

Statewide BASIS Assessment Committee
Thursday, July 22, 2010 – 9:00 a.m.

Present:

Greg Wintle, SRS/DBHC/CSS, MR/DD Program Manager
Co-Chairpersons: Paul Heidrick, Carrie McMahon
All CDDOs represented

Question 13 regarding Time Out Procedures;

We have a question from a CSP about time outs, one of the people they serve according to their perspective is placed in time outs. In her behavior plan it states that when she is displaying tantrums it is best to remove her to her room to protect her and others from harm. Staff are to stay close by to prevent her from self-injury. When she tries to come out of her room staff should ask her if she is ready and offer her a wet towel at this time to help her calm down. If she is not calm then guide her back to her room and tell her to let you know when she is ready. Our reply to this was that the intention of time outs in BASIS is it must be used as a form of punishment as a result of a specific behavior, not a method to help someone calm down. Upon reading the behavior support plan it is described as physical intervention to remove her from the situation to protect her and others from harm. It is noted that staff can offer her a wet towel to help her calm down and she can let staff know when she is ready to come out of her room. Our BASIS team felt this did not meet the criteria for time outs to count.

It was agreed that this does meet the criteria to qualify as a time out, including, but not limited to, the response steps are in the BSP, having to leave the area or activity is a punitive procedure, it's being used for de-escalation of a behavior and occurring on at least a weekly basis.

Question 13 regarding Behavior Support Plans;

Who should track for severity & frequency?

If the BSP plan is developed at school, and includes severity & frequency, then we expect the school to track for those components. In Johnson County the Parents are trying to track the severity / frequency at home for the BSP plan that was created at the school. Tracking in this manner doesn't appear to be consistent or reliable. Would CDDO's agree statewide that BSP tracking should be collected in the setting where the BSP was created ?

Parents can report for BASIS only in-so-far as what is reported to them by the school.

Summer VS. School Year

Some individuals have a BSP throughout the school year, but their summer school does not use the BSP during the summer months. If the BASIS is completed during the summer then the person is not presently on a BSP, even though the BSP will *likely* resume when the standard school year starts up again in the fall. Should the BSP question be captured as a "NO" since there is not a current BSP in place and it is unknown if there will be one established for the upcoming school year ? Should it captured as a "YES" if we have supporting documentation that shows that the BSP will in fact resume when the standard school year does ?

IEPs are a year round plan and if the BSP is part of that, then the answer for BASIS is YES no matter when the birthday occurs.

Tracking Severity Levels

We are being given supporting documentation for the BSP's which does not explain the severity levels that are to be captured. Since severity levels are not being explained it is impossible for the providers to know which severity level best applies to the behavior that they observe. Would CDDO's agree statewide that the severity levels for a BSP should be explained either - In the BSP itself **(OR)** On the BSP tracking sheets ?

Most CDDOs are not tracking/collecting severity data, only frequency. Greg commented that the BSP and PCSP should explain why behavior is being tracked and documentation may occur in those documents or in incident reports.

Other Business

Peggy Shear reported that the behavior workgroup she is chairing has not met and asked if there was still an interest. The response was yes. She will work on getting the group together.

Cindy Wichman reported that the service section workgroup she is chairing has not met and due to issues arising in contract negotiations it will not proceed.

Linda Parker had a mechanics question concerning the service section -- we should close then re-enter case management when only the case management provider changes. The answer is DO NOT close, simply enter the revision date in the upper left hand corner and change the name of the provider in the appropriate section. Start dates are historical for the service, not the provider.

Greg Wintle reported on some outcomes from the FY 2011 contract negotiations:

- Previously the contract specified this group was to meet quarterly, however the FY 2011 contract says annually. Technically, this meeting would fulfill that requirement. However, Greg and the co-facilitators agreed that we should probably have one more meeting, probably in early 2011. There was no objection to that and Greg will be sending out a meeting date after the first of the year.
- New language in the FY 2011 contract states that all BASIS assessments will be performed by CDDO staff or a contracted entity that does not provide any direct services, including case management, to a person they serve. Areas that are in conflict with this method have until January 1, 2011, to develop a new plan.
- SRS indicated at contract negotiations an intent to eliminate conducting BASIS assessments for unserved persons on the waiting list. The exception will probably be those who are tier 0. Greg will work with Peggy Shear, JCDS, and Mary Rose Sudbeck, NCTC, to develop guidelines with an implementation target date of January 1, 2011.

Next meeting – after January 1, 2011; Greg will send out the date.

Submitted by
Dixie Williams
Achievement Services CDDO

Statewide BASIS Assessment Committee
Thursday, April 22, 2010 – 9:00 a.m.

Present:

Greg Wintle, SRS/DBHC/CSS, MR/DD Program Manager
Co-Chairpersons: Paul Heidrick, Carrie McMahon
All CDDOs were represented

General Questions:

With all of the differences in the behavior data collection process, should a subgroup be assembled to develop guidelines for tracking behaviors?

