



New Jersey Division of Developmental Disabilities



**New Jersey Department of Human Services
Division of Developmental Disabilities**

***Support Coordinator Monitoring Tool
Work Instructions 2014***

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* *The Support Coordination Monitoring Tool is not to be used as a communication log. Only information collected at the time of the visit should be captured on the Support Coordination Monitoring Tool Report. All other correspondence regarding the individual should be completed and maintained in the electronic progress notes in iRecord. Progress notes should include crisis/emergency events in addition to any contacts or issues addressed between Monitoring Tools.*

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IDENTIFYING INFORMATION

1. **Individual Name** - Indicate the name of the individual who is being reviewed.
2. **DDD ID** - Indicate the individual's MIS #.
3. **Date of Contact** – Indicate the day the review is being conducted.
4. **Support Coordinator** - Indicate the name of the Support Coordinator completing the review.
5. **Support Coordination Agency** - Indicate the name of the agency assigned to provide Support Coordination for the individual being reviewed.
6. **Individual's Contact #** - Indicate the telephone number where the individual being reviewed was reached (home, cell, other).
Note: Changes to an individual's demographic information must be updated in iRecord.
7. **Name/Relationship of Person Providing Information to Support Coordinator** – indicate the full name and relationship to individual served of the primary person to whom the Support Coordinator spoke, e.g. individual, family member, parent, program staff, etc.
8. **Contact Period** - Indicate the type of contact: Monthly, Quarterly or Annual Home Visit.
9. **Contact Method** - Indicate if the review is being conducted via telephone or face-to-face.
10. **Contact Location** - Indicate where the review is being conducted: provider agency, home worksite or other.
 - **If other, please specify** - Indicate where the contact location is being made
11. **Date of Approved Plan** – please indicate the latest approved plan date, i.e. the ISP in effect at the time of the monitoring
12. **Reporting Period** – please indicate 30 day time period for this monitoring. Note that due to the 30 day time period, there may be two monitoring tools in one month, such as on July 1st and July 31st (30 days apart). This can be recorded on the monitoring tool in one of two ways:
 - **30 day periods** – Indicate the number of days since the ISP was approved to indicate the correct time period, e.g. 30, 60, 90, etc. **OR**
 - **30 day timeframe** – indicate specific dates for each monitoring tool, e.g. October 14 – November 13, 2014

Please complete all of the following sections based on your observations/conversations. This review should be a facilitated discussion and not just a series of yes/no questions. Please include in your comments the type of service you are commenting about, including but not limited to employment/day, transportation, individuals supports, etc.

OUTSTANDING ISSUES/OUTCOMES OF CORRECTIVE ACTIONS

1. **Were there any outstanding issues from the last point of contact** - Indicate yes/no
 - If yes, complete next question
2. **Provide an update of the status of the issue and progression of corrective action** - Provide a brief description of current status of prior issues and any additional follow up action that needs to occur.

MEDICAID ELIGIBILITY STATUS

1. **Is your Medicaid/waiver eligibility still maintained (Redetermination)?** – Indicate yes/no
 - If no, complete next question
 - Ask the individual and/or family member if a redetermination letter was received.
2. **Describe corrective actions to be taken** - Provide a brief description of issue, current status, and additional follow up action to occur. Ensure a Medicaid Eligibility Troubleshooting Form was completed and

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submitted to the Medicaid Eligibility Help Desk at DDD.MediElighelpdesk@dhs.state.nj.us. Provide updates to the Medicaid Eligibility Help Desk and in progress notes on iRecord.

BUDGET & ASSESSMENT

1. **Are you continuing to operate within your budget?** Indicate yes/no.
 - If no, complete next question
2. **Describe corrective actions to be taken** - Provide a brief description of issue, current status, and additional follow up action to occur. Will the person have enough funds to last the plan year for the services identified? Are there any changes needed to the service plan?
3. **Has there been any change that warrants a reassessment of need?** Indicate yes/no.
4. **Please describe** - Indicate if the Interdisciplinary (Planning) Team (IDT) has decided to request reassessment of need for the individual (see Communication section). Indicate why the IDT recommends a reassessment of need. Was the reassessment approved? If yes, what are the results? Review any reports or other documentation and provide an explanation of each.

