:	---
A move to a new living situation:	---
Changes in residential staff:	Yes
Changes in school or day/vocational staff:	Yes
A move to a new living situation:	No
A change in a day program, job or schools/classroom assignment:	---
Changes in the level or rate or type of contacts with family or significant people:	Yes
Illness of a loved one, caretaker, friend or peer:	No

- If the answer to Hospitalizations is "Yes" use the drop-down menu to the right to specify if the hospitalization's purpose was medical or psychiatric. If **both** types of hospitalizations have occurred within the past six months, choose the most recent type here and use the "Other" box in the next question to note the other type of hospitalization occurred as well

Hospitalizations:	Yes	Medical
-------------------	-----	---------

- If there were other stressing situations in the client's life in the past six months, please use the text box to explain the stressor

Other (please list):

- Check that all questions have been answered and then click the **Submit** button at the bottom of the page

Changes in sleep pattern:	No
New onset of falling or changes in gait:	No
Any new or unusual movements of any kind:	Yes
Other changes in routines, even small, that might affect this person:	Yes
Hospitalizations:	Yes <input type="text" value="Medical"/>
Other (please list):	<input type="text" value="hurricane damaged residence"/>
<input type="button" value="Submit"/> <input type="button" value="Close"/>	

- Once you've submitted your answers you'll be sent back to the previous screen and can now edit the existing previous stressors record you've just created, or add another set of recent stressors data for this client at a later date

Recent Stressors Questionnaire		<input type="button" value="add"/> <input type="button" value="hide"/>
<b>11/2013</b>		<input type="button" value="edit"/> <input type="button" value="delete"/>
Date administered:	11/2013	
Changes in residential staff:	Yes	

- If you log out of SIRS and wish to go back into this client's RSQ data, when you next go into their record, you'll need to open the assessment tools again, and this time under RSQ choose open instead of add

## VIII. Individual START Plans and Evaluations

- To add **Individual START Plans and Evaluation Data** information to an individual's record:
- Click the **add** button in the **Individual START Plans and Evaluations** section of the individual's record
- Choose a plan or evaluation type
- Enter information and click **Submit**
- Updates to crisis and START plans can be made by clicking the blue add link and entering the information requested

The screenshot shows a web application interface for adding individual START plans and evaluations. At the top, there is a navigation menu with links: Home, Individuals, Time, Intake/Triage Information, Service Outcomes, Assessment Tools, Reports, Import, Users, Regions, Admin, Help, and Logout. The main heading is "Individual START Plans and Evaluations". Below the heading, a note states "All dates should be in MM/YYYY format". The form is divided into three sections:

- Comprehensive Service Evaluation (CSE)**: Includes a "Date Completed:" field with an empty text input box.
- Crisis Plan - Provisional**: Includes a "Date Completed:" field with an empty text input box.
- Crisis Plan - Full**: Includes a "Date Completed:" field with an empty text input box and a "Revision(s):" field with a blue "Add" link below it.

The **START Action Plan** section includes:

- "Date Completed:" field with the value "6/2014".
- "Involvement:" field with a dropdown menu showing "-- Select --".
- "Intensity:" field with a dropdown menu showing "-- Select --".
- "Stability:" field with a dropdown menu showing "-- Select --".
- "Mode of Contact:" field with a dropdown menu showing "-- Select --".
- "Revision(s):" field with a blue "Add" link below it.

At the bottom right of the form, there are two buttons: "Submit" and "Close".

## IX. Editing

**For Regional Administrators:** To **edit** individual information for any other section of the individual record, click **open** within the section of the individual record that requires an edit (**'A' in the screen shot**). Find the information that needs to be edited and click the **edit** button (**'B' in the screen shot**).

Individual Local ID: 77777

**A**

Individual Information	view	open
START Time Tracking	add	open
Intake/Triage Information	view	open
Individual Services and Outcomes Data	add	open
Medication List	add	open
Assessment Tools		open
Individual START Plans and Evaluations	edit	open

**B**

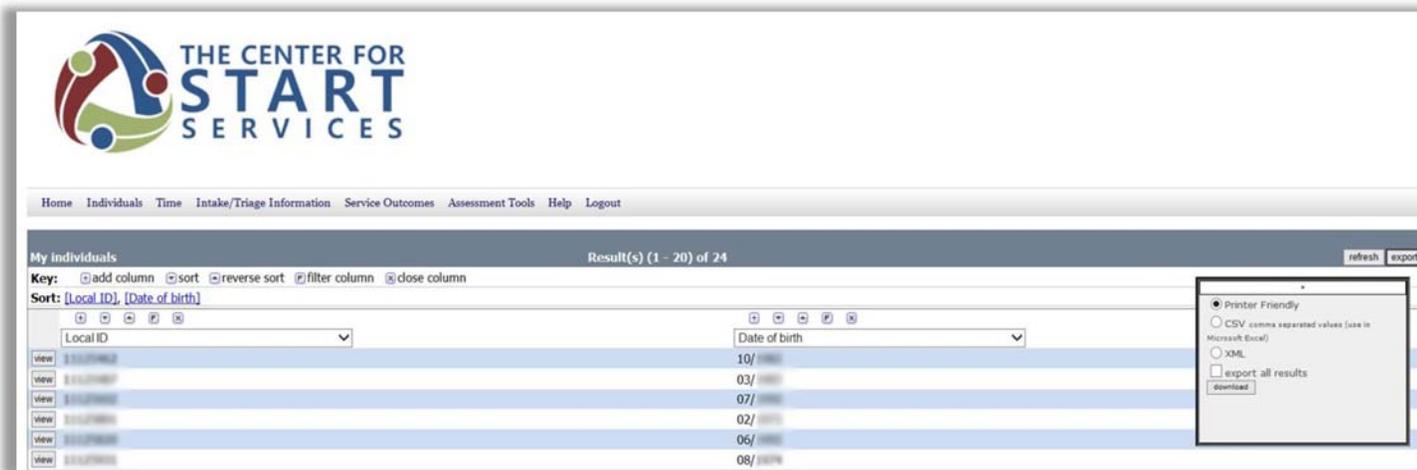
## X. Exporting Individual Information

Users have the ability to export individual data they've entered into SIRS.

- Click on **Individuals** from the main menu



- The export button can be found on the right side of the My Individuals browser screen. Click on the export button, choose a file type and click download. **Please note that users have the ability to query a specific individual or individuals in this view by utilizing filter options.** More information can be found in the RecordSet User's Guide in the SIRS Help section



## XI. Exiting SIRS

To ensure the security of individual data, users should log out of SIRS each time they finish working in the system. Users can log out of the system using the **Logout** button in the main menu.



THE CENTER FOR  
**START**  
SERVICES

[Home](#) [Individuals](#) [Time](#) [Intake/Triage Information](#) [Service Outcomes](#) [Assessment Tools](#) [Reports](#) [Users](#) [Regions](#) [Admin](#) [Help](#) [Logout](#)

# SECTION X:

## Fidelity to the START Model

- Fidelity to the START Model
- START Program Certification
- START Fidelity Monitoring Tools
  - Record Review Checklist
  - Resource Center Environmental Checklist
  - Satisfaction Surveys

## **FIDELITY TO THE START MODEL**

Fidelity to the START Model means that START Programs share common core visions, missions, values, and practices. START meets the system where it is and employs positive wellness approaches, linkages, and outreach to promote systems change. START Programs are first, and foremost, learning communities in which data is collected, analyzed, shared, and used to inform clinical practice. Rigor is employed through the use of evidence informed decision making to promote a network of continued learning and growth.

The Center for START Services provides ongoing support in the form of on-site visits, online-training, regular action planning meetings and case consultation with the focus being on providing support and training to all new START Programs. This on-going consultation also includes regular QA Record Review during planned on-site, visits to assure fidelity to the START Model.

Once START Programs have completed initial training and Coordinators are certified, the Teams themselves will undergo regular START Program Certification reviews. START Teams are typically prepared for Program Certification in years 4-5 of implementation, though this may vary depending on the program. These reviews are opportunities for the Center for START Services to offer support and guidance to START Programs as well as to identify training needs through the use of quality assurance monitoring tools. It also promotes reliability across the National START Network as it assures the same standards are set for all programs.

The tools used by the Center for START Services in conducting on-site record reviews are located at the end of this section. While it is the Center for START Services responsibility to assist programs with assuring fidelity, it is expected that START Programs employ the same rigor on a regular basis. It is highly recommended that all regional START Programs do regular Quality Assurance Reviews and monthly record reviews using the tools in this section.

START Program Certification Reviews generally focus on three areas: program operations, quality assurance through START record review, and consumer satisfaction.

### **PROGRAM OPERATIONS**

The review team assigned by the Center for START Services will ensure adherence to minimum standards through on-site and online review of program operations at least annually, but likely much more frequently during the first several years. Requirements

include ongoing participation in training (web-based and/or live) through the National Center for START Services and adherence to quality standards as outlined in review checklists. Minimum standards of START program operations include:

- Ongoing training for all START Team members including participation in the START Network's work groups (85% participation is required), the START On-line Training Series, and START Coordinator Certification Training
- Accurate, timely, and complete use of Intake Assessments, RSQ, START Plan, CSEs, CSCPIPs, Resource Center admissions and discharge summaries, ABCs, MEDS (as measured through QA reviews)
- Ongoing, regularly scheduled CETs
- Ongoing training and consultation provided to families and community stakeholders
- Accurate data collection, usage, and reporting through the SIRS
- Ongoing, regularly scheduled Advisory Council Meetings
- Renewal of Affiliation and/or Linkage Agreements with stakeholders and the development of additional Affiliation and/or Linkage Agreements as needed.
- Ensuring recommended personnel are maintained or hired to fill outlined roles

## QUALITY ASSURANCE PROCESS AND PROCEDURES

The Quality Assurance Process for START Programs includes a QA Record Review, which is used to continuously monitor START services being rendered (and in what timeframe) as well as the outcomes associated with START Program involvement. The process focuses on the individuals receiving services within a system and assesses the quality of care, timeliness, and outcomes.

The QA Record Review Process is used to promote fidelity to the START model by ensuring that recommended plans of action for an individual are based on clinical need, supported by members of the team and rendered in a timely manner (as outlined in the START Clinical Teams Manual). Services that may be employed through the course of START case activity include completion of the Cross-Systems Crisis Prevention and Intervention Plan, Comprehensive Service Evaluations, regularly scheduled Community Education Team Meetings, and that outreach and systems linkage meetings are scheduled as needed. It also ensures that the ABC (Aberrant Behavior Checklist) and RSQ (Recent Stressors Questionnaire) is completed and scored at time of intake and at regular intervals as outlined in the clinical manual. For programs that have therapeutic support services, the QA Review also assures that in-home or center-based supports are utilized as clinically needed and that the therapeutic milieu supports positive wellness approaches. Lastly, it will insure that the MEDS (Matson Evaluation of Medication Side Effects) is administered and it, along with other strategies learned, is shared with providers after a stay at the Resource Center or after in-home therapeutic supports are provided.

As previously stated, it is highly recommended that all regional START Programs conduct their own internal Quality Assurance reviews on a regular basis. Here are some basic guidelines to consider when conducting regularly scheduled QA Record Reviews:

- QA Reviews should be conducted by the local START Administrators on a regular basis. The review team can consist of the Clinical Director, the Director and others as appointed by the team.
- Each month a minimum number of cases should be reviewed (determined by program size), reflecting START referrals from different START Coordinators, ensuring each Coordinator is reviewed twice per year.
- The utilization review committee shall verify that for each case reviewed:
  - A referral is completed, presented to the team, entered and assigned to a Coordinator within 3 business days.
  - An intake meeting is scheduled within 5-7 days of referral and conducted within 30 days of receipt of referral. Documents completed should include: Intake and Assessment form, ABC, RSQ, and START Action Plan
  - ABC score(s) recorded at time of intake, at 12 month intervals following intake, and at the time of case inactivity; RSQ completed at intake and at every subsequent crisis event.

- If a crisis call is received a face to face emergency assessment is completed as soon as possible but no longer than 2 hours following the call (\*this is the minimum standard for most START Programs. For those programs that vary in this response time, this is a decision that is made in conjunction with the Center for START Services to fit the need of that particular program and region). A crisis assessment should include the following documents: The START Emergency Assessment; Crisis Medical and Behavioral Screening; Recent Stressors Questionnaire.
- If START Therapeutic Supports are utilized the following documents should be completed: Admissions and Discharge Summary outlining measurable and achievable goals; Pre-Screening; CSCPIP or CSCPIP Short Form; MEDS.
- Projected/current services to be provided reflect need in accordance with intensity of issue, stability of individual/system referred, and projected services to be provided are proposed with measurable timeframes using the START Plan.
- Based on the QA Review, the team can determine if further review of specific documentation is needed such as crisis plan and/or crisis assessment documentation. The review team may also recommend additional follow-up or modification to proposed services to be provided.

## **CONSUMER SATISFACTION**

To ensure that START services are not only viewed by professionals and through outcomes measures as satisfactory, consumers, family members, and other stakeholders should be surveyed on a regular basis. START Program Certification that is conducted by the Center for START Services includes interviews of family members, service users and stakeholders as necessary.

The two surveys at the end of this section have been used by START Programs in the past to elicit feedback from stakeholders. The Center for START Services recommends that regional START Programs survey stakeholders on an annual basis to ascertain information about timeliness, appropriateness, community perception and quality of services used. The information obtained should be used in conjunction with other data collected to modify procedures and operations to meet the needs of the local community.

# START QA RECORD REVIEW CHECKLIST

<b>COMPLETED</b>  v-if completed  <i>**If completed the score received is a 2. If not, the score received is a 4.</i>	<b>REQUIRED COMPONENTS OF DOCUMENT</b>	<b>QUALITY OF DOCUMENT</b>  1-exceeds expectation 2-meets standards 3-needs revisions 4-inadequate <i>**When reviewing CSE and CSCPIP attached rubrics are needed**</i>	<b>COMMENTS</b>
<b>REFERRAL</b>			
	Referral complete immediately		
	Referral assigned within 3 business days		
<b>INTAKE/ASSESSMENT</b>			
	Complete within 30 days of case assignment		
	ABC is complete and submitted		
	Recent Stressors Questionnaire		
<b>START ACTION PLAN</b>			
	Completed at time of intake		
	Revised quarterly during year 1 of case activity		
	Revised based on case intensity after year 1		
	Accurately reflects projected needs of case		
<b>COMPREHENSIVE SERVICE EVALUATION (CSE)</b>			
	Completed within 30 days of receipt of records		

	Meets quality standards		
	Action plan completed with team following evaluation		
<b>CROSS SYSTEMS CRISIS PREVENTION AND INTERVENTION PLAN (CSCPIP)</b>			
	Complete within 45 days of case assignment		
	Revised at least annually		
	Revised to make more accurate		
<b>EMERGENCY ASSESSMENT</b>			
	Crisis Assessment form		
	Crisis Medical/Behavioral Screening		
	Recent Stressors Questionnaire		
<b>START CENTER BASED SUPPORTS DOCUMENTATION</b>			
	Admissions/discharge summary is completed within timeframe		
	Assessments conducted attached -MEDS -ABC -Sleep Data		
	CSCPIP Short Form is completed		
	Admission/ discharge Meeting notes		
	START Center Documentation completed -Guest Notes -Behavior Tracking Data -Group Notes		
	In-Home Mobile Supports documentation competed if service was rendered		

AVERAGE SCORE: \_\_\_\_\_

ADDITIONAL AREAS TO BE REVIEWED	Y	N	COMMENTS
Clinical Education Team has been completed			
Systems Linkage Meetings have been completed			
Outreach visits have been completed			
Individual, family and stakeholder surveys are completed			
<b>ADDITIONAL SERVICES NECESSARY BASED ON INFORMATION REVIEWED</b>			
Clinical Education Team			
Systems Linkage Meetings			
Comprehensive Service Evaluation			
Outreach visit			
Other:			
Other:			
Other:			

**RESOURCE CENTER PROGRAMMING AND ENVIRONMENTAL EVALUATION**

*\*\*If completed the score received is a 2. If not, the score received if a 4.*

<b>GENERAL MILIEU</b>	<b>Y-2</b>	<b>N-4</b>	<b>COMMENTS</b>
Menu Posted			
Menu being followed			
Schedule: Is posted and specific			
Activities match the schedule posted			
Word of the day: is written and reviewed with guests			
Daily goals: are identified and specific			
<b>GUEST INTERACTION AT THE CENTER</b>			
Counselors are actively engaged with guests			
Counselors are participating in the activity			
Counselors are praising guest participation			
Energy level is high and interactions are positive			
Counselors are helping guests meet admission goals			
Body language suggests engagement and interest			
<b>CENTER THERAPEUTIC ACTIVITIES</b>			
Activities meet one of the goals of therapeutic respite (mindfulness, coping with stress, social skills, independence, self esteem)			
Activities follow the prescribed sequence of events: set up; review steps; show example; completion of activity; process with guests/concurrent documentation			



**REVIEWERS:**

<b>Name of reviewer/title</b>	<b>Signature</b>

## START ADULT CONSUMER/FAMILY MEMBER PERCEPTION SURVEY

*In order to provide the best possible services, START wants to know what you think about the services they provided during the last year.*

1. Which of the following best describes you?
  - I received START services in the past year
  - I am a family member of someone who received START services
  - Other \_\_\_\_\_
  
2. When did you or your family member **last receive** START services?
  - Within the last week
  - Within the last month
  - Within the last 3 months
  - Within the last 6 months
  - Within the last 7-12 months
  
3. Which **planned service(s)** did you or your family member receive from START?  
*(Check all that apply.)*
  - Phone call(s)
  - In-person meeting(s)
  - Help to develop a crisis plan
  - Family member education and training
  - Planned visit to Resource Center
  - In-home supports
  - Other \_\_\_\_\_
  - None of the above
  
4. Which **crisis service(s)** did you or your family member receive from START?  
*(Check all that apply.)*
  - Phone call
  - In-person help
  - Resource Center Admission
  - Other \_\_\_\_\_
  - None of the above
  
5. If you or your family member received services in an emergency, what happened?  
*(Check all that apply.)*  
*I or my family member...*
  - Was able to stay at home/current residence
  - Had a visit at the START Resource Center
  - Was admitted to a community hospital
  - Was admitted to a public hospital
  - Was connected to someone else who could help
  - Does not apply — Did not receive crisis services
  - Other \_\_\_\_\_

Considering the services START provided for you or your family member over the past year, please indicate how much you agree or disagree with each of the statements below.