- Consensus: Reporting/interpreting data differently from CDDO to CDDO is a valid concern. To address these reported inconsistencies, a work group was identified to establish general guidelines with regard to the mechanics of reporting behavior tracking. This work group, headed by Johnson County CDDO, will consist of the following members: Paul H. – Tri Co, Susie K. – Shawnee Co., Teri K. – McPherson Co., Pam –JC, Dixie W. - ASNEK, Paula D. Tri-Valley, Karen G. – SDSI, Susan D. – Cottonwood, Angie F. – JC, and Christa J.- Futures. Greg will assist with getting this process started.

Do we keep people in BASIS who do not want any services?

- Consensus: No. If individuals want nothing from the system there is no reason for them to be in the system.

What is the status on development/implementation of a new Level of Care tool?

- By Greg's report, the System Transformation Testing Development – under DELMARVA- has made a recommendation to use a tool other than the DDP to determine level of care needs. They have identified three other possible tools. There seems to be the strongest support for considering the SIS (Supports Intensity Scale). The main barrier is that this tool is only normed for adults (age 16 and older). SRS is working with KU on a study to validate the children's version of this tool, but that is likely a couple years out. There will be more information presented on this topic next month at the CCDO business meeting.

Would folks like to devote a meeting (or part of a meeting) for Q&A on the BASIS Services Section?

- Consensus: As Q&A with regard to the mechanics of accurately reporting information in the Services Section of BASIS always seem to come up, especially as the snapshot date approaches, establishing some guidelines would be helpful and provide more consistency across the state. A small group, headed by Big Lakes, was identified to follow-up on this. This group includes the following: Cindy W. – Big Lakes, Sandy – Shawnee Co., Angela – Cottonwood, Peggy – JC, Brandy – COF, and Teri and Nancy – McPherson Co. Greg will assist with getting this group “up and rolling” as well.

Greg reminded everyone that Thurs., April 29 is state-wide snapshot date. He asked that CDDOs “clean up” information reported in BASIS before that date.

Greg also advised participants that at contract negotiations in June SRS will want to have serious discussions about the need to continue annually assessing, through BASIS, individuals who are only on a waiting list and not receiving any services. The waiver does not require an annual assessment until individuals are actually funded and on the waiver. It was suggested that this be discussed within each CDDO so that everyone is prepared for a meaningful exchange of information during contract negotiations.

Assessment Questions:

Question 3: How do we handle a situation where an individual is diagnosed with an allergy to plastics? Skin breaks out in a rash. No meds/but staff has to restructure his day services environment to avoid anything plastic. Would this be captured under respiratory (where other allergies are typically captured) or where should this be captured?

- Consensus: This would not be captured under respiratory unless there is a respiratory reaction. As this doesn't really require any additional staff support it appears that it would not be captured through BASIS.

Question 4a:

How should we capture pseudo-seizures?

- Consensus: Only seizures of an epileptic nature are counted. Pseudo-seizures would not be included.

Question 4c:

How are other CDDO's dealing with question #4c for individuals that are having seizures that have been documented through medical testing (EEG) but the individual and or family has no idea how often they are happening?

- If no one has actually observed the seizures you cannot count their frequency. Based on the EEG, you could track that at least one happened during the past year. **Mark it as less than once a month until you can document that it is happening more frequently.

Question 5d:

Level of Support. If a person takes medications all through the week with no problems at school, but refuses to take them on the weekends with their family then which level of support would be appropriate?

- Consensus: This question is about level of support. It's not about refusing or the behaviors associated with that. Capture the level of support that they need the five days that they are not refusing to take the medication.

Question 5d:

Level of Support. If the person takes medications all throughout the year and refuses on five (5) occasions then which level of support should be captured? What should be the threshold for capturing refusals?

- See above response as it applies to this situation as well.

Question 6:

Medical Consequences. Health Assessments in this CDDO area are completed every other year. Since they often times include the special diet information is it okay to only require documentation of a special diet on this same time table?

- Consensus: This information should be clearly reflected in the Medical Section of the PCSP which is updated at least annually. Supporting documentation should be available for the assessor to review if need be.

Question 6

Medical Consequences. Scenario: The individual has a community job and due to a medical condition they can't go to their community job, but they can instead participate in a day program. Should this be captured as a "YES" to missing 14 days of regular activities, since their community job is their regular activity?

- Consensus: No.

Question 6

Medical Consequences. Can this section be marked "YES" if the person missed 14 days of regular activities due to Alzheimer's?

- What is their regular activity? JCDS will follow up with CSP to get a clearer picture of what the intent of this question is and we'll follow up with this next time. An individual's day activities should take the Alzheimer's condition into consideration when planning.

Question 6

Medical Consequences. Can the following be captured as a Special Health Care Procedure? Ted Hose – Require training for how to correctly place these on an individual for a medical condition which requires them, Hearing Aids – Training is needed for battery replacement & general maintenance, Transtelephonic Transmitter for Pacemakers – Requires training for monitoring pacemaker by phone.