SERVICE PLAN REVIEW (Review all services indicated on the ISP)

Needs:

1. **Are all of your assessed needs being met through the current service plan?** Indicate yes/no
2. **Do the services in the plan continue to meet your needs?** Indicate yes/no
 - If no to either of the above questions, complete next question
3. **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan.** Describe the issues and corrective actions to ensure that all assessed needs are being met including but not limited to, reassessment, service plan revision, modification of service provider, contacting additional support agencies e.g. Mental Health Services, Social services, etc.)

Services:

4. **Are the services being delivered in accordance with the service plan?** Indicate yes/no
5. **Are there any issues or barriers to your service delivery?** Indicate yes/no
 - If no to either of the above questions, complete next question
6. **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan.** Explain/discuss issues or problems with service delivery (i.e. provider did not show up, individual/family refused services, provider refused to provide services, etc.) Identify corrective actions/steps required to ensure that services are being delivered as outlined in the service plan. Identify and discuss barriers to service delivery, such as transportation, provider quality, dissatisfied with program/provider, etc. Describe what steps have been taken to remove/address barriers to service delivery. Are there alternate service providers? Was a revision to the service plan/modification submitted? Has the service plan revision been approved?

Progress:

7. **Is progress being made towards the planning goals/outcomes?** Indicate yes/no
 - If no, complete next question
8. **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan.** Identify and discuss barriers to progress of planning goals/outcomes including but not limited to availability/lack of qualified provider or specified service, significant change in medical/function status, behavioral changes, Fiscal intermediary problem, etc. Indicate what corrective actions are being implemented to ensure goals/outcomes are appropriate and or relevant for the individual.

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PROVIDER SATISFACTION

1. **Are you having any issues with providers or staff who work with you or other people around you?**
Indicate yes/no
 - If yes, complete next question.
2. **Explain and describe follow up needed** - Ask the individual how they feel things are going. Are they happy and satisfied with their services? Indicate how current concerns with staff or providers are being addressed. Are there any quality concerns to report to DDD? Does an IDT need to be scheduled?

BEHAVIOR

1. **Have there been any changes in type/frequency of behaviors?** Indicate yes/no
2. **Are there any trends or concerns needing follow-up?** Indicate yes/no
 - If yes to either of the above, complete next question
3. **Description of behaviors** - Indicate the time and location of the circumstances surrounding the event. Were other people involved? Were authorized restraints utilized? Did 911 need to be called? Was the individual or anyone injured during the behavior or as a result of the behavior?
4. **Follow-up/corrective action to be taken** - Were crisis services accessed? Were behavioral resources contacted or recommended? Describe follow up on recommendations as applicable. Indicate if there were any changes to the Service Plan or Behavior Support Plan (if applicable) as a result of the behavior. Indicate if there were changes to medication, diet, services, daily schedule, and/or living arrangement. Was a UIR generated? IDT meeting scheduled/held? Additional follow up to take place?

COMMUNITY INVOLVEMENT

1. **Do you have the supports you need to access your community as frequently as you would like?**
Indicate yes/no
 - If no, complete next question
2. **Describe follow up needed** - Indicate what is being done to address issues or barriers to community involvement, such as transportation or supports (e.g. if individual expresses an interest in attending local religious service, explain what is being done to accommodate this new interest).

FRIENDSHIPS AND SOCIAL INTERACTIONS

1. **Do you have the supports you need to make and maintain your friendships as much as you would like?** Indicate yes/no
 - If no, complete next question
2. **Describe follow up needed** - Indicate follow up actions including but not limited to addressing concerns and minimizing barriers to friendship and social interactions. Indicate the individual's preferences/interest in making or maintaining friendships. Does the person need assistance in arranging time with friends, transportation, individual supports, using the telephone, etc.?

CHOICE AND DECISION MAKING

Individuals who are non-verbal can make choices and have their choices respected, regardless of whether support is needed to do so. The Support Coordinator should ensure that the individual can make choices in areas of their life that are important to him/her and/or assist with identifying needed supports to do so.

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1. **Are you making your own choices and are your choices being respected?** Indicate yes/no
2. **Do you have the supports you need to make your own decisions?** Indicate yes/no
 - If no to either of the above, complete next question
3. **Describe follow up needed** - Are there any other choices that the individual would like to make? If so, please describe. Does the individual have the means necessary to communicate choices (e.g. communication device)? Are there any barriers to the individual making his/her own choices? If so, please explain and indicate what is being done to address these issues, such as conflict resolution with family, referral to self-advocacy groups, communication device, etc.