If you or your family member did not request or receive the service in question, please choose “Does not Apply.”

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>	<b>Does not Apply</b>
6. START responded to all of my requests for help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. START responded quickly to my requests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. START helped me with a crisis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. START staff knew what to do to help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I was satisfied with my START crisis plan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The START crisis plan worked	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Family member training and support was helpful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Resource Center staff were helpful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I feel that Resource Center home activities good for me or my family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Overall, I am satisfied with the services START provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Overall, START services were of high quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I would recommend START services to others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Would you like to provide START with any other feedback?

## START STAKEHOLDER PERCEPTION SURVEY

*In order to provide the best possible services, START needs to know what you think about your experiences with them and the services they provided during the last year.*

1. Which of the following best describes your organization/role?

<input type="checkbox"/> MCO- Care Coordinator	<input type="checkbox"/> Hospital/Emergency Department
<input type="checkbox"/> MCO- Other	<input type="checkbox"/> Psychiatric Inpatient
<input type="checkbox"/> Mobile Crisis	<input type="checkbox"/> Police/Emergency Response
<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Developmental Center
<input type="checkbox"/> IDD Provider	<input type="checkbox"/> State Hospital
<input type="checkbox"/> Other _____	
  
2. In the past 12 months, approximately **how many** interactions (e.g., phone calls/consultations, trainings, consumer crisis interventions, etc.) did your organization have with START?

<input type="checkbox"/> 1 to 3	<input type="checkbox"/> 10 to 12
<input type="checkbox"/> 4 to 6	<input type="checkbox"/> More than 12
<input type="checkbox"/> 7 to 9	
  
3. When was your organization's **most recent** interaction with START?

<input type="checkbox"/> Within the last week	<input type="checkbox"/> Within the last 6 months
<input type="checkbox"/> Within the last month	<input type="checkbox"/> Within the last 7-12 months
<input type="checkbox"/> Within the last 3 months	
  
4. What **services** are you aware that START provided to your consumers/organization over the past year?  
*(Check all that apply.)*

<input type="checkbox"/> Consultation	<input type="checkbox"/> Provider education and training
<input type="checkbox"/> Crisis intervention	<input type="checkbox"/> Planned Center Based Supports
<input type="checkbox"/> Crisis plan development	<input type="checkbox"/> Emergency Center Based Support
<input type="checkbox"/> Team planning	<input type="checkbox"/> In home respite supports
<input type="checkbox"/> Transition planning support	<input type="checkbox"/> Other _____
<input type="checkbox"/> Caregiver education and training	
  
5. Which **crisis response services** are you aware that START provided to your consumers/organization during the past year?  
*(Check all that apply.)*

<input type="checkbox"/> Phone consultation	<input type="checkbox"/> None of the above- No crisis services requested
<input type="checkbox"/> On-site consultation/crisis assessment	<input type="checkbox"/> None of the above- Requested services not provided
<input type="checkbox"/> On-site crisis intervention	<input type="checkbox"/> Other _____
<input type="checkbox"/> Crisis Center Based Supports	
  
6. Which of the following **consumer outcomes** are you aware occurred after START crisis interventions for your consumers?  
*(Check all that apply.)*

<input type="checkbox"/> Consumer was able to maintain current residence	<input type="checkbox"/> Consumer was admitted to a state hospital
<input type="checkbox"/> Consumer went to crisis respite	<input type="checkbox"/> Consumer was connected to other resources or someone else who could help
<input type="checkbox"/> Consumer was admitted to a community hospital	<input type="checkbox"/> Does not apply- No crisis services provided
	<input type="checkbox"/> Other _____

Considering your organization's interactions with START over the past year, please indicate your level of agreement with each of the following statements.

If, to your knowledge, the service in question was not requested or provided, please select, "Does not Apply."

	Strongly Disagree	Disagree	Does not Apply	Agree	Strongly Agree
7. START responded to all of my organization's requests for assistance	<input type="radio"/>				
8. START response to individual crisis events was timely	<input type="radio"/>				
9. START crisis responses resulted in positive outcomes for consumers	<input type="radio"/>				
10. START involvement in consumer crises was helpful to my agency/organization	<input type="radio"/>				
11. START crisis response coordinators were knowledgeable	<input type="radio"/>				
12. START was helpful in the development of consumer crisis plans	<input type="radio"/>				
13. Crisis plan development was timely	<input type="radio"/>				
14. Consumer crisis plans were effective	<input type="radio"/>				
15. START crisis plan provider training was effective	<input type="radio"/>				
16. Other START training and education events were helpful	<input type="radio"/>				
17. Training staff were knowledgeable of topics presented	<input type="radio"/>				
18. The respite home clinical team provided effective consultation	<input type="radio"/>				
19. Respite home staff were knowledgeable and effective	<input type="radio"/>				
20. Therapeutic activities provided at the START Resource Center were helpful	<input type="radio"/>				
21. Overall, I am satisfied with the services START provided	<input type="radio"/>				
22. Overall, START services were of high quality	<input type="radio"/>				
23. I would recommend START services to others	<input type="radio"/>				

24. Would you like to provide START with any other feedback?



# Appendix A



## Supplemental Forms and Resources

- The START Transition Plan
- Transition Planning Checklist for START Coordinators
- Follow-Up Call Form

This section includes additional supplemental forms and tools that have been used by START Programs in the past but are not required forms of documentation. Teams who are part of the START Network may use the resources in this section as needed

# START TRANSITION PLAN

## PART I - FACE SHEET & GENERAL INFORMATION

Demographics	
Name:	Region:
Date:	Medical Record:
D.O.B.:	
Current Address:	Telephone:
Care/Support Coordinator:	Telephone:
Guardian:	Telephone:
START Coordinator:	Telephone:

Current Living Situation	
<input type="checkbox"/> Community ICF/ID	<input type="checkbox"/> Hospital
<input type="checkbox"/> Supervised Group Living	<input type="checkbox"/> Family Home
<input type="checkbox"/> Supported Living	<input type="checkbox"/> Foster Care Home
<input type="checkbox"/> Alternative Family Living	<input type="checkbox"/> Homeless Sheltered
<input type="checkbox"/> Independent	<input type="checkbox"/> Homeless Unsheltered
<input type="checkbox"/> Living/Apartment/Own Home	<input type="checkbox"/> Other:
<input type="checkbox"/> Developmental Center	

Estimated Transitioning Date:

<b>Transition Location</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Contact:</b>	
<input type="checkbox"/> Community ICF/ID <input type="checkbox"/> Supervised Group Living <input type="checkbox"/> Supported Living <input type="checkbox"/> Alternative Family Living <input type="checkbox"/> Independent <input type="checkbox"/> Living/Apartment/Own Home <input type="checkbox"/> Developmental Center	<input type="checkbox"/> Hospital <input type="checkbox"/> Family Home <input type="checkbox"/> Foster Care Home <input type="checkbox"/> Homeless Sheltered <input type="checkbox"/> Homeless Unsheltered <input type="checkbox"/> Other:

<b><u>Reason for Transition</u></b>
<p><i>Include information about where the individual has been living, how long, for what reason, and why the team agrees that it is time for the individual to transition.</i></p>

<b><u>Past Stressors</u></b>
<p><i>Include any major challenges the individual has faced in the past and any factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):</i></p>

<b><u>Progress</u></b>
<p><i>Include any significant progress that has led to the upcoming transition.</i></p>

<b>PART II - Individual's Feelings about Transition</b>
---

How does the Individual feel about the transition?

--

How does the Individual communicate feelings about upcoming changes?

--

How has the Individual reacted to transitions in the past?

--

### **PART III – How to Best Support Individual during Transition**

*Consider the Individuals current comfort level with transitions. Identify supports needed to make transitions as smooth and comfortable as possible.*

Preferred activities/people

Which activities calm the individual in times of stress/change?

--

Which activities could be a potential stressor for individual during times of stress/change?

--

Who does the individual trust during times of stress/change?

--

Who/what could be a potential stressor for individual during times of stress/change?

--

Has the individual visited the new placement? If so, how did the individual respond to the visit? If the individual has not visits the new placement, why?

--

Would it be beneficial for the individual to visit the transitioning location several times before the transition date?

--

Safety

What steps should be taken to ensure Individual's safety in the home? (this should include whether support staff should be trained and able to use restrictive intervention, when and if enhanced staffing would be necessary)

--

What steps should be taken to ensure Individual's safety in the community?

--

What specific steps should be taken if elopement occurs?

--

--

<b>Is it safe for the individual to have alone time at home? Explain.</b>

<b>Is it safe for the individual to have alone time in the community? Explain.</b>

<b>What is the Individual's knowledge of abuse, neglect, &amp; exploitation? Is the Individual capable of advocating independently in these situations?</b>

<b>What extra support does the individual need during the transition? (behavior plan, consultative services, training, collaboration with emergency services including mobile crisis teams, local law enforcement, local emergency department)</b>

<b>Required staffing ratio to support individual? Ex: does the person require enhanced staffing pattern? How can the team evaluate the need for additional staffing during the transition period?</b>

Community Supports and Services

<b>Does the individual require continued therapeutic services? (physical therapy, occupational therapy, vocational therapy, outpatient therapy, etc)</b>
--

--

<b>Are day supports needed? What should these supports look like?</b>

<b>Are residential supports needed? What should these supports look like?</b>

<b>Are psychiatric supports needed ? What should these supports look like?</b>

<b>Is one-on-one staffing needed?</b>

<b>Are crisis services needed?</b>

How can the team best support the needs of the individual during transition?

<b>Current Living Situation</b>
---------------------------------

What is currently working? Be specific.	How will it be replicated or modified in order to be effective at new program/residence?
---	--

<i>Type</i>	<i>Support Needed</i>
<i>Current Team Includes</i>	
<i>Guardian:</i> <i>name:</i> _____	
<i>Family Contact:</i> <i>name:</i>	
<i>Residential Program:</i> <i>name:</i>	
<i>Service Provider:</i> <i>name:</i> _____	
<i>Work Program:</i> <i>name:</i> _____	
<i>Clinical Home:</i> <i>name:</i> _____	
<i>START Coordinator:</i> <i>name:</i> _____	
<i>Primary Care Physician:</i> <i>name:</i> _____	
<i>Psychiatrist:</i> <i>name:</i> _____	
<i>Therapist:</i> <i>name:</i> _____	
<i>Neurologist:</i> <i>name:</i> _____	
<i>MH Team (MCM, ACT, etc):</i> <i>name:</i> _____	

<p style="text-align: center;"><i>Direct Support Professional:</i> <i>name: _____</i></p>	
---	--

<b>PART IV- TIMEFRAME FOR TRANSITION</b>
--

Estimated Transition Date:			
<u>Requirements for Transition</u> (below are examples and all may not apply. Add other transition requirements as outlined in the plan above)	<u>Individuals Involved</u>	<u>Target Date</u>	<u>Completed Date</u>
Visit new provider/home			
Visit START Center (if utilization is part of the transition plan)			
Locate additional direct support professionals if the need for enhanced staffing is outlined.			
CSCPIP Plan development			
Behavior Support Plan development (if needed)			
Training for staff re: CSCPIP Plan and BSP			

**PART V- Signatures**

\_\_\_\_\_  
Transition Contact/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
START Coordinator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other team member

\_\_\_\_\_  
Date

## Transition Planning Checklist for START Coordinator

Please use the right column to provide the information requested

Check ✓	Item	Responses
	Records requested from:	
	Previous placement:	
	State facility: <input type="checkbox"/> Developmental Center	
	<input type="checkbox"/> State Psychiatric Facility <input type="checkbox"/> neither <input type="checkbox"/> other	
	START Documentation:	
	• Intake and Assessment complete	
	• Cross-Systems Crisis Plan	
	• Has the team requested a CET?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Services Identified:	
	• Type of funding (Medicaid, Innovations Waiver, IPRS?)	
	• Residential provider?	
	o Type:	
	o 1:1 staff (if applicable):	
	o What do 1:1 supports look like? How often will the need for additional 1:1 supports be evaluated?	
	▪ If the individual is not receiving 1:1 supports, is it recommended? Why? What would these supports look like?	
Check ✓	Item	Responses
	o Emergency protocol of the provider (layer of supports outlined and agreed upon by team members):	
	o Additional support or training needed for residential provider:	
	▪ Day Supports(start date and frequency)	

	<ul style="list-style-type: none"> <li>▪ Psychiatry (start date and frequency)</li> <li>▪ Primary Care Physician (start date and frequency)</li> </ul>	
	* NOTE: someone should not be transferred without the BSP in place if one already exists– How will the team minimize the gap?	

### Questions

	Who is the transition team?:	
	Who will be this individual's new community team?:	
	What role would the guardian like to play in this transition and continued support?:	
	Who will be completing the behavior support plan for the community team?:	
	After the BSP is complete, what follow up will occur?	

Check ✓	Item	Responses
<b>Psychiatry and Medical Follow-up</b>		
	Has the current prescribing doctor collaborated with the community doctor? If not, what can START do to facilitate?:	
	What are the medications currently prescribed?:	
	Are there any issues with prescribing these medications in the community? (ie, sliding scale insulin, clozaril, liquid medication that cannot be obtained in the community?):	
	Who will take the lead at getting this individual to all scheduled appointments?:	
	Who will take the lead in communicating necessary information to providers?:	
<b>Follow-up</b>		

	Outline schedule of transition and follow-up meetings and participants. Are all major team members available and able to participate?:	
	Training times scheduled for residential and other community supports scheduled?:	
	What is the support plan following the transition look like? (ie. Will the developmental center participate in team meetings? What additional training is needed following the transition?)	

# FOLLOW-UP CALL

Case Re-Activated?
Yes <input type="checkbox"/>
No <input type="checkbox"/>

Date: \_\_\_\_\_ Time of Contact: \_\_\_\_ AM/PM

Length of Contact: \_\_\_\_\_

Person's Name: \_\_\_\_\_

Date of Last Contact: \_\_\_\_\_

Type of Last Contact:  Call  Face to Face  
 Center-based  Other

Person Talked to: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Is the person currently in crisis:  Yes  No If "yes" describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EVENTS or CHANGES SINCE LAST CONTACT (check all that apply)

Crisis/ED/Hospitalization - How many times? \_\_\_\_\_

Date(s) : \_\_\_\_\_

Describe: \_\_\_\_\_

Change in Residence/ - How many times? \_\_\_\_\_

Date(s) : \_\_\_\_\_

Residential Provider

Describe: \_\_\_\_\_

Change in Provider - How many times? \_\_\_\_\_

Date(s) : \_\_\_\_\_

(ACTT, CST, Day Service, OPT, Psychiatrist)

Describe: \_\_\_\_\_

Change in Clinical Home/Date: \_\_\_\_\_

Describe: \_\_\_\_\_

Medical Condition Date: \_\_\_\_\_

Describe: \_\_\_\_\_

Other \_\_\_\_\_

**OUTCOME INFORMATION**

As a Result of This Call: (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Re-Activate Case                      | <input type="checkbox"/> Crisis Center Admission |
| <input type="checkbox"/> Scheduled Planned Center Visit        | <input type="checkbox"/> Hospital Diversion      |
| <input type="checkbox"/> Revision of Cross-Systems Crisis Plan | <input type="checkbox"/> De-escalation of Crisis |
| <input type="checkbox"/> START Collaboration w/Comm Resource   | <input type="checkbox"/> Stable/In-activate case |
| <input type="checkbox"/> Schedule Team Meeting                 | <input type="checkbox"/> Other _____             |

Narrative Description/Disposition:

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---

*(Make 3 attempts to contact)*

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
DATE

*Developed by the NC START Central Team*

# Appendix B



## Glossary

# Glossary of Terms

## A

**Aberrant Behavior Checklist (ABC):** A checklist of symptomatic behaviors common among people with intellectual disability. Developed by Aman and Singh (1986) and the most widely used assessment tool in the world for its target population.

**Advisory Council:** Comprised of key stakeholders, the council meets quarterly and members review progress reports and share their expertise by providing knowledge of constituent perspectives; connections to local, national or international resources, colleagues or peers; philanthropic support or other forms of needed assistance.

## C

**Capacity to consent:** All adults are presumed to have sufficient capacity to decide on their own medical treatment and services unless there is significant evidence to suggest otherwise.

"Capacity" means the ability to use and understand information to make a decision. Any evidence that a person does not have this capacity has to show both of the following:

- a person's mind is impaired or disturbed
- The impairment or disturbance is significant to render a judgment inadequate for the decision to be made. A formal medical assessment must be conducted to make this determination. Capacity may be temporarily or permanently impaired. examples of conditions leading to loss of capacity include:
  - mental health conditions, such as schizophrenia or bipolar disorder,
  - dementia
  - moderate intellectual disability
  - severe head injury
  - physical or mental conditions that cause confusion, drowsiness or a loss of consciousness
  - delirium (mental confusion)
  - intoxication caused by drug or alcohol misuse

Someone is thought to be unable to make a decision if they are unable to:

- understand information about the decision
- remember that information
- use that information as part of their decision-making process
- communicate their decision by talking, using sign language or by any other means

**Clinical Education Team (CET):** An educational forum coordinated by the START Clinical Director to improve the capacity to provide supports to individuals with IDD and behavioral health needs through clinical teaching. The team consists of START Coordinators and members of the Clinical Team, community providers and participants. Family and guardians are not included.