- Consensus: Ted Hose – yes, Hearing Aids – yes, Transtelephonic transmitting for Pacemakers - yes

Question 6

Are daily or weekly enemas counted under special health care procedures?

- Consensus: Yes. Check the guidelines: “The person requires regularly prescribed enemas on an ongoing basis.”

Question 13

Behavior Consequences. This question is regarding school BIP and data collection. Schools write BIP’s to IEP’s because there is a clear behavior issue. The BIP’s are clearly a part of the person’s education plan and not a part of the BASIS, and most BIP’s that are written are following similar guidelines as the BASIS

1. clear definition of the behavior(s) at issue &
2. There is a clear definition of what support staff are doing with regard to the behavior (Prevention and support strategies, responses) &
3. There is collection of information as to the Frequency
4. The plan ensures that the supports are specific to the individual involved

The only piece missing from most BIP’s which is not mandated by an IEP/BIP is collection of information to the Severity of the behavior. With regards to the BASIS, because of this one small piece missing from the BIP, the BIP cannot be marked “Yes” on # 13 Behavior consequences.

My question to the round table is, is it possible for the BIP to be counted on BASIS question #13 as a “yes” because it meets all but one fraction of the criteria to be marked “yes” and that is “collection of severity”? As this round table knows families or outside parties can not mandate a school to provide data that supports the BASIS, their mandate in data collection of frequency is determine that the goal/objective of the behavior support is to decrease the behavior, which is tracked by data collection of “frequency of a behavior”. I think that when there is a IEP/BIP present and it meets all but a fraction of the question 13 then it needs to be captured on the BASIS as being present.

- Consensus: The criteria outlined in BASIS must be met. School BIPs can count if they meet all of the criteria outlined in BASIS.

Question 14

We would like to have a clear consciences and written guidance as to what is considered total support for the following:

Toileting bowels (does the person have to require an enema)

Toileting bladder (does the person have to require a catheter)

Crossing the street (does the person have to be physically unable to walk)

Shopping for simple meals (does this mean that the person cannot assist with ANY items)

Taking the bus for a direct trip (does the person have to not have any idea that they are on the bus etc)

- Consensus: A great deal of guidance has been provided in the manual. Refer to it. Each activity should be viewed as to the actual start and end of the activity (not getting there or what happens after). Screeners must listen to and use their best judgment as to which level of support they believe best applies. If you have to set them on the stool and wipe them – how much are they participating in the process? If they are only “there” and not participating it’s a one. If they can assist in any way it is more likely a two. If you have to tell them what to do and they do it, it’s a three. (Total support for bowels would not require an enema nor would bladder require a catheter.) ***The event is the actual event—not whatever leads up to it or happens after it. Captured other support needs where appropriate.

Question 15

We would like more clarification between total support and assistance with regard to the questions in this section. Also between following a one step task directive and comprehending what the task is for (such as a

child can make a sandwich if he is told step by step what to do, but has not understanding of what he is doing). This question came from a parent.

- Consensus: Different support needs are captured in different sections of the BASIS. Section 15 looks at the task as defined in the answer above. If you tell someone to do something and they are capable of doing (even if they don't understand why) it would be supervision. The question about comprehension or understanding should/would be captured under section 11.

Other general questions:

Requiring behavior documentation for individuals who are "waiting list only" continues to be a challenge. Is there a way we can use what the parents are saying has happened if they have not actually tracked their behaviors? It seems unfair to ask them to track behaviors when they aren't receiving a waived service and not counting behavior the parents are verbally reporting could cause them to drop to a tier 0 and lose their HCBS eligibility.

- Consensus: As long as we have the documentation guidelines in place we need to follow them. Best practice would be to provide parents with documentation requirements and options when they are initially assessed so they fully understand the importance of and need for behavior documentation. If the decision is made to stop annual assessments for individuals who are waiting list only, Greg would be open to having a discussion about doing an updated BASIS at the time funding is determined to be available and accepting anecdotal information with regard to behaviors for that assessment and then move toward more data support information from that point on.

How do we show people that lost funding?

- If funding is restored we'll get this figured out. It's a much bigger problem than just what is being reflected in BASIS.

Eligibility Roundtable—Are we ever going to get together again?

- Greg will get with Mary Ellen and try to set one up after contract negotiations.

The next BASIS Committee meeting will be Thurs., July 22, 9 – 11 a.m.

Submitted by
Melody Magette
Arrowhead West, Inc. CDDO

Statewide BASIS Assessment Committee
Thursday, January 21, 2010 – 9:00 a.m.

Present

Greg Wintle, SRS/DBHC/CSS, MR/DD Program Manager
Co-Chairpersons: Paul Heidrick and Carrie McMahon
All CDDOs were represented.

Information Section

Section 17 (Day Programs): How are screeners marking children who are being home schooled (by parent) or enrolled in school but receiving school services in their home due to medical issues?

- Consensus: Mark as #11 (other) and make note of it in the file.