EMPLOYMENT

1. **Do you have the supports you need to reach your employment goals?** Indicate yes/no
2. **Was the ISP approved with employment follow up required?** Indicate yes/no
 - If no to #1 or yes to #2 above, complete next question
3. **Describe follow up needed** - Indicate what is being done to address needed supports and/or follow up to be addressed to have progress made on employment goals. Indicate what follow up items have not yet been addressed and the reasons why. Note the plan for follow up to have progress made on employment goals. Include contact/concerns with DVRS referrals.

COMMUNICATION

This section is designated to report on contact(s) made with the IDT outside of monthly monitoring contacts. While this information should also be in progress note(s), this section should be used to note the reason and issue for the additional contact as well as the outcome. This section does not need to be filled out for only regular monthly contacts.

1. **Contact with the Interdisciplinary Team (IDT)** - Indicate yes/no. *Note: The Interdisciplinary (Planning) Team is defined in the Interim Policy Guide to Support Coordination.*
 - If yes, complete next questions
2. **Date of contact** - Indicate the date the contact with the IDT occurred.
3. **Reason for contact** - Indicate the issue or need that was presented to and/or addressed by the IDT, such as discussion of issues with services, programming, behaviors, etc. What was the outcome?

HEALTH & SAFETY

1. **Are you protected from abuse, neglect, exploitation, physical harm, emotional distress (as reported by the individual, family, and/or service providers/DSP or based on observations)?** Indicate yes/no
 - If no, complete next question
2. **Description** - Provide a detailed summary regarding why the individual feels they are not protected from abuse, neglect, exploitation, physical harm, emotional distress, etc. or observations/reports by you or others.
3. **Describe corrective actions to be taken** - Was the incident reported and a UIR completed? Was there an investigation? Were any disciplinary actions and/or legal actions taken? Did an IDT meeting need to be held? Did the incident result in modifications to the Service Plan? Were other agencies involved (Adult Protective Services, police, child abuse hotline, etc.)? Did the incident result in a change in living arrangement? Does additional follow up need to occur?

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4. **Date reported to DDD:** Indicate the date that the incident was reported to DDD. Please note that incidents must be reported immediately to the Division by telephone to the respective Regional UIR Coordinator (see Guide to Unusual Incident Reporting for Support Coordinators).
5. **Indicate if there have been any changes in your health status (e.g. changes in seizure or aspiration frequency, sleep patterns, bowel/bladder function, activity level, mood, or other typical behavior/routines that may indicate a health concern, significant weight gain or loss, wounds, signs of pain- including dental pain, medication changes, hospital or ER since last visit, etc.)? Indicate yes/no**
 - If yes, complete next question.
6. **Description of change in health status:** Indicate if there have been changes in the individual's health status including but not limited to the examples above, including scheduled surgery, and provide description/details of change.
7. **Date reported to medical professional (as applicable)** - Indicate the date that the change in the individual's health status was reported to an appropriate medical professional, if applicable to the situation.
8. **Follow-up/corrective action to be taken, including name of medical professional involved** - If a medical professional was needed, indicate the full name and type of medical professional, including hospital, if applicable. Indicate if there were changes to medication, diet, services, adaptive equipment, daily schedule, and/or living arrangement. Indicate if there were there any changes to the Service Plan or Behavior Support Plan (if applicable) as a result of the change in health status. Was a UIR generated? Do any of these changes require long-term follow up?
9. **Indicate if there is any health, welfare or safety related needs or issues that need attention at this time** - Indicate yes/no
 - If yes, complete next question
10. **Description of issue/need:** Provide a brief description of any health, welfare, and safety issues/needs requiring attention at this time including but not limited to fall or choking risk, seizure safety, elopement, etc. Does this issue/need involve a family member, service provider or both?
11. **Follow-up/corrective action to be taken:** Indicate if medical/dental appointments are to be scheduled, if there have been changes to medication, diet, services, adaptive equipment, daily schedule, and/or living arrangement. Indicate if there were any changes to the Service Plan or Behavior Support Plan (if applicable) as a result of the health, welfare, and safety related issue. Was a UIR generated?
12. **Date reported to DDD:** Indicate the date that the need/issue was reported to DDD. Please note that incidents must be reported immediately to the Division by telephone to the respective Regional UIR Coordinator (see Guide to Unusual Incident Reporting for Support Coordinators).
13. **Do any of the above health and safety issues require a change to the service plan? If so, describe and update plan** – Indicate specific changes that are needed to the service plan to address any health, welfare or safety needs, if applicable, and revise plan as indicated.