**Clinical Director:** An advanced practice mental health clinician who is responsible for providing consultation, leadership and training to the START team.

**Clinical Team:** Each START Clinical

Team includes local experts to

enhance the team's ability to meet the program's goals. It is important to remember that a START Clinical

Team aims to enhance the system of care, not replace it.

**Challenging behavior :** A term specific to people with intellectual disability; "Culturally abnormal behavior of such intensity, frequency, or duration that the physical safety of the person or others is placed in serious jeopardy, or behavior which is likely to seriously limit or deny access to the use of ordinary community facilities." This modern term was developed by Eric Emerson in 1995 and is the term used by the World Health Organization, as well as being a diagnosis in the *Diagnostic Criteria-Learning Disability*, developed by the Royal College of Psychiatry.

**Crisis contact:** Interaction, either in person or via phone, with a person or their system, which is not planned and is considered emergent in nature. The purpose of the contact is to avoid further exacerbation of the problem and find options to bring the person's functioning and system back to baseline.

**Cross-Systems Crisis Prevention & Intervention Plan (CSCPIP):** An individualized, person-specific plan of response that provides a specific, clear, concrete, and realistic set of supportive interventions that prevents, de-escalates, and protects a person experiencing a mental health or challenging behavior health crisis. The goal of the CSCPIP is to identify problems that have or may arise and map out a strategy that offers the tools for the circle of support to assist the individual to address problems and prevent crises from occurring.

### **Comprehensive Service Evaluation**

**(CSE):** Provides an in-depth overview of an individual's services in order to identify opportunities to strengthen service outcomes for individuals with intellectual / developmental disabilities and their families in the community.

## **D**

**Data tracker:** START Coordinators track data about their work that helps provide vital information for quarterly updates and annual reports. If a START Project does not use SIRS (START's online information reporting system) Coordinators will track data via an Excel document.

**Director:** A master's level or equivalent Clinical Team Staff Director who also supervises the Respite Director and the Clinical Team Leader.

## **E**

**Ecomap:** The ecomap is a graphic representation of the person's connectedness to others

(subsystems) in his/her life. It serves as a tool to highlight different relationships and human resources in a person's life, which serves as a starting point when addressing the person's social connections and needs.

**Emergency Assessment:** The process of collecting relevant information to both determine the likely contributors to the presenting problem and the interventions that may be employed to intervene effectively.

## F

**Face Sheet:** Part of the CSCPIP; serves as a quick reference to information that is important for on- site and/or responding support persons/agencies.

**Fidelity to the Model:** A measure of a program model that is measured at specific intervals to insure adherence to minimum standards through on-site and online review of program operation, typically annually, but likely much more frequently during the first several years of development.

## I

**ICF/MR (from ABC implementation):** Intermediate Care Facility for Persons with Mental Retardation

**Intellectual Disability (ID).** A neurodevelopmental impairment resulting in intellectual disability, defined as deficits equivalent to an IQ below 70 in : conceptual domain (e.g., language, reading, memory, knowledge), social domain (e.g., social skills, empathy), and practical domain (e.g., ability to manage self-care, get about the community). DSM-V also uses the term *Intellectual Developmental Disorder (IDD)*.

**Intellectual and Developmental Disabilities (IDD):** Term used in many settings to include those with Intellectual Disability as well as those with Autism Spectrum Disorder and other conditions such as Spina Bifida. The person. Thus, those without intellectual disability but another developmental disorder can also be included in a population to serve or study. START typically helps a number of people who do not have intellectual disability but other neurodevelopmental disorders.

## L

**Live supervision:** Video recording as a training technique to assist the supervisee to join with the system by actively listening, engaging all members of the team, and by establishing a non-judgmental, non- threatening posture. Sensitivity to body language and group dynamics (who sits where, how people introduce themselves, who has eye contact with whom, etc.) is essential in the supervisee figuring out how the particular system works.

## M

**Matson Evaluation of Medication Side Effects (MEDS):** A questionnaire developed by Matson & Baglio (1998) that identified possible side effects of all psychiatric medications

targeting people with intellectual disabilities. It has excellent psychometric properties and has been shown to be effective. The MEDS is used at the Resource Center and shared with all involved upon discharge to address possible side effects and reconsider current psychiatric medications prescribed.

**Medical Director:** A Psychiatrist responsible for providing consultation to the START team, evaluating guests at START Resource Center, and offering consultation and training to psychiatrists in the community.

**Mobile Crisis Response Teams:** For START projects with a Resource Center, in-home supports are designed to assess and stabilize an individual in his or her natural setting. This service is part of the mobile crisis capacity of START.

## O

**Outreach:** An important activity for all START Projects, outreach is a systematic attempt to provide services beyond conventional limits (to go above and beyond). The goal is to help the systems that support people with intellectual disability work more effectively through the comprehensive supports and training provided by START.

## P

**Peer-Review:** Document review of CSEs and CSCPIPs among peers within the START project or START Network as a process of evaluation to maintain standards, improve performance and provide credibility and education.

**Positive Behavior Supports (PBS):** a form of applied behavior analysis that uses a system to understand an individual's challenging behavior (all behavior is functional and serves a purpose) and teaches skills to replace challenging behavior. PBS involves goal identification, information gathering, hypothesis development, support plan design, implementation and monitoring.

**Presenting problem:** The reason for the emergency/crisis contact, and it is often described as an "incident."

**PRN:** Latin medical term that translates to *as the situation demands or according to circumstances*.

**Process oriented assessment:** all assessment requires continuous dialogue and discussion with stakeholders. The forms used do not drive the process; rather, they are tools used to refine communication and collaboration and to test hypotheses regarding our interventions and supports.

## R

**Recent Stressors Questionnaire (RSQ):** A checklist developed by Lauren Charlot, Ph.D. to screen for stressors that may have been related to a crisis, emergency, or development of a psychiatric condition. This is a valuable tool used by START at intake and for re-

evaluation, especially when a person seems to change and be distressed, and as part of an emergency assessment.

**Resource Center:** A specialized home in the community where people helped by START may live for up to 30 days either as a planned or emergency visit. The Center is therapeutic and aims to assess, intervene, and develop plans for discharge to help the person further on return to his or her home.

**Resource Center Director:** Provides clinical and administrative support and supervision of counselors, as well as other duties as outlined in the job description.

## S

**SIRS:** The START Information Reporting System is an online HIPAA compliant database that allows projects to capture vital data about START, which is used for annual reports and improved service outcomes. Projects that do not opt in to SIRS track data for the Center using Excel forms.

**START Coordinator:** Clinical Team staff support, linkages, outreach and consultation services. If the START program has a Resource Center, the Coordinator also provides 24-hour emergency consultation and works in close conjunction with the Resource Center.

**START Coordinator Certification:** A comprehensive training program typically requiring 18-months including an internship. The program is offered by the Center for START Services that leads to certification upon successful completion of requirements and demonstration of training competencies. Certification is valid for two years; re-certification applications are mandatory for continued status as a certified START Coordinator.

**The START Model:** The START (Systemic, Therapeutic, Assessment, Resources, and Treatment) model was developed in 1989 by Joan Beasley, Ph.D., and serves a target population of people diagnosed with co-occurring diagnoses of intellectual/developmental disability (IDD) and mental health and/or challenging behavioral needs. START has provided person-centered service supports, clinical, emergency and Resource Center services since 1989.

**START Project Manager:** An expert, typically from the Center for START Services, who provides technical assistance, mentoring, document review, and coordinates meetings as needed throughout the START Project Development phase.

**START Team Leader:** A certified START Coordinator with experience who supervises START Coordinators, maintains linkages and relationships with community partners, and oversees a variety of activities as outlined in the job description.

**Systemic consultation:** Based on the family systems work of Dr. Salvador Minuchin, START Coordinators are trained on systemic consultation activities to enhance service outcomes

by training and influencing the way the systems work together to help people with intellectual disability.

## T

**Triangulate/d:** An individual is triangulated when two members within their system would have difficulty interacting in a functional way without him/her. Thus, 3 people are involved.

## ATTACHMENT D

# Best Practice Guidelines for NY START Resource Centers

Below are the non-negotiable requirements, other environmental requirements as outlined in the 2013-2014 University of New Hampshire START Center Manual, can be evaluated as properties are identified to determine if modifications are needed to meet the needs of the program.

### ***Non-Negotiable Physical Plant***

1. All guest bedrooms must be private rooms.
2. Property should have a sprinkler system. If the property does not have a sprinkler system safeguards can be built in through additional staffing.
3. Entry/exits need to be fenced if they open to a road. The entire property does not have to be fenced in.
4. The property should not have stairs that lead to a second floor. Stairs are acceptable for a recessed living room or other programming space.
5. Property must have programming space. This space does not have to be located within the house it can be located in the space adjacent (i.e. 2 family home – one side is the programming space and other side is the living space).
6. Must have appropriate amount of sensory space.
7. Space separate from the kitchen to store food, refrigeration, extra supplies, etc.
8. One handicap accessible bathroom.

### ***Factors to Consider in Planning/Design/Location***

1. Private (away from busy thoroughfares).
2. Large yard which is fully fenced in. If yard is not large, consider a home within walking distance to a park or recreation center.
3. One floor of living space: broad lines of sight, common dining, 2 common areas (one living/sitting area and one activity area).
4. Secure medication storage area.
5. Open kitchen cooking area facing out onto main living area with separate locked pantry area.
6. Kitchen table must be large enough for all guests and counselors to support family style dining.
7. One bedroom should be equipped with its own ¾ or full bathroom.
8. Sensory Room.

9. Staff resource room, computers, supplies, telemedicine equipment.
10. Laundry area equipped with 2 washers and 2 dryers.
11. Closet areas (linen/bedding closet, cleaning supply closet and programming supply closet).
12. Tempered glass windows. Can be replaced over time.
13. Durable flooring.
14. Door alerts (egresses) and window alerts (bedrooms).
15. Central Air-conditioning.
16. Central fire/CO system – residential sprinkler.
17. 4-6 private bedrooms.
18. Overhead room lights (No CFC.)
19. Outdoor security lighting.

***Furnishings/Equipment***

1. 1 dresser and 1 night stand for each bedroom.
2. Durable washable living room furniture (leather).
3. Common areas should accommodate 10 people.
4. Teleconference equipment.
5. 1 small Refrigerator.
6. 1 large Refrigerator (will be in locked pantry).
7. 1 full size freezer upright or chest (will be in locked pantry).
8. Linens color coordinate to specific bedrooms.

ATTACHMENT E

State of New York  
Master Contract for Grants

**STATE OF NEW YORK MASTER CONTRACT FOR GRANTS FACE PAGE**

<p>STATE AGENCY (Name &amp; Address):</p>	<p>BUSINESS UNIT/DEPT. ID:</p> <p>CONTRACT NUMBER:</p> <p>CONTRACT TYPE:</p> <p><input type="checkbox"/> Multi-Year Agreement</p> <p><input type="checkbox"/> Simplified Renewal Agreement</p> <p><input type="checkbox"/> Fixed Term Agreement</p>
<p>CONTRACTOR SFS PAYEE NAME:</p>	<p>TRANSACTION TYPE:</p> <p><input type="checkbox"/> New</p> <p><input type="checkbox"/> Renewal</p> <p><input type="checkbox"/> Amendment</p>
<p>CONTRACTOR DOS INCORPORATED NAME:</p>	<p>PROJECT NAME:</p>
<p>CONTRACTOR IDENTIFICATION NUMBERS:</p> <p>NYS Vendor ID Number:</p> <p>Federal Tax ID Number:</p> <p>DUNS Number (if applicable):</p>	<p>AGENCY IDENTIFIER:</p> <p>CFDA NUMBER (Federally Funded Grants Only):</p>
<p>CONTRACTOR PRIMARY MAILING ADDRESS:</p> <p>CONTRACTOR PAYMENT ADDRESS:</p> <p><input type="checkbox"/> Check if same as primary mailing address</p> <p>CONTRACT MAILING ADDRESS:</p> <p><input type="checkbox"/> Check if same as primary mailing address</p>	<p>CONTRACTOR STATUS:</p> <p><input type="checkbox"/> For Profit</p> <p><input type="checkbox"/> Municipality, Code:</p> <p><input type="checkbox"/> Tribal Nation</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Not-for-Profit</p> <p>Charities Registration Number:</p> <p>Exemption Status/Code:</p> <p><input type="checkbox"/> Sectarian Entity</p>

Contract Number: # \_\_\_\_\_



IN WITNESS THEREOF, the parties hereto have electronically executed or approved this Master Contract on the dates below their signatures.

In addition, I, acting in the capacity as Contractor, certify that I am the signing authority, or have been delegated or designated formally as the signing authority by the appropriate authority or official, and as such I do agree, and I have the authority to agree, to all of the terms and conditions set forth in the Master Contract, including all appendices and attachments. I understand that (i) payment of a claim on this Master Contract is conditioned upon the Contractor's compliance with all applicable conditions of participation in this program and ( if I am acting in the capacity as a not-for profit Contractor) the accuracy and completeness of information submitted to the State of New York through the Gateway vendor prequalification process and (ii) by electronically indicating my acceptance of the terms and conditions of the Master Contract, I certify that (a) to the extent that the Contractor is required to register and/or file reports with the Office of the Attorney General's Charities Bureau ("Charities Bureau"), the Contractor's registration is current, all applicable reports have been filed, and the Contractor has no outstanding requests from the Charities Bureau relating to its filings and (b) all data and responses in the application submitted by the Contractor are true, complete and accurate. I also understand that use of my assigned User ID and Password on the State's contract management system is equivalent to having placed my signature on the Master Contract and that I am responsible for any activity attributable to the use of my User ID and Password. Additionally, any information entered will be considered to have been entered and provided at my direction. I further certify and agree that the Contractor agrees to waive any claim that this electronic record or signature is inadmissible in court, notwithstanding the choice of law provisions.

CONTRACTOR:

\_\_\_\_\_  
\_\_\_\_\_  
By: \_\_\_\_\_  
Printed Name  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

In addition, the party below certifies that it has verified the electronic signature of the Contractor to this Master Contract.

STATE AGENCY:

\_\_\_\_\_  
\_\_\_\_\_  
By: \_\_\_\_\_  
Printed Name  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

ATTORNEY GENERAL'S SIGNATURE  
APPROVED AS TO FORM

By: \_\_\_\_\_  
Printed Name  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

STATE COMPTROLLER'S SIGNATURE

By: \_\_\_\_\_  
Printed Name  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**STATE OF NEW YORK  
MASTER CONTRACT FOR GRANTS**

This State of New York Master Contract for Grants (Master Contract) is hereby made by and between the State of New York acting by and through the applicable State Agency (State) and the public or private entity (Contractor) identified on the face page hereof (Face Page).

**WITNESSETH:**

**WHEREAS**, the State has the authority to regulate and provide funding for the establishment and operation of program services, design or the execution and performance of construction projects, as applicable and desires to contract with skilled parties possessing the necessary resources to provide such services or work, as applicable; and

**WHEREAS**, the Contractor is ready, willing and able to provide such program services or the execution and performance of construction projects and possesses or can make available all necessary qualified personnel, licenses, facilities and expertise to perform or have performed the services or work, as applicable, required pursuant to the terms of the Master Contract;

**NOW THEREFORE**, in consideration of the promises, responsibilities, and covenants herein, the State and the Contractor agree as follows:

**STANDARD TERMS AND CONDITIONS**

**I. GENERAL PROVISIONS**

**A. Executory Clause:** In accordance with Section 41 of the State Finance Law, the State shall have no liability under the Master Contract to the Contractor, or to anyone else, beyond funds appropriated and available for the Master Contract.

**B. Required Approvals:** In accordance with Section 112 of the State Finance Law (or, if the Master Contract is with the State University of New York (SUNY) or City University of New York (CUNY), Section 355 or Section 6218 of the Education Law), if the Master Contract exceeds \$50,000 (or \$85,000 for contracts let by the Office of General Services, or the minimum thresholds agreed to by the Office of the State Comptroller (OSC) for certain SUNY and CUNY contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount including, but not limited to, changes in amount, consideration, scope or contract term identified on the Face Page (Contract Term), it shall not be valid, effective or binding upon the State until it has been approved by, and filed with, the New York Attorney General Contract Approval Unit (AG) and OSC. If, by the Master Contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by, and filed with, the AG and OSC.

**Budget Changes:** An amendment that would result in a transfer of funds among program activities or budget cost categories that does not affect the amount, consideration, scope or other terms of such contract may be subject to the approval of the AG and OSC where the amount of such modification is, as a portion of the total value of the contract, equal to or greater than ten percent for contracts of less than five million dollars, or five percent for contracts of more than

Contract Number: # \_\_\_\_\_

five million dollars; and, in addition, such amendment may be subject to prior approval by the applicable State Agency as detailed in Attachment D (Payment and Reporting Schedule).