Assessment Section

Question 5c (Does individual receive medication by injection): A CSP has their own dental clinic and their dentist has signed documentation for some consumers that they receive a shot of Versed to calm them before every cleaning, which occurs quarterly. The CSP felt this question should be answered “yes” since the client received the medication by injection. Versed is then counted as “other” prescription medications.

- Consensus: do not count since there is not a medical condition to justify the need for medication.

Question 5d (Level of support): Since shots are not personally administered, should Question 5d be answered “total support”? Since BASIS guidance already states that assessors should count the most assistance a client requires, most answers would be marked “total support” anyway. Ongoing shots and not annual shots (flu shot) are the focus in this question.

- Consensus: Count as “total support” so long as meets criteria.

Question 6, #3 (Presently requires care giver to be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices): Special health care procedures do not include CPR, seizure training, Heimlich or behavior management unless those trainings are specific to the individual’s needs. If staff receives specialized training for the implementation of individualized behavior management interventions, can assessor answer #3 as “yes”?

- Consensus: Strike behavior management language from BASIS guidelines. The revised language will be posted on the SRS website along with the implementation date. This is a medical question, not a behavioral question. Behavior management is covered in other questions.

Question 12 (Behavior section): Are CDDOs capturing unwelcomed hugs and kisses in the “displays sexually inappropriate behavior” category?

- Consensus: If the behavior(s) is/are being tracked, count the behaviors.

Behavior Tracking: Would SRS consider alternatives to the current BASIS behavior reporting system? Can tracking be optional and decided by individual CDDOs? ETC. Some CDDOs reported that collating and calculating behavior tracking data is very time-consuming. Considering this, progress is nonetheless being made. Various discussion points are noted below:

- We cannot mandate the schools to track behavior(s).
- Some case managers collect and tabulate the data, and then gives it to the screener at the BASIS.
- Another CDDO: BASIS screener summarizes the data sheets at the BASIS appointment.
- Some providers use a behavior tracking form that their CDDO created.
- Another CDDO does 10% sampling and considers every piece of documentation.
- Computer-generated data is acceptable. Parents/guardians can sign off on the printout at the BASIS appointment. CSPs that have questions regarding computer-generated data may contact Greg Wintle.
- Consensus: Behavior tracking will continue with its current expectations. CDDOs are encouraged to contact other CDDOs to investigate and/or incorporate their tracking methods to create more efficiencies. The need for statewide reporting consistency is the prevailing reason why no alternate reporting system will be considered.

CSP-generated question: How to handle behavior data on individuals who are new to the system (BASIS) and/or new to accessing funded services?

- We already have guidance regarding this.
- Behavior tracking data is not required at initial evaluations, but is at all re-evaluations thereafter. Families get a “free pass” at the initial and are alerted that behavior tracking data is needed at the next scheduled BASIS. For those whose re-evaluation is close to when the initial was completed, behavior tracking should be presented.
- For clients whose initial BASIS is close to re-evaluation (example was 2 months):
- If someone is receiving newly funded services, someone should be tracking his/her behaviors.

Unresolved issues from last meeting

- Addison’s disease: is an endocrine disorder so assessors can count under “Genito-Urinary”.
- Fingernails: ingesting fingernails is considered eating an inedible object. Mark as “self-injurious” only if nail biting is causing tissue damage or other physical harm to the person.

New Discussion – Greg Wintle, Liz Long

Individuals on the waiting list – Greg Wintle: SRS is strongly considering to eliminate annual BASIS re-evaluations for individuals who receive no services and are waiting list only. TCM only recipients would also not be reassessed. To avoid receiving a BASIS error, CDDOs would revise the date on the current BASIS and submit within the birth month. This process would occur annually, until funding is received. At the time funding is received, a special re-evaluation would be completed. If an individual goes into crisis, a special re-evaluation would be completed. Concern: BASIS would not be current. A yearly family/consumer contact by the CDDO was discussed. Funded individuals, regardless of funding source, would be reassessed

- Consensus: CDDOs were in favor of not completing re-evaluations for those receiving TCM only, those on the waiting list/not receiving services. SRS will discuss further and Greg will inform CDDOs of their final decision.

Children’s Assessment (DDP): the website version is still wrong. Greg will investigate and ensure that the corrected version gets posted. Cottonwood has a corrected version and will send out to all CDDOs.

Notices of Action (NOA) – Liz Long

Beginning 1/22/10, CDDOs will receive Notices of Action electronically via .pdf file from Vicky Metz. Paper copies will continue to be mailed to guardians/consumers. CDDOs receive NOAs because it is a waiver requirement. CMS would want to see the form to verify waiver eligibility. NOAs need to be available for review or kept in the client’s file. CDDOs are responsible for distributing the NOAs they receive.

Vicky Metz will e-mail this week’s NOAs to those on her current distribution list. CDDOs have been instructed to contact PERT if they do not receive the message. CDDOs can specify which of their staff should receive NOAs by e-mailing Vicky. Contact Liz if problems are encountered.

Concluding items

- Guideline changes and implementation date will be posted on the SRS website.
- Next meeting date: Thursday, April 22, 9:00 – 11:00 a.m.