UNUSUAL INCIDENT REPORTS (UIR)

See Guide to Unusual Incident Reporting for Support Coordinators

1. **Please indicate if any UIR's occurred since the last point of contact** - Indicate yes/no
 - If yes, complete next section(s)

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New Incident Report:

2. **Type/description of incident(s)** - Indicate the **category(s)** of Unusual Incidents **reported during this review period** by checking the type listed (Abuse, Neglect, Exploitation, Danielle's Law or "other").
3. **Date of incident** - Indicate the date that the incident occurred.
4. **Description of incident** - Indicate when the incident was reported to the Support Coordinator and by whom. Indicate how, when, and where the incident occurred. Indicate if the individual, family/friend, roommate or staff was injured during the incident.
5. **Follow-up actions taken** - Indicate follow up actions including but not limited to the following: changes to medication, diet, services, adaptive equipment, daily schedule, and/or living arrangement; modification to the Service Plan or Behavior Support Plan; IDT meeting; staff training; disciplinary and/or legal action taken.
6. **Resolution(s)** - Indicate the end result of the UIR. What was the outcome?

Pending Incident Report:

A pending incident report is one in which the incident is not yet closed and is waiting for additional follow up that the Support Coordinator may need to assist in accessing, in coordination with the DDD UIR Coordinator and/or Division Mentor.

7. **Indicate if there are any UIRs still pending this month** - Indicate yes/no
 - If yes, complete next questions
8. **Type/description of incident(s)** - Indicate the **category(s)** of Unusual Incidents **still pending during this review period** by checking the types listed (Abuse, Neglect, Exploitation, Danielle's Law or "other").
9. **Date of incident** - Indicate the date that the incident occurred.
10. **Description of incident** - Indicate when the incident was reported to the Support Coordinator and by whom. Indicate how, when and where the incident occurred. Indicate if the individual, family/friend, roommate or staff was injured during the incident.
11. **Follow-up actions taken** - Indicate follow up actions including but not limited to the following: changes to medication, diet, services, adaptive equipment, daily schedule, and/or living arrangement; modification to the Service Plan or Behavior Support Plan; IDT meeting; staff training; disciplinary and/or legal action taken. Is there a pending investigation taking place?
12. **New/additional information on this incident report** - Note status at this time for the pending incident.

SUMMARY OF CONTACT (Required Narrative)

1. Summarize the monitoring contact by indicating who the Support Coordinator talked to, the highlights of information gathered, and overall impressions of how the individual is doing. Include any needs, issues or concerns that are not being addressed on this form elsewhere. If an additional face-to-face review is conducted (beyond the required quarterly face-to-face contact), indicate this in the summary of contact section, using questions from the Quarterly Face-to-Face Review section below as a guide as needed.

QUARTERLY FACE-TO-FACE REVIEW (If applicable)

It is expected that during the face-to-face contact the Support Coordinator will take the necessary time to engage the individual to ascertain this information. The Support Coordinator should exercise good situational awareness and should be sensitive to the possibility that the individual may not disclose accurate information in the presence of the family member or provider. If warranted, ask the individual if they would like to speak privately.

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1. **Summary of observations and impressions of individual** – summarize the monitoring contact by indicating who the Support Coordinator talked to, the interaction with the individual, the highlights of information gathered, and overall impressions of how the individual is doing, e.g. positive demeanor, expresses/appears satisfied/content with services/provider, appropriate interactions, etc.. Observe the individual in his/her environment and comment on where the face-to-face review took place as well as how the individual interacted with family and/or provider as applicable.
2. **Please describe any concerns or issues that you identified during the course of the face to face visit related to the individual and/or program site visited** – Examples of issues/concerns include but are not limited to the following:
 - The individual's physical appearance (example: make certain to denote any bruising or scarring, personal hygiene issues, weight loss/gain or any physical changes from the previous visit, clothing concerns).
 - The individual's emotional state or affect (example: individual appears depressed/withdrawn, anxiety, or anger issues.)
 - If applicable, the individual's verbalizations (example: content of speech, does the individual perseverate – fixated on one issue/topic, does the individual express negative feelings towards the service provider, what concerns are expressed by the individual).
 - Indicate interactions with provider/staff/family members of concern
 - Indicate observations of the physical environment, such as issues with safety and cleanliness
 - Note any concerns/issues that need to be reported to DDD (UIRs, provider issue, etc.).
3. **Have you noticed any ongoing issues or trends within the quarter that need to be addressed?**
Indicate yes/no
 - If yes, complete next question
4. **Please describe** - Indicate any patterns that you observe, including but not limited to missed medical appointments, poor attendance in program, new/re-occurring behaviors, significant decrease in community involvement, increase in UIRs, health and safety issues. Be specific about the trends and patterns that you observed this quarter. Do you have reports or other documentation to support/supplement your observations? List the reports and provide copies (where applicable).