### **C. Order of Precedence:**

In the event of a conflict among (i) the terms of the Master Contract (including any and all attachments and amendments) or (ii) between the terms of the Master Contract and the original request for proposal, the program application or other attachment that was completed and executed by the Contractor in connection with the Master Contract, the order of precedence is as follows:

1. Standard Terms and Conditions
2. Modifications to the Face Page
3. Modifications to Attachment A-2<sup>1</sup>, Attachment B, Attachment C and Attachment D
4. The Face Page
5. Attachment A-2<sup>2</sup>, Attachment B, Attachment C and Attachment D
6. Modification to Attachment A-1
7. Attachment A-1
8. Other attachments, including, but not limited to, the request for proposal or program application

**D. Funding:** Funding for the term of the Master Contract shall not exceed the amount specified as “Contract Funding Amount” on the Face Page or as subsequently revised to reflect an approved renewal or cost amendment. Funding for the initial and subsequent periods of the Master Contract shall not exceed the applicable amounts specified in the applicable Attachment B form (Budget).

**E. Contract Performance:** The Contractor shall perform all services or work, as applicable, and comply with all provisions of the Master Contract to the satisfaction of the State. The Contractor shall provide services or work, as applicable, and meet the program objectives summarized in Attachment C (Work Plan) in accordance with the provisions of the Master Contract, relevant laws, rules and regulations, administrative, program and fiscal guidelines, and where applicable, operating certificate for facilities or licenses for an activity or program.

**F. Modifications:** To modify the Attachments or Face Page, the parties mutually agree to record, in writing, the terms of such modification and to revise or complete the Face Page and all the

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<sup>1</sup> To the extent that the modifications to Attachment A-2 are required by Federal requirements and conflict with other provisions of the Master Contract, the modifications to Attachment A-2 shall supersede all other provisions of this Master Contract. See Section I(V).

<sup>2</sup> To the extent that the terms of Attachment A-2 are required by Federal requirements and conflict with other provisions of the Master Contract, the Federal requirements of Attachment A-2 shall supersede all other provisions of this Master Contract. See Section I(V).

appropriate attachments in conjunction therewith. In addition, to the extent that such modification meets the criteria set forth in Section I.B herein, it shall be subject to the approval of the AG and OSC before it shall become valid, effective and binding upon the State. Modifications that are not subject to the AG and OSC approval shall be processed in accordance with the guidelines stated in the Master Contract.

**G. Governing Law:** The Master Contract shall be governed by the laws of the State of New York except where the Federal Supremacy Clause requires otherwise.

**H. Severability:** Any provision of the Master Contract that is held to be invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, shall be ineffective only to the extent of such invalidity, illegality or unenforceability, without affecting in any way the remaining provisions hereof; provided, however, that the parties to the Master Contract shall attempt in good faith to reform the Master Contract in a manner consistent with the intent of any such ineffective provision for the purpose of carrying out such intent. If any provision is held void, invalid or unenforceable with respect to particular circumstances, it shall nevertheless remain in full force and effect in all other circumstances.

**I. Interpretation:** The headings in the Master Contract are inserted for convenience and reference only and do not modify or restrict any of the provisions herein. All personal pronouns used herein shall be considered to be gender neutral. The Master Contract has been made under the laws of the State of New York, and the venue for resolving any disputes hereunder shall be in a court of competent jurisdiction of the State of New York.

**J. Notice:**

1. All notices, except for notices of termination, shall be in writing and shall be transmitted either:
  - a) by certified or registered United States mail, return receipt requested;
  - b) by facsimile transmission;
  - c) by personal delivery;
  - d) by expedited delivery service; or
  - e) by e-mail.
2. Notices to the State shall be addressed to the Program Office designated in Attachment A-1 (Program Specific Terms and Conditions).
3. Notices to the Contractor shall be addressed to the Contractor's designee as designated in Attachment A-1 (Program Specific Terms and Conditions).
4. Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or e-mail, upon receipt.

5. The parties may, from time to time, specify any new or different e-mail address, facsimile number or address in the United States as their address for purpose of receiving notice under the Master Contract by giving fifteen (15) calendar days prior written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under the Master Contract. Additional individuals may be designated in writing by the parties for purposes of implementation, administration, billing and resolving issues and/or disputes.

**K. Service of Process:** In addition to the methods of service allowed by the State Civil Practice Law & Rules (CPLR), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. The Contractor shall have thirty (30) calendar days after service hereunder is complete in which to respond.

**L. Set-Off Rights:** The State shall have all of its common law, equitable, and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold, for the purposes of set-off, any moneys due to the Contractor under the Master Contract up to any amounts due and owing to the State with regard to the Master Contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of the Master Contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies, or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State Agency, its representatives, or OSC.

**M. Indemnification:** The Contractor shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the Contractor or its subcontractors pursuant to this Master Contract. The Contractor shall indemnify and hold harmless the State and its officers and employees from claims, suits, actions, damages and cost of every nature arising out of the provision of services pursuant to the Master Contract.

**N. Non-Assignment Clause:** In accordance with Section 138 of the State Finance Law, the Master Contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet, or otherwise disposed of without the State's previous written consent, and attempts to do so shall be considered to be null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract, let pursuant to Article XI of the State Finance Law, may be waived at the discretion of the State Agency and with the concurrence of OSC, where the original contract was subject to OSC's approval, where the assignment is due to a reorganization, merger, or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that the merged contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless the Master Contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

**O. Legal Action:** No litigation or regulatory action shall be brought against the State of New York, the State Agency, or against any county or other local government entity with funds provided under the Master Contract. The term “litigation” shall include commencing or threatening to commence a lawsuit, joining or threatening to join as a party to ongoing litigation, or requesting any relief from any of the State of New York, the State Agency, or any county, or other local government entity. The term “regulatory action” shall include commencing or threatening to commence a regulatory proceeding, or requesting any regulatory relief from any of the State of New York, the State Agency, or any county, or other local government entity.

**P. No Arbitration:** Disputes involving the Master Contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

**Q. Secular Purpose:** Services performed pursuant to the Master Contract are secular in nature and shall be performed in a manner that does not discriminate on the basis of religious belief, or promote or discourage adherence to religion in general or particular religious beliefs.

**R. Partisan Political Activity and Lobbying:** Funds provided pursuant to the Master Contract shall not be used for any partisan political activity, or for activities that attempt to influence legislation or election or defeat of any candidate for public office.

**S. Reciprocity and Sanctions Provisions:** The Contractor is hereby notified that if its principal place of business is located in a country, nation, province, state, or political subdivision that penalizes New York State vendors, and if the goods or services it offers shall be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that it be denied contracts which it would otherwise obtain.<sup>3</sup>

**T. Reporting Fraud and Abuse:** Contractor acknowledges that it has reviewed information on how to prevent, detect, and report fraud, waste and abuse of public funds, including information about the Federal False Claims Act, the New York State False Claims Act, and whistleblower protections.

**U. Non-Collusive Bidding:** By submission of this bid, the Contractor and each person signing on behalf of the Contractor certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his or her knowledge and belief that its bid was arrived at independently and without collusion aimed at restricting competition. The Contractor further affirms that, at the time the Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive binding certification on the Contractor’s behalf.

**V. Federally Funded Grants and Requirements Mandated by Federal Laws:** All of the Specific Federal requirements that are applicable to the Master Contract are identified in Attachment A-2 (Federally Funded Grants and Requirements Mandated by Federal Laws) hereto. To the extent

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<sup>3</sup>As of October 9, 2012, the list of discriminatory jurisdictions subject to this provision includes the states of Alaska, Hawaii, Louisiana, South Carolina, West Virginia and Wyoming. Contact NYS Department of Economic Development for the most current list of jurisdictions subject to this provision.

that the Master Contract is funded, in whole or part, with Federal funds or mandated by Federal laws, (i) the provisions of the Master Contract that conflict with Federal rules, Federal regulations, or Federal program specific requirements shall not apply and (ii) the Contractor agrees to comply with all applicable Federal rules, regulations and program specific requirements including, but not limited to, those provisions that are set forth in Attachment A-2 (Federally Funded Grants and Requirements Mandated by Federal Laws) hereto.

## II. TERM, TERMINATION AND SUSPENSION

**A. Term:** The term of the Master Contract shall be as specified on the Face Page, unless terminated sooner as provided herein.

**B. Renewal:**

**1. General Renewal:** The Master Contract may consist of successive periods on the same terms and conditions, as specified within the Master Contract (a “Simplified Renewal Contract”). Each additional or superseding period shall be on the forms specified by the State and shall be incorporated in the Master Contract.

**2. Renewal Notice to Not-for-Profit Contractors:**

a) Pursuant to State Finance Law §179-t, if the Master Contract is with a not-for-profit Contractor and provides for a renewal option, the State shall notify the Contractor of the State’s intent to renew or not to renew the Master Contract no later than ninety (90) calendar days prior to the end of the term of the Master Contract, unless funding for the renewal is contingent upon enactment of an appropriation. If funding for the renewal is contingent upon enactment of an appropriation, the State shall notify the Contractor of the State’s intent to renew or not to renew the Master Contract the later of: (1) ninety (90) calendar days prior to the end of the term of the Master Contract, and (2) thirty (30) calendar days after the necessary appropriation becomes law. Notwithstanding the foregoing, in the event that the State is unable to comply with the time frames set forth in this paragraph due to unusual circumstances beyond the control of the State (“Unusual Circumstances”), no payment of interest shall be due to the not-for-profit Contractor. For purposes of State Finance Law §179-t, “Unusual Circumstances” shall not mean the failure by the State to (i) plan for implementation of a program, (ii) assign sufficient staff resources to implement a program, (iii) establish a schedule for the implementation of a program or (iv) anticipate any other reasonably foreseeable circumstance.

b) Notification to the not-for-profit Contractor of the State’s intent to not renew the Master Contract must be in writing in the form of a letter, with the reason(s) for the non-renewal included. If the State does not provide notice to the not-for-profit Contractor of its intent not to renew the Master Contract as required in this Section and State Finance Law §179-t, the Master Contract shall be deemed continued until the date the State provides the necessary notice to the Contractor, in accordance with State Finance Law §179-t. Expenses incurred by the not-for-profit Contractor during such extension shall be reimbursable under the terms of the Master Contract.

## **C. Termination:**

### **1. Grounds:**

- a) Mutual Consent: The Master Contract may be terminated at any time upon mutual written consent of the State and the Contractor.
- b) Cause: The State may terminate the Master Contract immediately, upon written notice of termination to the Contractor, if the Contractor fails to comply with any of the terms and conditions of the Master Contract and/or with any laws, rules, regulations, policies, or procedures that are applicable to the Master Contract.
- c) Non-Responsibility: In accordance with the provisions of Sections IV(N)(6) and (7) herein, the State may make a final determination that the Contractor is non-responsible (Determination of Non-Responsibility). In such event, the State may terminate the Master Contract at the Contractor's expense, complete the contractual requirements in any manner the State deems advisable and pursue available legal or equitable remedies for breach.
- d) Convenience: The State may terminate the Master Contract in its sole discretion upon thirty (30) calendar days prior written notice.
- e) Lack of Funds: If for any reason the State or the Federal government terminates or reduces its appropriation to the applicable State Agency entering into the Master Contract or fails to pay the full amount of the allocation for the operation of one or more programs funded under this Master Contract, the Master Contract may be terminated or reduced at the State Agency's discretion, provided that no such reduction or termination shall apply to allowable costs already incurred by the Contractor where funds are available to the State Agency for payment of such costs. Upon termination or reduction of the Master Contract, all remaining funds paid to the Contractor that are not subject to allowable costs already incurred by the Contractor shall be returned to the State Agency. In any event, no liability shall be incurred by the State (including the State Agency) beyond monies available for the purposes of the Master Contract. The Contractor acknowledges that any funds due to the State Agency or the State of New York because of disallowed expenditures after audit shall be the Contractor's responsibility.
- f) Force Majeure: The State may terminate or suspend its performance under the Master Contract immediately upon the occurrence of a "force majeure." For purposes of the Master Contract, "Force majeure" shall include, but not be limited to, natural disasters, war, rebellion, insurrection, riot, strikes, lockout and any unforeseen circumstances and acts beyond the control of the State which render the performance of its obligations impossible.

### **2. Notice of Termination:**

- a) Service of notice: Written notice of termination shall be sent by:
  - (i) personal messenger service; or

(ii) certified mail, return receipt requested and first class mail.

b) Effective date of termination: The effective date of the termination shall be the later of (i) the date indicated in the notice and (ii) the date the notice is received by the Contractor, and shall be established as follows:

(i) if the notice is delivered by hand, the date of receipt shall be established by the receipt given to the Contractor or by affidavit of the individual making such hand delivery attesting to the date of delivery; or

(ii) if the notice is delivered by registered or certified mail, by the receipt returned from the United States Postal Service, or if no receipt is returned, five (5) business days from the date of mailing of the first class letter, postage prepaid, in a depository under the care and control of the United States Postal Service.

### ***3. Effect of Notice and Termination on State's Payment Obligations:***

a) Upon receipt of notice of termination, the Contractor agrees to cancel, prior to the effective date of any prospective termination, as many outstanding obligations as possible, and agrees not to incur any new obligations after receipt of the notice without approval by the State.

b) The State shall be responsible for payment on claims for services or work provided and costs incurred pursuant to the terms of the Master Contract. In no event shall the State be liable for expenses and obligations arising from the requirements of the Master Contract after its termination date.

### ***4. Effect of Termination Based on Misuse or Conversion of State or Federal Property:***

Where the Master Contract is terminated for cause based on Contractor's failure to use some or all of the real property or equipment purchased pursuant to the Master Contract for the purposes set forth herein, the State may, at its option, require:

a) the repayment to the State of any monies previously paid to the Contractor; or

b) the return of any real property or equipment purchased under the terms of the Master Contract; or

c) an appropriate combination of clauses (a) and (b) of Section II(C)(4) herein.

Nothing herein shall be intended to limit the State's ability to pursue such other legal or equitable remedies as may be available.

**D. Suspension:** The State may, in its discretion, order the Contractor to suspend performance for a reasonable period of time. In the event of such suspension, the Contractor shall be given a formal written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor shall comply with the particulars of the notice. The State shall have no obligation to reimburse Contractor's expenses during such suspension period. Activities may resume at such time

as the State issues a formal written notice authorizing a resumption of performance under the Master Contract.

### **III. PAYMENT AND REPORTING**

#### **A. Terms and Conditions:**

1. In full consideration of contract services to be performed, the State Agency agrees to pay and the Contractor agrees to accept a sum not to exceed the amount noted on the Face Page.
2. The State has no obligation to make payment until all required approvals, including the approval of the AG and OSC, if required, have been obtained. Contractor obligations or expenditures that precede the start date of the Master Contract shall not be reimbursed.
3. Contractor must provide complete and accurate billing invoices to the State in order to receive payment. Provided, however, the State may, at its discretion, automatically generate a voucher in accordance with an approved contract payment schedule. Billing invoices submitted to the State must contain all information and supporting documentation required by Attachment D (Payment and Reporting Schedule) and Section III(C) herein. The State may require the Contractor to submit billing invoices electronically.
4. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the head of the State Agency, in the sole discretion of the head of such State Agency, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC's procedures and practices to authorize electronic payments.
5. If travel expenses are an approved expenditure under the Master Contract, travel expenses shall be reimbursed at the lesser of the rates set forth in the written standard travel policy of the Contractor, the OSC guidelines, or United States General Services Administration rates. No out-of-state travel costs shall be permitted unless specifically detailed and pre-approved by the State.
6. Timeliness of advance payments or other claims for reimbursement, and any interest to be paid to Contractor for late payment, shall be governed by Article 11-A of the State Finance Law to the extent required by law.
7. Article 11-B of the State Finance Law sets forth certain time frames for the Full Execution of contracts or renewal contracts with not-for-profit organizations and the implementation of any program plan associated with such contract. For purposes of this section, "Full Execution" shall mean that the contract has been signed by all parties thereto and has obtained the approval of the AG and OSC. Any interest to be paid on a missed payment to the Contractor based on a delay in the Full Execution of the Master Contract shall be governed by Article 11-B of the State Finance Law.

## **B. Advance Payment and Recoupment:**

1. Advance payments, which the State in its sole discretion may make to not-for-profit grant recipients, shall be made and recouped in accordance with State Finance Law Section 179(u), this Section and the provisions of Attachment D (Payment and Reporting Schedule).
2. Initial advance payments made by the State to not-for-profit grant recipients shall be due no later than thirty (30) calendar days, excluding legal holidays, after the first day of the Contract Term or, if renewed, in the period identified on the Face Page. Subsequent advance payments made by the State to not-for-profit grant recipients shall be due no later than thirty (30) calendar days, excluding legal holidays, after the dates specified in Attachment D (Payment and Reporting Schedule).
3. For subsequent contract years in multi-year contracts, Contractor will be notified of the scheduled advance payments for the upcoming contract year no later than 90 days prior to the commencement of the contract year. For simplified renewals, the payment schedule (Attachment D) will be modified as part of the renewal process.
4. Recoupment of any advance payment(s) shall be recovered by crediting the percentage of subsequent claims listed in Attachment D (Payment and Reporting Schedule) and Section III(C) herein and such claims shall be reduced until the advance is fully recovered within the Contract Term. Any unexpended advance balance at the end of the Contract Term shall be refunded by the Contractor to the State.
5. If for any reason the amount of any claim is not sufficient to cover the proportionate advance amount to be recovered, then subsequent claims may be reduced until the advance is fully recovered.

## **C. Claims for Reimbursement:**

1. The Contractor shall submit claims for the reimbursement of expenses incurred on behalf of the State under the Master Contract in accordance with this Section and the applicable claiming schedule in Attachment D (Payment and Reporting Schedule).

Vouchers submitted for payment shall be deemed to be a certification that the payments requested are for project expenditures made in accordance with the items as contained in the applicable Attachment B form (Budget) and during the Contract Term. When submitting a voucher, such voucher shall also be deemed to certify that: (i) the payments requested do not duplicate reimbursement from other sources of funding; and (ii) the funds provided herein do not replace funds that, in the absence of this grant, would have been made available by the Contractor for this program. Requirement (ii) does not apply to grants funded pursuant to a Community Projects Fund appropriation.