Respectfully submitted,
Teresa Still
CDDO Quality Assurance/Eligibility Specialist
Big Lakes Developmental Center CDDO

Statewide BASIS Assessment Committee

Thursday, October 29, 2009 – 9:00a.m.

Present:

Greg Wintle, SRS/DBHS/CSS

Co-Chairperson: Paul Heidrick and Carrie McMahon

All CDDOs were represented.

Assessment Section

Question #3

1. Does anyone count enlarged prostate? Genito-Urinary? (if they are taking medication for it and seeing a specialist regularly?)
 - Enlarged Prostate can count as Genito-Urinary if meets the medical conditions criteria.
2. Is Celiac disease Gastro-Instestinal? According to Celiaccentral.org: Celiac disease is an autoimmune digestive disease that damages the villi of the small intestine and interferes with absorption of nutrients from food.
 - Celiac disease is listed as gastro-intestinal in the new Medical Conditions Manual of definition and examples.
3. Capturing Pachygyria under Neurological? Pachygyria (from the Greek “pachy” meaning “thick” or “fat” gyri) is a congenital malformation of the cerebral hemisphere. It results in unusually thick convolutions of the cerebral cortex. Typically, children have developmental delay and seizures, the onset and severity depending on the severity of the cortical malformation. Infantile spasms are common in effected children, as is intractable epilepsy.
 - Pachygyria should be marked on the information section question #18 under identified disabilities #5 (other) and not under question #3 on the assessment section.
4. Does Adrenal Insufficiency or Addison’s Disease fit into any of the medical conditions listed in BASIS?
 - Adrenal Insufficiency or Addison’s Disease is an endocrine disorder and all endocrine disorders are allowed under genito-urinary. **Greg will review Tabers and let us know if this is not accurate.**

Question #4

5. Can Psychogenic non-epileptic seizures count in BASIS since BASIS only considers seizures of an epileptic nature.
 - Psychogenic non-epileptic seizures would not be counted under neurological, but does have a DSM-IV psychiatric diagnosis that would be listed on the information section question #21.

Question #13

6. In order to mark one-on-one supervision does it have to be ongoing or can it just be parts of the year?

- **For Children** - One-on-one supervision can be marked for children who need one-on-one supervision in school and not at home if the IEP designates the child needs one-on-one supervision all day at school due to behavior issues. If a para is only needed certain times of the school day, then it can not be counted as one-on-one supervision.
- **For Adults** – One-on-one supervision can only be marked if it is ongoing daily for at least 50% of the waking hours. One-on-one supervision can not be marked if the supervision is needed due to a behavior that spikes for a few months and requires supervision and then is not needed when the behavior subsides after a med change.

Question #12

7. Is a self reporting consumer a viable means of reporting?
 - Yes - See Statewide BASIS Assessment Committee minutes from April 30, 2009 meeting answer #15.
8. (Also answers question 9.) An affiliate of Cottonwood request consistency between CDDOs when scoring “eating inedible objects” with regards to toothpaste and soap. Shawnee County asked when is it appropriate to count fingernails, soap, or toothpaste as eating inedible objects? Shouldn’t some criteria be in place such as quantity consumer?
 - No quantity will be placed on eating inedible objects.
 - a. **Toothpaste** - Ingesting toothpaste directly from the tube would be considered eating an inedible object. When ingesting toothpaste off the toothbrush it can count as eating an inedible object if the intent to consume the toothpaste is there. The level of independence needs to be evaluated when brushing teeth to decide if intent is there. Swallowing toothpaste while brushing is not intent.
 - b. **Fingernails** - A consensus could not be reached by the group as to whether ingesting fingernails is in and of itself eating an inedible object or not unless it reaches the extent of being self injurious. **Greg, Paul, and Carrie will discuss and add language to clarify fingernail ingesting. Please submit opinions to any of the three regarding this issue for them to consider.**
10. A parent of a child had a concern about the definition of stealing and wrote a definition he would like the group to consider. “Taking belongings without the concept of ownership.”
 - The committee agreed not to make any changes to the current definition of stealing. It was stated that families or anyone reporting behavior information have the option not to recognize the behavior. However, they must be aware that this may change the outcome of the assessment.

General Guidelines for BASIS Screeners

11. Can BASIS Screeners use a clean copied printout, from whatever data system they use of the previous year’s BASIS instead of using a blank copy that needs filled in for the Assessment? Any changes to this year’s Assessment can be put directly onto the printed copy.

- BASIS assessors are not required to write the assessment on a blank copy when submitting for input. It is subject to the preference of each area how BASIS is received for input. However, Greg recommends that all notes and marking be saved in case of appeals.