ANNUAL IN-HOME REVIEW (If applicable)

It is expected that during the face-to-face contact the Support Coordinator will take the necessary time to engage the individual to ascertain this information. The Support Coordinator should exercise good situational awareness, be respectful of the individual's home, and should be sensitive to the possibility that the individual may not disclose accurate information in the presence of the family member or provider. If warranted, ask the individual if they would like to speak privately.

1. **Summary of observations and impressions of individual** – summarize the monitoring contact by indicating who the Support Coordinator talked to, the interaction with the individual, the highlights of information gathered, and overall impressions of how the individual is doing, e.g. positive demeanor, expresses/appears satisfied/content with services/provider, appropriate interactions, etc.. Observe the individual in his/her home environment and comment on how the individual interacted with family and/or caregiver.
2. **Please describe any concerns or issues that you identified during the course of the in-home visit related to the individual and/or the home visited** - Examples of issues/concerns include but are not limited to the following:

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- The individual's physical appearance (example: make certain to denote any bruising or scarring, personal hygiene issues, weight loss/gain or any physical changes from the previous visit, clothing concerns).
 - The individual's emotional state or affect (example: individual appears depressed/withdrawn, anxiety, or anger issues.)
 - If applicable, the individual's verbalizations (example: content of speech, does the individual perseverate – fixated on one issue/topic, does the individual express negative feelings towards the service provider, what concerns are expressed by the individual).
 - Indicate interactions with caretaker/family members of concern
 - Indicate observations of the physical environment, such as issues with safety, cleanliness, privacy/personal space in home
 - Note any concerns/issues that need to be reported to DDD (UIRs, provider issue, etc.).
3. **Have you noticed any ongoing issues or trends within the year that need to be addressed?**
Indicate yes/no
- If yes, complete next question
4. **Please describe** - Indicate any patterns that you observe, including but not limited to missed medical appointments, poor attendance in program, new/re-occurring behaviors, significant decrease in community involvement, increase in UIRs, health and safety issues. Be specific about the trends and patterns that you observed this year. Do you have reports or other documentation to support/supplement your observations? List the reports and provide copies (where applicable).

Annual Reminder: Advise individual to attend medical and dental visits at least once a year. Document this conversation in the Summary of Contact section.

ACKNOWLEDGEMENTS

1. **Completed by** - Indicate the name of the Support Coordinator completing the review. The Monitoring Tool will be uploaded to iRecord by the Support Coordinator in lieu of a hard signature. By submitting this document, the Support Coordinator is certifying that the information contained within this report is true and correct. Another Support Coordinator may conduct the monitoring review in the assigned Support Coordinator's absence, though this should be noted clearly and the name of that person conducting the review should be indicated.
2. **Title** - Indicate the reviewer's title.
3. **Date** - Indicate the date the Monitoring Tool is completed.
4. **Reviewed by (if applicable)** – Indicate the name of the Support Coordination Supervisor reviewing the completed Monitoring Tool. By submitting this document with this section indicated, the SC Supervisor is certifying that the information contained within this report has been reviewed and is correct to their knowledge. At a minimum, the Monitoring Tools must be reviewed by the SC Supervisor during the first 60 days of any new Support Coordinator, when performance issues with a Support Coordinator are identified, and for involved/difficult cases.
5. **Title** - Indicate the title of the SC Supervisor reviewing the completed report.
6. **Date** - Indicate the date the report was reviewed.

Upload the completed Monitoring Tool to iRecord under the Documents section, Monthly Contact Tab