2. Consistent with the selected reimbursement claiming schedule in Attachment D (Payment and Reporting Schedule), the Contractor shall comply with the appropriate following provisions:
  - a) Quarterly Reimbursement: The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency quarterly voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

b) Monthly Reimbursement: The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency monthly voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

c) Biannual Reimbursement: The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency biannually voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

d) Milestone/Performance Reimbursement:<sup>4</sup> Requests for payment based upon an event or milestone may be either severable or cumulative. A severable event/milestone is independent of accomplishment of any other event. If the event is cumulative, the successful completion of an event or milestone is dependent on the previous completion of another event.

Milestone payments shall be made to the Contractor when requested in a form approved by the State, and at frequencies and in amounts stated in Attachment D (Payment and Reporting Schedule). The State Agency shall make milestone payments subject to the Contractor's satisfactory performance.

e) Fee for Service Reimbursement:<sup>5</sup> Payment shall be limited to only those fees specifically agreed upon in the Master Contract and shall be payable no more frequently than monthly upon submission of a voucher by the contractor.

f) Rate Based Reimbursement:<sup>6</sup> Payment shall be limited to rate(s) established in the Master Contract. Payment may be requested no more frequently than monthly.

g) Scheduled Reimbursement:<sup>7</sup> The State Agency shall generate vouchers at the frequencies and amounts as set forth in Attachment D (Payment and Reporting Schedule), and service

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<sup>4</sup> A milestone/ performance payment schedule identifies mutually agreed-to payment amounts based on meeting contract events or milestones. Events or milestones must represent integral and meaningful aspects of contract performance and should signify true progress in completing the Master Contract effort.

<sup>5</sup> Fee for Service is a rate established by the Contractor for a service or services rendered.

<sup>6</sup> Rate based agreements are those agreements in which payment is premised upon a specific established rate per unit.

<sup>7</sup> Scheduled Reimbursement agreements provide for payments that occur at defined and regular intervals that provide for a specified dollar amount to be paid to the Contractor at the beginning of each payment period (i.e. quarterly, monthly or bi-annually). While these payments are related to the particular services and outcomes defined in the Master Contract, they are not dependent upon particular services or expenses in any one payment period and provide the Contractor with a defined and regular payment over the life of the contract.

reports shall be used to determine funding levels appropriate to the next annual contract period.

h) Interim Reimbursement: The State Agency shall generate vouchers on an interim basis and at the amounts requested by the Contractor as set forth in Attachment D (Payment and Reporting Schedule).

i) Fifth Quarter Payments:<sup>8</sup> Fifth quarter payment shall be paid to the Contractor at the conclusion of the final scheduled payment period of the preceding contract period. The State Agency shall use a written directive for fifth quarter financing. The State Agency shall generate a voucher in the fourth quarter of the current contract year to pay the scheduled payment for the next contract year.

3. The Contractor shall also submit supporting fiscal documentation for the expenses claimed.
4. The State reserves the right to withhold up to fifteen percent (15%) of the total amount of the Master Contract as security for the faithful completion of services or work, as applicable, under the Master Contract. This amount may be withheld in whole or in part from any single payment or combination of payments otherwise due under the Master Contract. In the event that such withheld funds are insufficient to satisfy Contractor's obligations to the State, the State may pursue all available remedies, including the right of setoff and recoupment.
5. The State shall not be liable for payments on the Master Contract if it is made pursuant to a Community Projects Fund appropriation if insufficient monies are available pursuant to Section 99-d of the State Finance Law.
6. All vouchers submitted by the Contractor pursuant to the Master Contract shall be submitted to the State Agency no later than thirty (30) calendar days after the end date of the period for which reimbursement is claimed. In no event shall the amount received by the Contractor exceed the budget amount approved by the State Agency, and, if actual expenditures by the Contractor are less than such sum, the amount payable by the State Agency to the Contractor shall not exceed the amount of actual expenditures.
7. All obligations must be incurred prior to the end date of the contract. Notwithstanding the provisions of Section III(C)(6) above, with respect to the final period for which reimbursement is claimed, so long as the obligations were incurred prior to the end date of the contract, the Contractor shall have up to ninety (90) calendar days after the contract end date to make expenditures; provided, however, that if the Master Contract is funded, in whole or in part, with Federal funds, the Contractor shall have up to sixty (60) calendar days after the contract end date to make expenditures.

#### **D. Identifying Information and Privacy Notification:**

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<sup>8</sup> Fifth Quarter Payments occurs where there are scheduled payments and where there is an expectation that services will be continued through renewals or subsequent contracts. Fifth Quarter Payments allow for the continuation of scheduled payments to a Contractor for the first payment period quarter of an anticipated renewal or new contract.

1. Every voucher or New York State Claim for Payment submitted to a State Agency by the Contractor, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property, must include the Contractor's Vendor Identification Number assigned by the Statewide Financial System, and any or all of the following identification numbers: (i) the Contractor's Federal employer identification number, (ii) the Contractor's Federal social security number, and/or (iii) DUNS number. Failure to include such identification number or numbers may delay payment by the State to the Contractor. Where the Contractor does not have such number or numbers, the Contractor, on its voucher or Claim for Payment, must provide the reason or reasons for why the Contractor does not have such number or numbers.

2. The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principle purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. The personal information is requested by the purchasing unit of the State Agency contracting to purchase the goods or services or lease the real or personal property covered by the Master Contract. This information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York, 12236.

#### **E. Refunds:**

1. In the event that the Contractor must make a refund to the State for Master Contract-related activities, including repayment of an advance or an audit disallowance, payment must be made payable as set forth in Attachment A-1 (Program Specific Terms and Conditions). The Contractor must reference the contract number with its payment and include a brief explanation of why the refund is being made. Refund payments must be submitted to the Designated Refund Office at the address specified in Attachment A-1 (Program Specific Terms and Conditions).

2. If at the end or termination of the Master Contract, there remains any unexpended balance of the monies advanced under the Master Contract in the possession of the Contractor, the Contractor shall make payment within forty-five (45) calendar days of the end or termination of the Master Contract. In the event that the Contractor fails to refund such balance the State may pursue all available remedies.

**F. Outstanding Amounts Owed to the State:** Prior period overpayments (including, but not limited to, contract advances in excess of actual expenditures) and/or audit recoveries associated with the Contractor may be recouped against future payments made under this Master Contract to Contractor. The recoupment generally begins with the first payment made to the Contractor following identification of the overpayment and/or audit recovery amount. In the event that there are no payments to apply recoveries against, the Contractor shall make payment as provided in Section III(E) (Refunds) herein.

#### **G. Program and Fiscal Reporting Requirements:**

Contract Number: # \_\_\_\_\_

1. The Contractor shall submit required periodic reports in accordance with the applicable schedule provided in Attachment D (Payment and Reporting Schedule). All required reports or other work products developed pursuant to the Master Contract must be completed as provided by the agreed upon work schedule in a manner satisfactory and acceptable to the State Agency in order for the Contractor to be eligible for payment.

2. Consistent with the selected reporting options in Attachment D (Payment and Reporting Schedule), the Contractor shall comply with the following applicable provisions:

a) If the Expenditure Based Reports option is indicated in Attachment D (Payment and Reporting Schedule), the Contractor shall provide the State Agency with one or more of the following reports as required by the following provisions and Attachment D (Payment and Reporting Schedule) as applicable:

(i) *Narrative/Qualitative Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a report, in narrative form, summarizing the services rendered during the quarter. This report shall detail how the Contractor has progressed toward attaining the qualitative goals enumerated in Attachment C (Work Plan). This report should address all goals and objectives of the project and include a discussion of problems encountered and steps taken to solve them.

(ii) *Statistical/Quantitative Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a detailed report analyzing the quantitative aspects of the program plan, as appropriate (e.g., number of meals served, clients transported, patient/client encounters, procedures performed, training sessions conducted, etc.)

(iii) *Expenditure Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a detailed expenditure report, by object of expense. This report shall accompany the voucher submitted for such period.

(iv) *Final Report*: The Contractor shall submit a final report as required by the Master Contract, not later than the time period listed in Attachment D (Payment and Reporting Schedule) which reports on all aspects of the program and detailing how the use of funds were utilized in achieving the goals set forth in Attachment C (Work Plan).

(v) *Consolidated Fiscal Report (CFR)*: The Contractor shall submit a CFR, which includes a year-end cost report and final claim not later than the time period listed in Attachment D (Payment and Reporting Schedule).

b) If the Performance-Based Reports option is indicated in Attachment D (Payment and Reporting Schedule), the Contractor shall provide the State Agency with the following reports as required by the following provisions and Attachment D (Payment and Reporting Schedule) as applicable:

- (i) *Progress Report*: The Contractor shall provide the State Agency with a written progress report using the forms and formats as provided by the State Agency, summarizing the work performed during the period. These reports shall detail the Contractor's progress toward attaining the specific goals enumerated in Attachment C (Work Plan). Progress reports shall be submitted in a format prescribed in the Master Contract.
- (ii) *Final Progress Report*: Final scheduled payment is due during the time period set forth in Attachment D (Payment and Reporting Schedule). The deadline for submission of the final report shall be the date set forth in Attachment D (Payment and Reporting Schedule). The State Agency shall complete its audit and notify the Contractor of the results no later than the date set forth in Attachment D (Payment and Reporting Schedule). Payment shall be adjusted by the State Agency to reflect only those services/expenditures that were made in accordance with the Master Contract. The Contractor shall submit a detailed comprehensive final progress report not later than the date set forth in Attachment D (Payment and Reporting Schedule), summarizing the work performed during the entire Contract Term (i.e., a cumulative report), in the forms and formats required.

3. In addition to the periodic reports stated above, the Contractor may be required (a) to submit such other reports as are required in Table 1 of Attachment D (Payment and Reporting Schedule), and (b) prior to receipt of final payment under the Master Contract, to submit one or more final reports in accordance with the form, content, and schedule stated in Table 1 of Attachment D (Payment and Reporting Schedule).

#### **H. Notification of Significant Occurrences:**

1. If any specific event or conjunction of circumstances threatens the successful completion of this project, in whole or in part, including where relevant, timely completion of milestones or other program requirements, the Contractor agrees to submit to the State Agency within three (3) calendar days of becoming aware of the occurrence or of such problem, a written description thereof together with a recommended solution thereto.
2. The Contractor shall immediately notify in writing the program manager assigned to the Master Contract of any unusual incident, occurrence, or event that involves the staff, volunteers, directors or officers of the Contractor, any subcontractor or program participant funded through the Master Contract, including but not limited to the following: death or serious injury; an arrest or possible criminal activity that could impact the successful completion of this project; any destruction of property; significant damage to the physical plant of the Contractor; or other matters of a similarly serious nature.

### **IV. ADDITIONAL CONTRACTOR OBLIGATIONS, REPRESENTATIONS AND WARRANTIES**

#### **A. Contractor as an Independent Contractor/Employees:**

1. The State and the Contractor agree that the Contractor is an independent contractor, and not an employee of the State and may neither hold itself out nor claim to be an officer, employee, or subdivision of the State nor make any claim, demand, or application to or for any right based upon any different status. Notwithstanding the foregoing, the State and the Contractor

agree that if the Contractor is a New York State municipality, the Contractor shall be permitted to hold itself out, and claim, to be a subdivision of the State.

The Contractor shall be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries and management of its project personnel. These functions shall be carried out in accordance with the provisions of the Master Contract, and all applicable Federal and State laws and regulations.

2. The Contractor warrants that it, its staff, and any and all subcontractors have all the necessary licenses, approvals, and certifications currently required by the laws of any applicable local, state, or Federal government to perform the services or work, as applicable, pursuant to the Master Contract and/or any subcontract entered into under the Master Contract. The Contractor further agrees that such required licenses, approvals, and certificates shall be kept in full force and effect during the term of the Master Contract, or any extension thereof, and to secure any new licenses, approvals, or certificates within the required time frames and/or to require its staff and subcontractors to obtain the requisite licenses, approvals, or certificates. In the event the Contractor, its staff, and/or subcontractors are notified of a denial or revocation of any license, approval, or certification to perform the services or work, as applicable, under the Master Contract, Contractor shall immediately notify the State.

#### **B. Subcontractors:**

1. If the Contractor enters into subcontracts for the performance of work pursuant to the Master Contract, the Contractor shall take full responsibility for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the State under the Master Contract. No contractual relationship shall be deemed to exist between the subcontractor and the State.

2. If requested by the State, the Contractor agrees not to enter into any subcontracts, or revisions to subcontracts, that are in excess of \$100,000 for the performance of the obligations contained herein until it has received the prior written permission of the State, which shall have the right to review and approve each and every subcontract in excess of \$100,000 prior to giving written permission to the Contractor to enter into the subcontract. All agreements between the Contractor and subcontractors shall be by written contract, signed by individuals authorized to bind the parties. All such subcontracts shall contain provisions for specifying (1) that the work performed by the subcontractor must be in accordance with the terms of the Master Contract, (2) that nothing contained in the subcontract shall impair the rights of the State under the Master Contract, and (3) that nothing contained in the subcontract, nor under the Master Contract, shall be deemed to create any contractual relationship between the subcontractor and the State. In addition, subcontracts shall contain any other provisions which are required to be included in subcontracts pursuant to the terms herein.

3. If requested by the State, prior to executing a subcontract, the Contractor agrees to require the subcontractor to provide to the State the information the State needs to determine whether a proposed subcontractor is a responsible vendor.

4. If requested by the State, when a subcontract equals or exceeds \$100,000, the subcontractor shall submit a Vendor Responsibility Questionnaire (Questionnaire).

5. If requested by the State, upon the execution of a subcontract, the Contractor shall provide detailed subcontract information (a copy of subcontract will suffice) to the State within fifteen (15) calendar days after execution. The State may request from the Contractor copies of subcontracts between a subcontractor and its subcontractor.

6. The Contractor shall require any and all subcontractors to submit to the Contractor all financial claims for Services or work to the State agency, as applicable, rendered and required supporting documentation and reports as necessary to permit Contractor to meet claim deadlines and documentation requirements as established in Attachment D (Payment and Reporting Schedule) and Section III. Subcontractors shall be paid by the Contractor on a timely basis after submitting the required reports and vouchers for reimbursement of services or work, as applicable. Subcontractors shall be informed by the Contractor of the possibility of non-payment or rejection by the Contractor of claims that do not contain the required information, and/or are not received by the Contractor by said due date.

**C. Use Of Material, Equipment, Or Personnel:**

1. The Contractor shall not use materials, equipment, or personnel paid for under the Master Contract for any activity other than those provided for under the Master Contract, except with the State's prior written permission.

2. Any interest accrued on funds paid to the Contractor by the State shall be deemed to be the property of the State and shall either be credited to the State at the close-out of the Master Contract or, upon the written permission of the State, shall be expended on additional services or work, as applicable, provided for under the Master Contract.

**D. Property:**

1. Property is real property, equipment, or tangible personal property having a useful life of more than one year and an acquisition cost of \$1,000 or more per unit.

a) If an item of Property required by the Contractor is available as surplus to the State, the State at its sole discretion, may arrange to provide such Property to the Contractor in lieu of the purchase of such Property.

b) If the State consents in writing, the Contractor may retain possession of Property owned by the State, as provided herein, after the termination of the Master Contract to use for similar purposes. Otherwise, the Contractor shall return such Property to the State at the Contractor's cost and expense upon the expiration of the Master Contract.

c) In addition, the Contractor agrees to permit the State to inspect the Property and to monitor its use at reasonable intervals during the Contractor's regular business hours.

d) The Contractor shall be responsible for maintaining and repairing Property purchased or procured under the Master Contract at its own cost and expense. The Contractor shall procure and maintain insurance at its own cost and expense in an amount satisfactory to the State Agency, naming the State Agency as an additional insured, covering the loss, theft or destruction of such equipment.

- e) A rental charge to the Master Contract for a piece of Property owned by the Contractor shall not be allowed.
  - f) The State has the right to review and approve in writing any new contract for the purchase of or lease for rental of Property (Purchase/Lease Contract) operated in connection with the provision of the services or work, as applicable, as specified in the Master Contract, if applicable, and any modifications, amendments, or extensions of an existing lease or purchase prior to its execution. If, in its discretion, the State disapproves of any Purchase/Lease Contract, then the State shall not be obligated to make any payments for such Property.
  - g) No member, officer, director or employee of the Contractor shall retain or acquire any interest, direct or indirect, in any Property, paid for with funds under the Master Contract, nor retain any interest, direct or indirect, in such, without full and complete prior disclosure of such interest and the date of acquisition thereof, in writing to the Contractor and the State.
2. For non-Federally-funded contracts, unless otherwise provided herein, the State shall have the following rights to Property purchased with funds provided under the Master Contract:
- a) For cost-reimbursable contracts, all right, title and interest in such Property shall belong to the State.
  - b) For performance-based contracts, all right, title and interest in such Property shall belong to the Contractor.
3. For Federally funded contracts, title to Property whose requisition cost is borne in whole or in part by monies provided under the Master Contract shall be governed by the terms and conditions of Attachment A-2 (Federally Funded Grants and Requirements Mandated by Federal Laws).
4. Upon written direction by the State, the Contractor shall maintain an inventory of all Property that is owned by the State as provided herein.
5. The Contractor shall execute any documents which the State may reasonably require to effectuate the provisions of this section.