General Questions

12. An affiliate asked about capturing Dyslexia. Vision could be normal under information section, so would it just be captured under question #10 of the assessment for reading?
 - Dyslexia is not counted as part of vision in the information section, but is captured under cognitive abilities in the **assessment section question #10**.
13. Would it be possible to form a workgroup to tackle some of the behavior tracking issues that are concerning? For example: parents with developmental disabilities, Spanish speaking parents who have trouble understanding behavior tracking, or other altered documentation.
 - Greg forwarded a Spanish translated behavior tracking form that Sedgwick County uses.
 - **Greg asks that anyone interested in being on a workgroup to tackle behavior tracking issues send him an email, and he will see if there is enough interest in having a workgroup.**
14. How do other CDDO's compile their behavior tracking sheets whenever they have multiple providers? Families have been told that we will not average their data. We need an accurate system that is not time consuming to determine the behavior frequency for the 13 behavior categories.
 - Greg forwarded to the group a behavior tracking cover page and example that Sedgwick County uses in their area.
15. When someone does not take routine medication it cannot be documented what support is needed for PRN medications. We cannot capture this information anywhere in the BASIS. For example if Sally does not take routine medication, but needs support with PRN medications on the question "does this individual require support with medication" it is marked that they are independent even though they are not with PRN medications.
 - PRN over-the-counter meds are not captured anywhere in BASIS. BASIS only allows for prescription meds that are scheduled and ongoing. If this needs to be addressed it will have to be addressed in the PCSP and not BASIS.
16. Person served now has a diagnosis of asthma. PRN nebulizer used for about a week, three times per year. Sees a doctor for routine care, but not specifically for the asthma. The handbook states that the person must meet one of these criteria, which can be met with the diagnosis documented by the doctor. With the utilization of medication being periodic, does it count as a 'yes' for respiratory in #3? Is the diagnosis enough or what is the threshold of the other qualifying criteria to meet an affirmative response?
 - Asthma can be counted as respiratory in question #3 on the assessment section if there is ongoing treatment/monitoring.
17. Can we extend the three-year out requirement for waiting in BASIS to possibly five years?

- Greg explained that the applied date is not used to determine someone's position on the waiting list, but it is the request date. Therefore, an individual is not gaining anything by getting the date in the system early. He says that extending this date out further would only be problematic from his point of view. It could give false information for predicting future service needs. Also, there would be system changes needed due to the BASIS reporting issues this would cause.
18. Why is diverticulitis not listed as a medical condition for **question #3 in the assessment section** under gastro-intestinal, but diverticulosis is?
- Carrie said that the nurse who gave input when compiling the medical conditions info said that diverticulitis is acute and can go away whereas diverticulosis is chronic. Carrie will make a change in the medical conditions examples to clarify this.

**Next meeting is set for January 21, 2010 at 9am by conference call.
Big Lakes will take the minutes.**

Statewide BASIS Assessment Committee

Thursday August 8th, 2009- 9:00a.m.

Present:

Greg Wintle, SRS/DBHS/CSS

DSNWK

Nemaha

Achievement

Cottonwood

Riverside

Hetlinger

Northview

Sunflower

SDSI

Arrowhead West

Tri-Valley

Futures

CDDO of SEK

Twin Valley

DPOK

Brown

Big Lakes

WDDS

TARC

COF

MCDS

TECH

ComCare

Flinthills

New Beginnings

CCDS

General Questions and Concerns:

- Greg has updated list for the BASIS gate keeping person and will email those out.

- Standard policy that if an assessor is going to do a Courtesy BASIS the assessor must have the correct contact information.
- Greg and Paul will go back over meeting minutes pertaining to changes to the Child Assessment.
- 30 days after posting to the BASIS manual is when these changes will be taken in effect.

1. Restless Leg Syndrome considered a neurological disease.

- a. Yes, you can count Restless Leg Syndrome under neurological diseases.

2. Changes made by the medical conditions work group.

- a. The work group updated language on **section 2: Assessment Information Medical Condition Definitions and Examples in the BASIS MANUAL.**
- b. Also changed wording in guidelines for **Assessment Question #3 (Medical Conditions).** Everyone decided that it has to be a current medical condition that is diagnosed by a doctor and has to meet at least one of the other criteria's captured in the BASIS MANUAL.

- c. **Under Section 3 & 4b Medical Conditions and Seizures Definitions and Examples** the work group made the following changes to these categories.
- d. **Respiratory Conditions** - the work group took the following sentence **see requirements for Chronic conditions** away from these conditions:
Bronchitis
Respiratory Conditions
Sinusitis
- e. **Gastro-Intestinal Conditions** - the work group decided that the **G-tube** itself does not count here. The condition that requires the tube may count. Also you may count **Interstitial Cystitis** only if ongoing not acute. Fatty liver falls under this category as well.
- f. **Genito-Urinary Conditions** - everyone decided to continue capturing diabetes under this category and also to capture thyroid disorders along with other endocrine disorders if meets ongoing medical conditions. **Gall Stones do not fit under this condition.**

g. **Neurological diseases-** Restless Leg Syndrome and Hydrocephaly are considered a neurological condition. Microcephaly , may be an identified disability. Encephalopathy might not apply for more than one year, and Encephalitis does not fit under this category.

h. **Diseases/Conditions that are not captured**
everyone chose to leave the menstrual diagnoses in BASIS MANUAL but has to meet criteria.