## **E. Records and Audits:**

### **1. General:**

- a) The Contractor shall establish and maintain, in paper or electronic format, complete and accurate books, records, documents, receipts, accounts, and other evidence directly pertinent to its performance under the Master Contract (collectively, Records).
- b) The Contractor agrees to produce and retain for the balance of the term of the Master Contract, and for a period of six years from the later of the date of (i) the Master Contract and (ii) the most recent renewal of the Master Contract, any and all Records necessary to substantiate upon audit, the proper deposit and expenditure of funds received under the Master Contract. Such Records may include, but not be limited to, original books of entry

(e.g., cash disbursements and cash receipts journal), and the following specific records (as applicable) to substantiate the types of expenditures noted:

(i) personal service expenditures: cancelled checks and the related bank statements, time and attendance records, payroll journals, cash and check disbursement records including copies of money orders and the like, vouchers and invoices, records of contract labor, any and all records listing payroll and the money value of non-cash advantages provided to employees, time cards, work schedules and logs, employee personal history folders, detailed and general ledgers, sales records, miscellaneous reports and returns (tax and otherwise), and cost allocation plans, if applicable.

(ii) payroll taxes and fringe benefits: cancelled checks, copies of related bank statements, cash and check disbursement records including copies of money orders and the like, invoices for fringe benefit expenses, miscellaneous reports and returns (tax and otherwise), and cost allocation plans, if applicable.

(iii) non-personal services expenditures: original invoices/receipts, cancelled checks and related bank statements, consultant agreements, leases, and cost allocation plans, if applicable.

(iv) receipt and deposit of advance and reimbursements: itemized bank stamped deposit slips, and a copy of the related bank statements.

c) The OSC, AG and any other person or entity authorized to conduct an examination, as well as the State Agency or State Agencies involved in the Master Contract that provided funding, shall have access to the Records during the hours of 9:00 a.m. until 5:00 p.m., Monday through Friday (excluding State recognized holidays), at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying.

d) The State shall protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records, as exempt under Section 87 of the Public Officers Law, is reasonable.

e) Nothing contained herein shall diminish, or in any way adversely affect, the State's rights in connection with its audit and investigatory authority or the State's rights in connection with discovery in any pending or future litigation.

## **2. Cost Allocation:**

a) For non-performance based contracts, the proper allocation of the Contractor's costs must be made according to a cost allocation plan that meets the requirements of OMB Circulars A-87, A-122, and/or A-21. Methods used to determine and assign costs shall conform to generally accepted accounting practices and shall be consistent with the method(s) used by the Contractor to determine costs for other operations or programs. Such accounting standards and practices shall be subject to approval of the State.

b) For performance based milestone contracts, or for the portion of the contract amount paid on a performance basis, the Contractor shall maintain documentation demonstrating that milestones were attained.

3. **Federal Funds:** For records and audit provisions governing Federal funds, please see Attachment A-2 (Federally Funded Grants and Requirements Mandated by Federal Laws).

**F. Confidentiality:** The Contractor agrees that it shall use and maintain personally identifiable information relating to individuals who may receive services, and their families pursuant to the Master Contract, or any other information, data or records marked as, or reasonably deemed, confidential by the State (Confidential Information) only for the limited purposes of the Master Contract and in conformity with applicable provisions of State and Federal law. The Contractor (i) has an affirmative obligation to safeguard any such Confidential Information from unnecessary or unauthorized disclosure and (ii) must comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

**G. Publicity:**

1. Publicity includes, but is not limited to: news conferences; news releases; public announcements; advertising; brochures; reports; discussions or presentations at conferences or meetings; and/or the inclusion of State materials, the State's name or other such references to the State in any document or forum. Publicity regarding this project may not be released without prior written approval from the State.

2. Any publications, presentations or announcements of conferences, meetings or trainings which are funded in whole or in part through any activity supported under the Master Contract may not be published, presented or announced without prior approval of the State. Any such publication, presentation or announcement shall:

a) Acknowledge the support of the State of New York and, if funded with Federal funds, the applicable Federal funding agency; and

b) State that the opinions, results, findings and/or interpretations of data contained therein are the responsibility of the Contractor and do not necessarily represent the opinions, interpretations or policy of the State or if funded with Federal funds, the applicable Federal funding agency.

3. Notwithstanding the above, (i) if the Contractor is an educational research institution, the Contractor may, for scholarly or academic purposes, use, present, discuss, report or publish any material, data or analyses, other than Confidential Information, that derives from activity under the Master Contract and the Contractor agrees to use best efforts to provide copies of any manuscripts arising from Contractor's performance under this Master Contract, or if requested by the State, the Contractor shall provide the State with a thirty (30) day period in which to review each manuscript for compliance with Confidential Information requirements; or (ii) if the Contractor is not an educational research institution, the Contractor may submit for publication, scholarly or academic publications that derive from activity under the Master Contract (but are not deliverable under the Master Contract), provided that the Contractor first

submits such manuscripts to the State forty-five (45) calendar days prior to submission for consideration by a publisher in order for the State to review the manuscript for compliance with confidentiality requirements and restrictions and to make such other comments as the State deems appropriate. All derivative publications shall follow the same acknowledgments and disclaimer as described in Section IV(G)(2) (Publicity) hereof.

**H. Web-Based Applications-Accessibility:** Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the Master Contract or procurement shall comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility Web-Based Information and Applications, and New York State Enterprise IT Standard NYS-S08-005, Accessibility of Web-Based Information Applications, as such policy or standard may be amended, modified or superseded, which requires that State Agency web-based intranet and Internet information and applications are accessible to person with disabilities. Web content must conform to New York State Enterprise IT Standards NYS-S08-005, as determined by quality assurance testing. Such quality assurance testing shall be conducted by the State Agency and the results of such testing must be satisfactory to the State Agency before web content shall be considered a qualified deliverable under the Master Contract or procurement.

**I. Non-Discrimination Requirements:** Pursuant to Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex (including gender expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that the Master Contract shall be performed within the State of New York, the Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under the Master Contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, the Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under the Master Contract. The Contractor shall be subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 of the Labor Law.

**J. Equal Opportunities for Minorities and Women; Minority and Women Owned Business Enterprises:** In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if the Master Contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting State Agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting State Agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting State Agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of

\$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the Contractor certifies and affirms that (i) it is subject to Article 15-A of the Executive Law which includes, but is not limited to, those provisions concerning the maximizing of opportunities for the participation of minority and women-owned business enterprises and (ii) the following provisions shall apply and it is Contractor's equal employment opportunity policy that:

1. The Contractor shall not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status;
2. The Contractor shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts;
3. The Contractor shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;
4. At the request of the State, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative shall not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative shall affirmatively cooperate in the implementation of the Contractor's obligations herein; and
5. The Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants shall be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

The Contractor shall include the provisions of subclauses 1 – 5 of this Section (IV)(J), in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (Work) except where the Work is for the beneficial use of the Contractor. Section 312 of the Executive Law does not apply to: (i) work, goods or services unrelated to the Master Contract; or (ii) employment outside New York State. The State shall consider compliance by the Contractor or a subcontractor with the requirements of any Federal law concerning equal employment opportunity which effectuates the purpose of this section. The State shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such Federal law and if such duplication or conflict exists, the State shall waive the applicability of Section 312 of the Executive Law to the extent of such duplication or conflict. The Contractor shall comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

**K. Omnibus Procurement Act of 1992:** It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and

women-owned business enterprises, as bidders, subcontractors and suppliers on its procurement contracts.

1. If the total dollar amount of the Master Contract is greater than \$1 million, the Omnibus Procurement Act of 1992 requires that by signing the Master Contract, the Contractor certifies the following:

a) The Contractor has made reasonable efforts to encourage the participation of State business enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

c) The Contractor agrees to make reasonable efforts to provide notification to State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of the Master Contract and agrees to cooperate with the State in these efforts.

**L. Workers' Compensation Benefits:**

1. In accordance with Section 142 of the State Finance Law, the Master Contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of the Master Contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

2. If a Contractor believes they are exempt from the Workers Compensation insurance requirement they must apply for an exemption.

**M. Unemployment Insurance Compliance:** The Contractor shall remain current in both its quarterly reporting and payment of contributions or payments in lieu of contributions, as applicable, to the State Unemployment Insurance system as a condition of maintaining this grant.

The Contractor hereby authorizes the State Department of Labor to disclose to the State Agency staff only such information as is necessary to determine the Contractor's compliance with the State Unemployment Insurance Law. This includes, but is not limited to, the following:

1. any records of unemployment insurance (UI) contributions, interest, and/or penalty payment arrears or reporting delinquency;

2. any debts owed for UI contributions, interest, and/or penalties;

3. the history and results of any audit or investigation; and
4. copies of wage reporting information.

Such disclosures are protected under Section 537 of the State Labor Law, which makes it a misdemeanor for the recipient of such information to use or disclose the information for any purpose other than the performing due diligence as a part of the approval process for the Master Contract.

**N. Vendor Responsibility:**

1. If a Contractor is required to complete a Questionnaire, the Contractor covenants and represents that it has, to the best of its knowledge, truthfully, accurately and thoroughly completed such Questionnaire. Although electronic filing is preferred, the Contractor may obtain a paper form from the OSC prior to execution of the Master Contract. The Contractor further covenants and represents that as of the date of execution of the Master Contract, there are no material events, omissions, changes or corrections to such document requiring an amendment to the Questionnaire.
2. The Contractor shall provide to the State updates to the Questionnaire if any material event(s) occurs requiring an amendment or as new information material to such Questionnaire becomes available.
3. The Contractor shall, in addition, promptly report to the State the initiation of any investigation or audit by a governmental entity with enforcement authority with respect to any alleged violation of Federal or state law by the Contractor, its employees, its officers and/or directors in connection with matters involving, relating to or arising out of the Contractor's business. Such report shall be made within five (5) business days following the Contractor becoming aware of such event, investigation, or audit. Such report may be considered by the State in making a Determination of Vendor Non-Responsibility pursuant to this section.
4. The State reserves the right, in its sole discretion, at any time during the term of the Master Contract:
  - a) to require updates or clarifications to the Questionnaire upon written request;
  - b) to inquire about information included in or required information omitted from the Questionnaire;
  - c) to require the Contractor to provide such information to the State within a reasonable timeframe; and
  - d) to require as a condition precedent to entering into the Master Contract that the Contractor agree to such additional conditions as shall be necessary to satisfy the State that the Contractor is, and shall remain, a responsible vendor; and
  - e) to require the Contractor to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity. By signing the Master Contract, the Contractor agrees

to comply with any such additional conditions that have been made a part of the Master Contract.

5. The State, in its sole discretion, reserves the right to suspend any or all activities under the Master Contract, at any time, when it discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor shall be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the State issues a written notice authorizing a resumption of performance under the Master Contract.

6. The State, in its sole discretion, reserves the right to make a final Determination of Non-Responsibility at any time during the term of the Master Contract based on:

a) any information provided in the Questionnaire and/or in any updates, clarifications or amendments thereof; or

b) the State's discovery of any material information which pertains to the Contractor's responsibility.

7. Prior to making a final Determination of Non-Responsibility, the State shall provide written notice to the Contractor that it has made a preliminary determination of non-responsibility. The State shall detail the reason(s) for the preliminary determination, and shall provide the Contractor with an opportunity to be heard.

**O. Charities Registration:** If applicable, the Contractor agrees to (i) obtain not-for-profit status, a Federal identification number, and a charitable registration number (or a declaration of exemption) and to furnish the State Agency with this information as soon as it is available, (ii) be in compliance with the OAG charities registration requirements at the time of the awarding of this Master Contract by the State and (iii) remain in compliance with the OAG charities registration requirements throughout the term of the Master Contract.

**P. Consultant Disclosure Law:**<sup>9</sup> If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal, or similar services, then in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

**Q. Wage and Hours Provisions:** If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the

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<sup>9</sup> Not applicable to not-for-profit entities.

prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

**ATTACHMENT A-1  
PROGRAM SPECIFIC TERMS AND CONDITIONS**

**Instructions for Agencies**

Include any agency-specific and/or programmatic requirements that apply in this attachment.

A) Agency Specific Terms and Conditions

Examples of agency-specific content include, but are not limited to provisions governing the following: Program Office, Publications and Copyrights, Patents, and Performance Audit requirements. *At a minimum*, a Program Office and a Contractor's Designee must be designated for the purpose of notice as set forth in the Standard Terms and Conditions, Sections I(J)(2) and I(J)(3).

B) Program Specific Terms and Conditions

Examples of programmatic content include, but are not limited to provisions identifying: Program Standards, Program Requirements, Performance Measures and Matching Requirements not detailed elsewhere in the Master Contract.

**ATTACHMENT A-2  
FEDERALLY FUNDED GRANTS**

**Instructions for Agencies**

Include any terms and conditions specifically applicable to Federally funded grants in this attachment. Examples of Federally funded grant terms and conditions include, but are not limited to, provisions governing Federal pass-through funds, single audits and sub-recipient audits.

**ATTACHMENT B-1 - EXPENDITURE BASED BUDGET  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: \_\_\_\_\_ From: \_\_\_\_\_

To: \_\_\_\_\_

CATEGORY OF EXPENSE	GRANT FUNDS	MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
1. Personal Services					
a) Salary					
b) Fringe					
Subtotal					
2. Non Personal Services					
a) Contractual Services					
b) Travel					
c) Equipment					
d) Space/Property & Utilities					
e) Operating Expenses					
f) Other					
Subtotal					
TOTAL					

**ATTACHMENT B-1 - EXPENDITURE BASED BUDGET  
PERSONAL SERVICES DETAIL**

SALARY						TOTAL
POSITION TITLE	ANNUALIZED SALARY PER POSITION	STANDARD WORK WEEK (HOURS)	PERCENT OF EFFORT FUNDED	NUMBER OF MONTHS FUNDED		
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
					Subtotal	
FRINGE - TYPE/DESCRIPTION						
						PERSONAL SERVICES TOTAL

**ATTACHMENT B-1 - EXPENDITURE BASED BUDGET  
NON-PERSONAL SERVICES DETAIL**

CONTRACTUAL SERVICES - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

TRAVEL - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

EQUIPMENT - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

SPACE/PROPERTY EXPENSES: RENT - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
SPACE/PROPERTY EXPENSES: OWN - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
TYPE/DESCRIPTION OF UTILITY EXPENSES		TOTAL
1.		
2.		
3.		
	TOTAL	

OPERATING EXPENSES - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

OTHER - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

**ATTACHMENT B-1(A) - EXPENDITURE BASED BUDGET (AMENDMENT)  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

AMENDMENT VERSION NUMBER: \_\_\_\_\_

CATEGORY OF EXPENSE	GRANT FUNDS			MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
	CURRENT BUDGET	CHANGE	REVISED BUDGET				
1. Personal Services							
a) Salary							
b) Fringe							
Subtotal							
2. Non Personal Services							
a) Contractual Services							
b) Travel							
c) Equipment							
d) Space/Property & Utilities							
e) Operating Expenses							
f) Other							
Subtotal							
TOTAL							

**ATTACHMENT B-1 (A) - EXPENDITURE BASED BUDGET (AMENDMENT)  
PERSONAL SERVICES DETAIL**

SALARY					
POSITION TITLE	ANNUALIZED SALARY PER POSITION	STANDARD WORK WEEK (HOURS)	PERCENT OF EFFORT FUNDED	NUMBER OF MONTHS FUNDED	TOTAL
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
				Subtotal	
FRINGE - TYPE/DESCRIPTION					
				PERSONAL SERVICES TOTAL	

**ATTACHMENT B-1 (A) - EXPENDITURE BASED BUDGET (AMENDMENT)**  
***NON-PERSONAL SERVICES DETAIL***

CONTRACTUAL SERVICES - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

TRAVEL - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

EQUIPMENT - TYPE/DESCRIPTION		TOTAL COST
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

SPACE/PROPERTY EXPENSES: RENT - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
SPACE/PROPERTY EXPENSES: OWN - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
UTILITY EXPENSES - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
	TOTAL	

OPERATING EXPENSES - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

OTHER - TYPE/DESCRIPTION		TOTAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

**ATTACHMENT B-1 (A) EXPENDITURE BASED BUDGET (AMENDMENT)**  
***JUSTIFICATION***

Please provide a justification for the amendments herein:

**ATTACHMENT B-2 - PERFORMANCE BASED BUDGET  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: \_\_\_\_\_ From: \_\_\_\_\_

To: \_\_\_\_\_

#	DELIVERABLE/OUTCOME	TOTAL AMOUNT PER UNIT	GRANT AMOUNT PER UNIT	NUMBER OF UNITS	GRANT FUNDS	MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
1									
2									
3									
4									
5									
				Subtotal					
			Available Bonus						
			TOTAL						

**ATTACHMENT B-2(A) - PERFORMANCE BASED BUDGET (AMENDMENT)  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: \_\_\_\_\_ From: \_\_\_\_\_

To: \_\_\_\_\_

AMENDMENT VERSION NUMBER: \_\_\_\_\_

#	DELIVERABLE/OUTCOME	TOTAL AMOUNT PER UNIT	GRANT AMOUNT PER UNIT	NUMBER OF UNITS	GRANT FUNDS	MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
1									
2									
3									
4									
5									
				Subtotal					
				Available Bonus					
				TOTAL					

**ATTACHMENT B-2(A) - PERFORMANCE BASED BUDGET (AMENDMENT)**  
**DETAIL**

#	GRANT AMOUNT PER UNIT			NUMBER OF UNITS			GRANT FUNDS		
	ORIGINAL	CHANGE	REVISED AMOUNT	ORIGINAL	CHANGE	REVISED NUMBER	ORIGINAL BUDGET	CHANGE	REVISED BUDGET
1									
2									
3									
4									
5									
<b>TOTAL</b>									

**ATTACHMENT B-2(A) - PERFORMANCE BASED BUDGET (AMENDMENT)  
JUSTIFICATION**

Please provide a justification for the amendments herein:

**ATTACHMENT B-3 – CAPITAL BASED BUDGET  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: From: \_\_\_\_\_

To: \_\_\_\_\_

CATEGORY OF EXPENSE	GRANT FUNDS	MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
1. Scoping and Pre-Development					
2. Design					
3. Acquisition					
4. Construction					
5. Administration					
6. Working Capital/Reserves					
7. Other					
<b>TOTAL</b>					

**ATTACHMENT B-3 – CAPITAL BASED BUDGET  
DETAIL**

SCOPING AND PRE DEVELOPMENT - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

DESIGN - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

ACQUISITION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

CONSTRUCTION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

ADMINISTRATION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

WORKING CAPITAL/RESERVES - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

OTHER - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

**ATTACHMENT B-3(A) – CAPITAL BASED BUDGET (AMENDMENT)  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: From: \_\_\_\_\_

To: \_\_\_\_\_

AMENDMENT VERSION NUMBER: \_\_\_\_\_

CATEGORY OF EXPENSE	GRANT FUNDS			MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
	ORIGINAL BUDGET	CHANGE	REVISED BUDGET				
1. Scoping and Pre Development							
2. Design							
3. Acquisition							
4. Construction							
5. Administration							
6. Working Capital/Reserves							
7. Other							
<b>TOTAL</b>							

**ATTACHMENT B-3(A) – CAPITAL BASED BUDGET (AMENDMENT)**  
**DETAIL**

SCOPING AND PRE DEVELOPMENT TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

DESIGN - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

ACQUISITION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

CONSTRUCTION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

ADMINISTRATION - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

WORKING CAPITAL/RESERVES - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

OTHER - TYPE/DESCRIPTION	ITEM # (IF APPLICABLE)	QUANTITY (IF APPLICABLE)	UNIT PRICE (IF APPLICABLE)	TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

**ATTACHMENT B-3(A): CAPITAL BASED BUDGET (AMENDMENT)  
JUSTIFICATION**

Please provide a justification for the amendments herein:

**ATTACHMENT C – WORK PLAN  
SUMMARY**

PROJECT NAME: \_\_\_\_\_

CONTRACTOR SFS PAYEE NAME: \_\_\_\_\_

CONTRACT PERIOD: From: \_\_\_\_\_

To: \_\_\_\_\_

Provide an overview of the project including goals, tasks, desired outcomes and performance measures:

**ATTACHMENT C – WORK PLAN  
DETAIL**

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
1:	a.		i.
		ii.	
		iii.	
	b.		i.
		ii.	
		iii.	
	c.		i.
		ii.	
		iii.	