3. Elect a new Co-Chair person:

Carrie McMahon and Paul Heidrick are the nominees.
Please only 1 person from every CDDO cast a vote.

**Next meeting is set for October 29th, 2009 9am.
Brown County will take the minutes.**

Statewide BASIS Assessment Committee

Thursday August 8th, 2009- 9:00a.m.

Present:

Greg Wintle, SRS/DBHS/CSS	Twin Valley
DSNWK	DPOK
Nemaha	Brown
Achievement	Big Lakes
Cottonwood	WDDS
Riverside	TARC
Hetlinger	COF
Northview	MCDS
JCDS	TECH
SDSI	ComCare
Arrowhead West	Flinthills
Tri-Valley	New Beginnings
Futures	CCDS
CDDO of SEK	Tri-Ko

General Questions and Concerns:

- Greg has updated list for the BASIS gate keeping person and will email those out.
- Standard policy that if an assessor is going to do a Courtesy BASIS the assessor must have the correct contact information.
- Greg and Paul will go back over meeting minutes pertaining to changes to the Child Assessment.
- 30 days after posting to the BASIS manual is when these changes will be taken in effect.

1. Restless Leg Syndrome considered a neurological disease.

- a. Yes, you can count Restless Leg Syndrome under neurological diseases.

2. Changes made by the medical conditions work group.

- a. The work group updated language on **section 2: Assessment Information Medical Condition Definitions and Examples in the BASIS MANUAL.**
- b. Also changed wording in guidelines for **Assessment Question #3 (Medical Conditions)**. Everyone decided that it has to be a current medical condition that is diagnosed by a doctor and has to meet at least one of the other criteria's captured in the BASIS MANUAL.

- c. **Under Section 3 & 4b Medical Conditions and Seizures Definitions and Examples** the work group made the following changes to these categories.
- d. **Respiratory Conditions** - the work group took the following sentence **see requirements for Chronic conditions** away from these conditions:
Bronchitis
Respiratory Conditions
Sinusitis
- e. **Gastro-Intestinal Conditions** - the work group decided that the **G-tube** itself does not count here. The condition that requires the tube may count. Also you may count **Interstitial Cystitis** only if ongoing not acute. Fatty liver falls under this category as well.
- f. **Genito-Urinary Conditions** - everyone decided to continue capturing diabetes under this category and also to capture thyroid disorders along with other endocrine disorders if meets ongoing medical conditions. **Gall Stones do not fit under this condition.**
- g. **Neurological diseases-** Restless Leg Syndrome and Hydrocephaly are considered a neurological condition. Microcephaly , may be an identified disability. Encephalopathy might not apply for more than one year, and Encephalitis does not fit under this category.
- h. **Diseases/Conditions that are not captured** everyone chose to leave the menstrual diagnoses in BASIS MANUAL but has to meet criteria.

3. Elect a new Co-Chair person:

Carrie McMahan and Paul Heidrick are the nominees. Please only 1 person from every CDDO cast a vote.

Next meeting is set for October 29th, 2009 9am.

Brown County will take the minutes.

Statewide BASIS Assessment Committee
Thursday, April 30, 2009 - 9:00 a.m.

Present:

Greg Wintle, SRS/DBHS/CSS
Achievement Services
Arrowhead West
Big Lakes
Brown County
CDDO of SEKS
COF
Cottonwood
Cowley Co.
DSNWK
DPOK
Flinthills
Futures
Harvey-Marion County
Hetlinger

JCDS
MCDS
Nemaha County CDDO
New Beginnings
Reno County CDDO
Riverside Resources
Sedgwick County CDDO
Shawnee County CDDO
Tri-Ko
Tri-Valley
Twin Valley
Wyandotte County CDDO
CCL
Choices Network

Not Present:

SDSI
Advocate Representative

General Questions and Concerns:

1. Is any of the web-based training developed for BASIS screeners in June 2001 still applicable? See website: www.srskansas.org/hcp/css/basisWBT
 - Yes, the web-based training is still applicable. It was noted that some sections of the web-based training, such as the Medication Section, are now obsolete.
2. Are new BASIS screeners still required to obtain the Web-Based BASIS training certificate?
 - Yes
3. Could SRS begin re-issuing the BASIS Transmission Schedule as a periodic memo to CDDOs?
 - Yes, SRS would be able to re-issue the schedule periodically.
4. Update from Greg on the Delmarva Foundation surveys.
 - Approximately 300 responses to the survey were received. Around 80% of responses are from DD. The data has not been categorized by SRS program yet, when this is complete, the feedback will be shared with the Systems Transformation Team.
 - Greg believes that provider survey is now locked and no longer able to receive responses. However, consumer's surveys can still be entered. Please encourage families and individuals to complete the online or a hardcopy survey.
 - Surveys were originally sent to the broadest list SRS has with CDDOs and CSPs email address.
5. Can providers have input regarding interpretations of BASIS questions (ex: separate roundtable just for them)?
 - Greg recalled that CDDOs should be asking providers for input/questions and be bringing the providers input to the BASIS Committee for consideration. There are no

immediate plans to hold separate roundtables with providers; but if the contract were to mandate a separate roundtable for providers, then SRS would do that.