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
2:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

**ATTACHMENT D  
PAYMENT AND REPORTING SCHEDULE**

**I. PAYMENT PROVISIONS**

In full consideration of contract services to be performed the State Agency agrees to pay and the Contractor agrees to accept a sum not to exceed the amount noted on the Face Page hereof. All payments shall be in accordance with the budget contained in the applicable Attachment B form (Budget), which is attached hereto.

**A. Advance Payment, Initial Payment and Recoupment Language (if applicable):**

1. The State Agency will make an advance payment to the Contractor, during the initial period, in the amount of \_\_ percent (\_\_%) the budget as set forth in the most recently approved applicable Attachment B form (Budget).
  
2. The State Agency will make an initial payment to the Contractor in the amount of \_\_ percent (\_\_%) of the annual budget as set forth in the most recently approved applicable Attached B form (Budget). This payment will be no later than \_\_ days from the beginning of the budget period.
  
3. Scheduled advance payments shall be due in accordance with an approved payment schedule as follows:

Period: _____	Amount: _____	Due Date: _____
Period: _____	Amount: _____	Due Date: _____
Period: _____	Amount: _____	Due Date: _____
Period: _____	Amount: _____	Due Date: _____

4. Recoupment of any advance payment(s) or initial payment(s) shall be recovered by crediting (\_\_%) of subsequent claims and such claims will be reduced until the advance is fully recovered within the contract period.

**B. Interim and/or Final Claims for Reimbursement**

Claiming Schedule (*select applicable frequency*):

- Quarterly Reimbursement  
Due date \_\_\_\_\_
- Monthly Reimbursement

Due date \_\_\_\_\_

- Biannual Reimbursement  
Due date \_\_\_\_\_
- Fee for Service Reimbursement  
Due date \_\_\_\_\_
- Rate Based Reimbursement  
Due date \_\_\_\_\_
- Fifth Quarter Reimbursement  
Due date \_\_\_\_\_
- Milestone/Performance Reimbursement  
Due date/Frequency \_\_\_\_\_
- Scheduled Reimbursement  
Due date/Frequency \_\_\_\_\_
- Interim Reimbursement as Requested by Contractor \_\_\_\_\_

## II. REPORTING PROVISIONS

### A. Expenditure-Based Reports *(select the applicable report type):*

Narrative/Qualitative Report

The Contractor will submit, on a quarterly basis, not later than \_\_\_\_\_ days from the end of the quarter, the report described in Section III(G)(2)(a)(i) of the Master Contract

Statistical/Quantitative Report

The Contractor will submit, on a quarterly basis, not later than \_\_\_\_\_ days from the end of the quarter, the report described in Section III(G)(2)(a)(ii) of the Master Contract.

Expenditure Report

The Contractor will submit, on a quarterly basis, not later than \_\_\_\_\_ days after the end date for which reimbursement is being claimed, the report described in Section III(G)(2)(a)(iii) of the Master Contract.

Final Report

The Contractor will submit the final report as described in Section III(G)(2)(a)(iv) of the Master Contract, no later than \_\_\_\_\_ days after the end of the contract period.

Consolidated Fiscal Report (CFR)<sup>1</sup>

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<sup>1</sup> The Consolidated Fiscal Reporting System is a standardized electronic reporting method accepted by Office of Alcoholism & Substance Services, Office of Mental Health, Office of Persons with Developmental Disabilities and the State Education Department, consisting of schedules which, in

The Contractor will submit the CFR on an annual basis, in accordance with the time frames designated in the CFR manual. For New York City contractors, the due date shall be May 1 of each year; for Upstate and Long Island contractors, the due date shall be November 1 of each year.

## **B. Progress-Based Reports**

### 1. Progress Reports

The Contractor shall provide the report described in Section III(G)(2)(b)(i) of the Master Contract in accordance with the forms and in the format provided by the State Agency, summarizing the work performed during the contract period (see Table 1 below for the annual schedule).

### 2. Final Progress Report

Final scheduled payment will not be due until \_\_\_\_ days after completion of agency's audit of the final expenditures report/documentation showing total grant expenses submitted by vendor with its final invoice. Deadline for submission of the final report is \_\_\_\_\_. The agency shall complete its audit and notify vendor of the results no later than \_\_\_\_\_. The Contractor shall submit the report not later than \_\_\_\_ days from the end of the contract.

## **C. Other Reports**

The Contractor shall provide reports in accordance with the form, content and schedule as set forth in Table 1.

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different combinations, capture financial information for budgets, quarterly and/or mid-year claims, an annual cost report, and a final claim. The CFR, which must be submitted annually, is both a year-end cost report and a year-end claiming document.



### **III. SPECIAL PAYMENT AND REPORTING PROVISIONS**

## ATTACHMENT F

# A-1 - Agency Specific Terms and Conditions

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### **ATTACHMENT A A-1 Agency Specific Terms and Conditions**

#### **APPENDIX A: SUPPLEMENT**

The parties to the attached contract agree to be bound by the following, which are hereby made part of said contract

1. The contractor shall not discriminate against any applicant for services for reasons based upon religion or religious belief. The contractor shall not use any monies received from the State to benefit or inhibit a particular religion or religious belief.

2. The relationship of the contractor to the State is that of an independent contractor and the officers and employees of the contractor shall conduct themselves in a manner consistent with such status, shall neither hold themselves out as nor claim to be officers, employees, or agents of the State by reason thereof, and shall not make any claim, demand or application to or for any right of the State, including, but not limited to, Workers' Compensation coverage, unemployment insurance benefits, Social Security coverage or retirement membership credit.

3. The contractor shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons or property, including death, arising out of or related to the services to be rendered by the contractor. It shall indemnify and hold harmless the State and its officers and employees from any and all claims, suits, actions, damages and costs of every nature and description arising out of or related to the services to be rendered by the contractor or the violation by the contractor, its employees, servants, agents, or contractors, of any law, ordinance, rule or regulation in connection therewith.

4. Neither party shall be liable for losses, defaults, or damages under this contract which result from delays in performing, or inability to perform, all or any of the obligations or responsibilities imposed upon it pursuant to the terms and conditions of this contract, due to or because of acts of God, the public enemy, earthquake, floods, typhoons, civil strife, fire or any other cause beyond the reasonable control of the party that was so delayed in performing or so unable to perform, provided that such party was not negligent and shall have used reasonable efforts to avoid and overcome such cause. Such party shall resume full performance of such obligations and responsibilities promptly upon removal of any such cause.

5. If any term or provision of the contract shall be found to be illegal or unenforceable, then, notwithstanding, the contract shall remain in full force and effect and such term or provision shall be deemed stricken from the contract.

6. The contractor shall comply with all statutory requirements relating to the confidentiality of information obtained during the performance of the contract.

7. The contractor shall certify that payment requests do not duplicate reimbursement of costs and services received from other sources.

8. Upon termination of the contract, there shall be a reconciliation based upon the services provided by the contractor and the payments made by the State. The contractor shall refund to the State any overpayments made by the State pursuant to the contract.

9. Unless otherwise provided, the contract may be amended, modified, renewed, and/or renegotiated by written agreement of the parties which shall become effective upon approval by the Office of the State Comptroller.

10. Unless otherwise provided, the OPWDD may cancel the contract without cause upon serving thirty (30) days' written notice on the contractor. Cancellation by mutual agreement of all parties to the contract will be allowed subject to documentation in writing.

11. No part of the contractor's income or resources shall be used directly or indirectly for the benefit of, or payment to, any State employee for services provided under this contract other than employees whose names are furnished to the OPWDD and no employee so identified shall receive any benefit or payment under this contract without prior written approval by the OPWDD.

12. This contract contains all the terms and conditions agreed upon by the parties and no statement or representation, oral or written, express or implied, shall be deemed to exist or to bind either party or to vary any of the terms and conditions of the contract.

13. Where applicable, the contractor shall maintain eligibility for reimbursement from any program that provides payment for services and shall apply for and obtain all funds available for the program from any public or private source. Upon request, the OPWDD shall assist in establishing the contractor's eligibility for such funds.

14. General conditions relating to Article 15-A of the Executive Law are set forth in the following pages.

15. A determination of vendor non-responsibility may be cause for termination of the contract.

16. Contractor must comply with the provisions of Mental Hygiene Law Section 16.33 and Executive Law Section 845-b, the regulations related to criminal history record checks adopted by OPWDD in connection with the fingerprinting of certain individuals and the policies and procedures of OPWDD in connection therewith. In particular, any individual employed by or affiliated as a volunteer with a provider of services as defined in Section 1.03(5) of the Mental Hygiene Law who has regular and substantial unsupervised or unrestricted physical contact with people receiving services (such contact hereinafter referred to as "consumer contact") and who hereafter submits or who has submitted an application for employment or otherwise becomes or became affiliated with the Contractor on or after April 1, 2005 (such individual hereinafter referred to as "a subject party") shall be required to consent and submit to a

## Appendix A Supplement

criminal history record check. Upon the completion thereof, the contractor shall deny or hold in abeyance employment or volunteer opportunities involving consumer contact to a subject party when directed to do so by OPWDD and in those instances the contractor shall notify the subject party that his or her criminal history record information is the basis for such action taken by the contractor.

17. Federal False Claims Act (31 USC Sections 3729-3733) and the New York State False Claims Act (State Finance Law Article XIII, Sections 187-194) – contractor is bound by all of the related laws. The law requires that OPWDD provide its contractors with information about the federal False Claims Act, the New York State False Claims Act, and other federal and State laws that play a role in preventing and detecting fraud, waste and abuse in federal health care programs. This information must include the whistleblower protections that are in these laws. OPWDD must also provide its contractors with information about OPWDD's own policies and procedures for detecting and preventing waste, fraud and abuse. You can find detailed descriptions of these laws, their whistleblower protections and OPWDD's policies on the OPWDD website – ([www.opwdd.ny.gov](http://www.opwdd.ny.gov)). At the home page, select Information for Providers on the left side of the page, then select False Claims Recoveries. You can also visit the New York State Medicaid Inspector General website at [www.omig.state.ny.us](http://www.omig.state.ny.us) to obtain information about these laws. A paper copy of the detailed descriptions of the laws and of OPWDD policies and procedures related to waste, fraud and abuse is available from the OPWDD Contract Management Unit, 3rd floor, 44 Holland Ave., Albany NY 12229-0001. As a contractor of OPWDD, you are required to participate in the reviews and audits described in OPWDD's policies, and to abide by these policies with respect to funding for OPWDD services. You are also required to make the information at the OPWDD website address listed above available to all your employees and to all of your contractors involved in performing work under your contract with OPWDD.

18. Both the United States Department of Health and Human Services and the Office of the Medicaid Inspector General (OMIG) can exclude persons and organizations from federal and State healthcare programs. If this contract is funded through the New York State Medicaid program, the following applies:

### **For contractors**

The contractor represents that:

- (1) The United States Secretary of Health and Human Services has not excluded the contractor from participation in a federal health care program (including the Medicaid program) under 42 U.S.C. §§1320a-7 or 1320a-7a, or excluded the contractor from eligibility to provide services under the Social Security Act on a reimbursable basis under 42 U.S.C. §1320c-5;
- (2) The Secretary of Health and Human Services has not directed the New York State Department of Health or any other New York State government agency to exclude the contractor from participation in a federal health care program (including the Medicaid program) under 42 U.S.C. §§1320a-7(d) or 1320a-7a(a);
- (3) The New York State Medicaid Inspector General has not excluded the contractor from participation in the New York Medicaid program under 18 NYCRR Part 515, and
- (4) No federal or State agency has otherwise excluded the contractor from participation in the New York Medicaid program or excluded the contractor from eligibility to provide services under the Social Security Act or the New York Medicaid program on a reimbursable basis.

If, during the term of this contract, the contractor is excluded from participation in a federal health care program or the New York Medicaid program, or is excluded from eligibility to provide services under the Social Security Act or the New York Medicaid program on a reimbursable basis, under the authorities stated above, this contract shall be immediately terminated.

19. On February 12, 2007 the Diesel Emissions Reduction Act took effect as law. Pursuant to new §19-0323 of the N.Y. Environmental Conservation Law ("NYECL"), it is now a requirement that heavy duty diesel vehicles in excess of 8,500 pounds use the best available retrofit technology ("BART") and ultra low sulfur diesel fuel ("ULSD"). The requirements of the law apply to all vehicles owned, operated by or on behalf of, or leased by State agencies and State or regional public authorities. As a contract vendor, the Law may be applicable to vehicles used by contract vendors "on behalf of" State agencies and State or regional public authorities. Therefore, the bidder/contractor hereby certifies and warrants that all heavy duty vehicles, as defined in NYECL §19-0323, to be used under this contract will comply with the specifications and provisions of NYECL §19-0323, and any regulations promulgated pursuant thereto, which requires the use of BART and ULSD, unless specifically waived by NYSDEC. Qualification and application for a waiver under this Law will be the responsibility of the bidder/contractor.

20. Notices:

- (1). All notices permitted or required hereunder shall be in writing and shall be transmitted either:
  - (a) via certified or registered United States mail, return receipt requested;
  - (b) by facsimile transmission;
  - (c) by personal delivery;
  - (d) by expedited delivery service; or
  - (e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time-to-time designate:

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State of New York, Office for People with Developmental Disabilities (OPWDD)

Name:  
Title:  
Address:  
Telephone Number:  
Facsimile Number:  
E-Mail Address:

[Contractor Name]

Name:  
Title:  
Address:  
Telephone Number:  
Facsimile Number:  
E-Mail Address:

(2). Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

(3). The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

21. 14 NYCRR Sec. 624.6(t)(2) An agency shall not take any retaliatory action against an employee or agent who believes that he or she has reasonable cause to suspect that a person receiving services has been subjected to a reportable incident or notable occurrence, and the employee or agent makes a report to the VPCR and/or OPWDD in accordance with this section and/or if the employee or agent cooperates with the investigation of a report made to the VPCR or OPWDD. This extends to NY State contractors; associated language can be found at [http://www.opwdd.ny.gov/regulations\\_guidance/opwdd\\_regulations/implemenation\\_of\\_the\\_PPSNA\\_and\\_reforms\\_to\\_incident-management-effective-12-25-13](http://www.opwdd.ny.gov/regulations_guidance/opwdd_regulations/implemenation_of_the_PPSNA_and_reforms_to_incident-management-effective-12-25-13).

**April 2015**

**PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS: REQUIREMENTS AND PROCEDURES**

**I. General Provisions**

- A. The NYS Office for People with Developmental Disabilities (NYS OPWDD) is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 140-145 (“MWBE Regulations”) for all State contracts as defined therein, with a value (1) in excess of \$25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of \$100,000 for real property renovations and construction.
- B. The contractor to the subject contract (the “Contractor” and the “Contract,” respectively) agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State NYS OPWDD, to fully comply and cooperate with the NYS OPWDD in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women (“EEO”) and contracting opportunities for certified minority and women-owned business enterprises (“MWBEs”). The Contractor’s demonstration of “good faith efforts” pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the “Human Rights Law”) or other applicable federal, state or local laws.
- C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to Section VII of this Appendix or enforcement proceedings as allowed by the Contract.

**II. Contract Goals**

- A. For purposes of this procurement, the NYS OPWDD hereby establishes an overall goal of 30% for Minority and Women-Owned Business Enterprises (“MWBE”) participation, 17% for New York State certified minority-owned business enterprises (“MBE”) participation and 13% for New York State certified women-owned business enterprises (“WBE”) participation (collectively, “MWBE Contract Goals”) based on the current availability of qualified MBEs and WBEs.
- B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the MWBE Contract Goals established in Section II-A hereof, the Contractor should reference the directory of New York State Certified MBWEs found at the following internet address: <https://ny.newnycontracts.com>.

Additionally, the Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on the Contract.

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- C. Where MWBE Contract Goals have been established herein, pursuant to 5 NYCRR §142.8, the Contractor must document “good faith efforts” to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if it is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the NYS OPWDD for liquidated or other appropriate damages, as set forth herein.

### **III. Equal Employment Opportunity (EEO)**

- A. The Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the “Division”). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.
- B. The Contractor shall comply with the following provisions of Article 15-A:
1. Contractor and subcontractor performing work on the Contract (“Subcontractor”) shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
  2. The Contractor shall submit an EEO policy statement to the NYS OPWDD within seventy two (72) hours after the date of the notice by NYS OPWDD to award the Contract to the Contractor.
  3. If the Contractor or Subcontractor does not have an existing EEO policy statement, the NYS OPWDD may provide the Contractor or Subcontractor a model statement (see Form 100– Minority and Women-Owned Business Enterprises Equal Employment Opportunity Policy Statement).
  4. The Contractor’s EEO policy statement shall include the following language:
    - a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
    - b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

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- c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
- d. The Contractor will include the provisions of Subdivisions (a) through (c) of this Subsection 4 and Paragraph "E" of this Section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each Subcontractor as to work in connection with the Contract.

### C. Form \_\_101\_\_ - Staffing Plan

To ensure compliance with this Section, the Contractor shall submit a staffing plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. The Contractor shall complete the Staffing plan form and submit it as part of their bid or proposal or within a reasonable time, but no later than the time of award of the contract.

### D. Form \_102\_\_\_\_ - Workforce Employment Utilization Report ("Workforce Report")

1. Once a contract has been awarded and during the term of Contract, the Contractor is responsible for updating and providing notice to the NYS OPWDD of any changes to the previously submitted Staffing Plan. This information is to be submitted on a quarterly basis during the term of the contract to report the actual workforce utilized in the performance of the contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
2. Separate forms shall be completed by Contractor and any Subcontractor.
3. In limited instances, the Contractor may not be able to separate out the workforce utilized in the performance of the Contract from the Contractor's and/or Subcontractor's total workforce. When a separation can be made, the Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the contract cannot be separated out from the Contractor's and/or Subcontractor's total workforce, the Contractor shall submit the Workforce Report and indicate that the information provided is the Contractor's total workforce during the subject time frame, not limited to work specifically under the contract.

- E. The Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. The Contractor and Subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital

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status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

### **IV. MWBE Utilization Plan**

- A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan, by submitting evidence thereof through the New York State Contract System (“NYSCS”), which can be viewed at <https://ny.newnycontracts.com>, provided, however, that the Contractor may arrange to provide such evidence via a non-electronic method to NYS OPWDD, either prior to, or at the time of, the execution of the contract.
- B. The Contractor agrees to use such MWBE Utilization Plan for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in Section III-A of this Appendix.
- C. The Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, NYS OPWDD shall be entitled to any remedy provided herein, including but not limited to, a finding of the Contractor non-responsiveness.

### **V. Waivers**

- A. For Waiver Requests, the Contractor should use the NYSCS, provided, however, that Bidder may arrange to provide such evidence via a non-electronic method to NYS OPWDD.
- B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the waiver request is complete, the NYS OPWDD shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.
- C. If the NYS OPWDD, upon review of the MWBE Utilization Plan and updated Quarterly MWBE Contractor Compliance Reports determines that the Contractor is failing or refusing to comply with the MWBE Contract Goals and no waiver has been issued in regards to such non-compliance, the NYS OPWDD may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

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### **VI. Quarterly MWBE Contractor Compliance Report**

The Contractor is required to submit a Quarterly MWBE Contractor Compliance Report through the NYSCS, provided, however, that Bidder may arrange to provide such evidence via a non-electronic method to the NYS OPWDD by the 5<sup>th</sup> day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

### **VII. Liquidated Damages - MWBE Participation**

- A. Where NYS OPWDD determines that the Contractor is not in compliance with the requirements of the Contract and the Contractor refuses to comply with such requirements, or if the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, the Contractor shall be obligated to pay to the NYS OPWDD liquidated damages.
- B. Such liquidated damages shall be calculated as an amount equaling the difference between:
  - 1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
  - 2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.
- C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the NYS OPWDD, the Contractor shall pay such liquidated damages to the NYS OPWDD within sixty (60) days after they are assessed by the NYS OPWDD unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development pursuant to Subdivision 8 of Section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the NYS OPWDD.

**MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES  
EQUAL EMPLOYMENT OPPORTUNITY POLICY STATEMENT**

**M/WBE AND EEO POLICY STATEMENT (Form 100)**

I, \_\_\_\_\_, the (awardee/contractor) \_\_\_\_\_ agree to adopt the following policies with respect to the project being developed or services rendered at \_\_\_\_\_

**M/WBE**

This organization will and will cause its contractors and subcontractors to take good faith actions to achieve the M/WBE contract participations goals set by the State for that area in which the State-funded project is located, by taking the following steps:

- (1) Actively and affirmatively solicit bids for contracts and subcontracts from qualified State certified MBEs or WBEs, including solicitations to M/WBE contractor associations.
- (2) Request a list of State-certified M/WBEs from AGENCY and solicit bids from them directly.
- (3) Ensure that plans, specifications, request for proposals and other documents used to secure bids will be made available in sufficient time for review by prospective M/WBEs.
- (4) Where feasible, divide the work into smaller portions to enhanced participations by M/WBEs and encourage the formation of joint venture and other partnerships among M/WBE contractors to enhance their participation.
- (5) Document and maintain records of bid solicitation, including those to M/WBEs and the results thereof. The Contractor will also maintain records of actions that its subcontractors have taken toward meeting M/WBE contract participation goals.
- (6) Ensure that progress payments to M/WBEs are made on a timely basis so that undue financial hardship is avoided, and that bonding and other credit requirements are waived or appropriate alternatives developed to encourage M/WBE participation.

**EEO**

(a) This organization will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing programs of affirmative action to ensure that minority group members are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on state contracts.

(b) This organization shall state in all solicitation or advertisements for employees that in the performance of the State contract all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex disability or marital status.

(c) At the request of the contracting agency, this organization shall request each employment agency, labor union, or authorized representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of this organization's obligations herein.

(d) The Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. The Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

(e) This organization will include the provisions of sections (a) through (d) of this agreement in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the State contract

Agreed to this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

By \_\_\_\_\_

Print: \_\_\_\_\_ Title: \_\_\_\_\_

\_\_\_\_\_ is designated as the Minority Business Enterprise Liaison  
(Name of Designated Liaison)

responsible for administering the Minority and Women-Owned Business Enterprises- Equal Employment Opportunity (M/WBE-EEO) program.

**M/WBE Contract Goals**

% Minority and Women's Business Enterprise Participation

% Minority Business Enterprise Participation

% Women's Business Enterprise Participation

**EEO Contract Goals**

\_\_\_\_\_ % Minority Labor Force Participation

\_\_\_\_\_ % Female Labor Force Participation

\_\_\_\_\_  
(Authorized Representative)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**STAFFING PLAN**

Submit with Bid or Proposal – Instructions on page 2

<b>Solicitation No.:</b>	<b>Reporting Entity:</b>	<b>Report includes Contractor's/Subcontractor's:</b> <input type="checkbox"/> Work force to be utilized on this contract <input type="checkbox"/> Total work force
<b>Offeror's Name:</b>		<input type="checkbox"/> Offeror <input type="checkbox"/> Subcontractor
<b>Offeror's Address:</b>		<b>Subcontractor's name</b> _____

Enter the total number of employees for each classification in each of the EEO-Job Categories identified

EEO-Job Category	Total Work force	Work force by Gender		Work force by Race/Ethnic Identification														
		Total Male (M)	Total Female (F)	White (M) (F)		Black (M) (F)		Hispanic (M) (F)		Asian (M) (F)		Native American (M) (F)		Disabled (M) (F)		Veteran (M) (F)		
Officials/Administrators																		
Professionals																		
Technicians																		
Sales Workers																		
Office/Clerical																		
Craft Workers																		
Laborers																		
Service Workers																		
Temporary /Apprentices																		
Totals																		

<b>PREPARED BY (Signature):</b>	<b>TELEPHONE NO.:</b> <b>EMAIL ADDRESS:</b>	<b>DATE:</b>
<b>NAME AND TITLE OF PREPARER (Print or Type):</b>		Submit completed with bid or proposal MWBE 101 (Rev 03/11)

**General instructions:** All Offerors and each subcontractor identified in the bid or proposal must complete an EEO Staffing Plan (MWBE 101) and submit it as part of the bid or proposal package. Where the work force to be utilized in the performance of the State contract can be separated out from the contractor's and/or subcontractor's total work force, the Offeror shall complete this form only for the anticipated work force to be utilized on the State contract. Where the work force to be utilized in the performance of the State contract cannot be separated out from the contractor's and/or subcontractor's total work force, the Offeror shall complete this form for the contractor's and/or subcontractor's total work force.

**Instructions for completing:**

1. Enter the Solicitation number that this report applies to along with the name and address of the Offeror.
2. Check off the appropriate box to indicate if the Offeror completing the report is the contractor or a subcontractor.
3. Check off the appropriate box to indicate work force to be utilized on the contract or the Offerors' total work force.
4. Enter the total work force by EEO job category.
5. Break down the anticipated total work force by gender and enter under the heading 'Work force by Gender'
6. Break down the anticipated total work force by race/ethnic identification and enter under the heading 'Work force by Race/Ethnic Identification'. Contact the OMWBE Permissible contact(s) for the solicitation if you have any questions.
7. Enter information on disabled or veterans included in the anticipated work force under the appropriate headings.
8. Enter the name, title, phone number and email address for the person completing the form. Sign and date the form in the designated boxes.

**RACE/ETHNIC IDENTIFICATION**

Race/ethnic designations as used by the Equal Employment Opportunity Commission do not denote scientific definitions of anthropological origins. For the purposes of this form, an employee may be included in the group to which he or she appears to belong, identifies with, or is regarded in the community as belonging. However, no person should be counted in more than one race/ethnic group. The race/ethnic categories for this survey are:

- **WHITE** (Not of Hispanic origin) All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- **BLACK** a person, not of Hispanic origin, who has origins in any of the black racial groups of the original peoples of Africa.
- **HISPANIC** a person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
- **ASIAN & PACIFIC ISLANDER** a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands.
- **NATIVE INDIAN (NATIVE AMERICAN/ ALASKAN NATIVE)** a person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

**OTHER CATEGORIES**

- **DISABLED INDIVIDUAL** any person who:
  - has a physical or mental impairment that substantially limits one or more major life activity(ies)
  - has a record of such an impairment; or
  - is regarded as having such an impairment.
- **VIETNAM ERA VETERAN** a veteran who served at any time between and including January 1, 1963 and May 7, 1975.
- **GENDER** Male or Female

# ATTACHMENT G

## A-2 - Federal Specific Terms and Conditions

# Federal Terms and Conditions

Certain of these assurances may not be applicable to your project or program. If you have questions, contact the Office of People with Developmental Disabilities (OPWDD). By signing and submitting this application, contract or contract amendment an authorized representative of the applicant or contractor asserts that the applicant or contractor:

1. Has the legal authority to apply for Federal Assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of the project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and Executive Order Number 11246 as amended by E.O. 11375 relating to Equal Employment Opportunity, which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notifications of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

13. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

14. This contract is funded in whole or part with federal funds under the CDFA No93.778. OPWDD is a pass-through entity of these federal funds. As a recipient of these federal funds, the Contractor may be determined, as shown on the first page of Appendix C or Appendix X for renewals, to be a sub-recipient of federal assistance. Sub-recipients of federal funds have the responsibility of reporting to OPWDD in addition to the sub-recipient's responsibility to file reports with the federal clearinghouse designated by Office of Management and Budget (OMB). If this contract will require the Contractor to expend \$750,000 or more of federal funds from this contract or in total with other contracts or grants of federal funds or assistance in the Contractor's fiscal year, regardless of the source of the funding, the Contractor is required to comply with the terms and provisions of the OMB Circular A-133. The Contractor will notify OPWDD if it reasonably expects to expend the sum of \$750,000 of federally derived funds, in its fiscal year, as soon as it has notice of awards,

grants or contracts totaling \$750,000 in federal funds, but in no event later than the close of the calendar year. The Contractor will have an audit performed pursuant to the requirements of OMB Circular A-133 and provide OPWDD with the required reports within 30 days of the Contractor's receipt of the independent audit report or within 9 months after the close of the Contractor's fiscal year, whichever event is sooner.

15. Certifies that Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1000 per day and/or the imposition of an administrative compliance order on the responsible entity. By signing and submitting this application the applicant/grantee certifies that it will comply with the requirements of the Act. The contractor/grantee further agrees that it will require the language of this certification be included in any subawards which contain provisions of children's services and all subgrantees shall certify accordingly.

16.A. By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below. (1) The certification set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act (41 USC 702 et seq.), the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act. (2) For grantees other than individuals, Alternate I applies. For grantees who are individuals, alternate II applies. (3) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements. (4) Workplace identifications must include the actual address of buildings (or parts of buildings) or sites where work under the grant takes place. Categorical descriptions may be used (e.g. all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios). (5) If the workplace identified to the agency changes during the performance of the grant, the grantee shall inform the agency of the change(s), if it previously identified the workplaces in question (see paragraph four). (6) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules: Controlled substance means a controlled substance in Schedules I through V of the Controlled Substances Act (21 USC 812) and as further defined by regulation (21 CFR 1308.11 through 1308.15); Conviction means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes; Criminal drug statute means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance; Employee means the employee of a grantee directly engaged in the performance of work under a grant, including; (a) All direct charge employees; (b) All indirect charge employees unless their impact or

involvement is insignificant to the performance of the grant; and (c) Temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g. volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

16.B. Alternate I (Grantees Other Than Individuals). 1. The grantee certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by: (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition; (b) Establishing an ongoing drug-free awareness program to inform employees about; (1) the dangers of drug abuse in the workplace; (2) the grantee's policy of maintaining a drug-free workplace; (3) Any available drug counseling, rehabilitation, and employee assistance programs; and (4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above; (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will (1) Abide by the terms of the statement; and (2) Notify the employer in writing of his or her conviction for violation of a criminal drug status occurring in the workplace no later than five calendar days after such conviction; (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant; (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted; (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or (2) Requiring such a Federal, State, or local health, law enforcement, or other appropriate agency; (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f). For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices: Division of Grants Policy and Oversight, Office of Management and Acquisition, Department of Health and Human Services, Room 517-D, 200 Independence Avenue, S.W., Washington, D.C., 20201

16.C. Alternate II (Grantees Who Are Individuals). 1. The grantee certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in conducting any activity with the grant; 2. If convicted of a criminal drug offense resulting from a violation occurring during the conduct of any grant activity, he or she will report the conviction, in writing, within 10 calendar days of the conviction, to every grant officer or other designee, unless the Federal agency designates a central point for the receipt of such notices. When notice is made to such a central point, it shall include the identification number(s) of each affected grant.

17. Agrees that, a) By signing and submitting this proposal, the prospective primary applicant is providing the certification set out below. b) The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction. c) The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default. d) The prospective primary participant shall provide immediate written notice to the department or agency to which this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstance. e) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the Office of People with Developmental Disabilities for assistance in obtaining a copy of those regulations. f) The prospective primary participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction. g) The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transaction" provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions. h) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4 debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs. i) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings. j) Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

18. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. b) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

19. Copeland "Anti-Kickback" Act (18 U.S.C. 874 and 40 U.S.C. 276c) - All contracts and subgrants in excess of \$2,000 for construction or repair awarded by recipients and subrecipients shall include a provision for compliance with the Copeland "Anti-Kickback" Act, 18 U.S.C. 874, as supplemented by Department of Labor regulations, 29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States." The Act provides that each contractor or subrecipient shall be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he is otherwise entitled. The recipient shall report all suspected or reported violations to the Federal awarding agency.

20. Davis-Bacon Act as amended (40 U.S.C. 276a to 276a-7) - When required by Federal program legislation, all construction contracts awarded by the recipients and subrecipients of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act, 40 U.S.C. 276a to a-7, and as supplemented by Department of Labor regulations, 29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction." Under this Act, contractors shall be required to pay wages to laborers and mechanics at a rate of not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination issued by the Department of Labor in each solicitation and the award of the contract shall be conditioned upon the acceptance of the wage determination. The recipient shall report all suspected or reported violations to the HHS awarding agency.

21. Byrd Anti-Lobbying Amendment (31 U.S.C. 1352) - Contractors who apply or bid for an award of more than \$100,000 shall file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient (See also 45 CFR Part 93).

22. Debarment and Suspension (E.O.s 12549 and 12689) - Certain contracts shall not be made to parties listed on the nonprocurement portion of the General Services Administration's "Lists of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with E.O.s 12549 and 12689, "Debarment and Suspension." (See 45 CFR Part 76.) This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than E.O. 12549. Contractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

23. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

24. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research,

development, and related activities supported by this award of assistance.

25. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.