Assessment Section

Question #3 regarding Medical Conditions:

6. **“Restless Leg Syndrome”**: should this be captured under “Neurological” or is it considered a sleep disorder? WebMD defines it as “a disorder of the part of the nervous system that affects movements of the legs. Because it usually interferes with sleep, it also is considered a sleep disorder.” It is also described as a progressive condition that can get worse over time.
 - Per web-based medical resources, restless leg syndrome is a neurological disorder, not a sleep disorder. Greg and Paul will research this question further and report back to the group.
7. **“Neuropathy”**: Would a diagnosis of simply “Neuropathy” (not Guillian-Barre or Charcot Marie-Tooth Disorder) be captured under Neurological? Research indicated that it is considered equivalent to Peripheral Neuropathy.
 - Neuropathy is defined as “any disease of the nerves” by Tabers. A CDDO would likely need to ask the provider for more information (dig deeper) to get more info. If a person has just a generic diagnosis of “Neuropathy” the screen should ask a follow up question about the specific underlying condition.

Question #5 regarding Medication by Injection;

8. **Currently taking maintenance medications** - Should this include ONLY *prescribed* medications?
 - Yes. Question specifies that maintenance medication must be prescription medication.
9. B-12 Injections – are they considered when marking “yes” or “no” for medication by injection?
 - Yes.

Question #6 regarding Special Health Care Procedures:

10. Does fluoride treatment fall under "Special Healthcare Procedures"?
 - In mark “yes”, it must be a fluoride treatment a doctor prescribes and requires the direct care provider to be trained by someone else to administer/apply product. Not just a toothpaste or mouthwash with fluoride in it.
11. Would a doctor ordered electric toothbrush be considered a 'special healthcare procedure' if the individual requires support using it?
 - The BASIS Screener should ask the follow up question: “Does the electric toothbrush require any more assistance than the person would need with a regular toothbrush?” Support for tooth brushing would most likely be captured under question #14. The person’s direct care staff must require specialized training to carry out the tooth brushing in order to count this as a special healthcare procedure.
12. How specific does a special diet need to be?
 - Some individuals in a specific region have gotten a prescription for a “special diet” because of a mineral deficiency. The diet does not appear to meet the threshold for “additional staff support” which is part of the criteria for special diet.

Question #9 regarding cutting with scissors along a straight line;

13. Must the individual cut exactly on the line in order to mark "yes"?
- Assessors did not feel that the person had to cut an exactly straight line in order to mark "yes" to this question. The general idea is that the person can cut a paper with scissors along a line. Doesn't imply that it needs to be a perfect line. "Perfection is not the threshold".

Question #11 regarding receptive and expressive communication skills:

14. "Indicates a "yes" or "no" response to a simple question" Do we still mark this question a yes even if the person being assessed does not know what yes or no really mean?
- Assessors felt that the individual must be asked a yes/no question they understood and be able to answer yes or no congruent with the question in order to mark "yes". Best practice would be a statement in the individual's PCP discussing that the person does not understand or use the words "yes and no" to express their wants/needs and that the support team should use an alternate way (described in the PCP) to assess the person's preferences.

Question #12 regarding frequency of behaviors;

15. Are all of the following considered acceptable forms of documentation for the purpose of scoring behavioral frequencies on Assessment Question 12:
- All are forms of documentation listed below are acceptable but not necessarily as stand-alone documentation. Assessors may use some or all of the following documentation to look for a common thread of information
 - Daily Tracking Logs/Calendars –primary and preferred source
 - Time Studies – could be primary for occasional behaviors
 - Case file notes – could be primary for occasional behaviors
 - Incident Reports – could be primary but likely supporting source for behaviors that occur on a frequent basis.
 - Person-Centered Support Plan – supporting source only
 - Risk Assessments – supporting source only
 - Behavior Plans – supporting source only; however behavioral data collection could be a good source of primary behavior tracking.
 - Individualized Education Plan – supporting source only
 - Consumer Self-Reporting (as long as it is ultimately documented by staff, community partners or anyone else who can provide accurate information regarding the consumer's behavior observed.) – could be primary
 - Nursing Notes – supporting source only
16. Some assessors raised concerns about "manufacturing data" (a CSP encouraging a parent to mark behavior data sheets so behavior frequency in the home matches behavior frequency at the CSP site).
- Greg is concerned about the issue of manufactured (false) behavioral frequency data, but this issue is a local problem and best addressed by the CDDO with the provider. A CDDO could certainly tell the family/CSP/etc. they would not accept false behavior tracking data, in the future, if the CDDO knows/highly suspects that data is being manipulated to keep the tier at the current level.

17. Assessors in one area raised concerns after hearing that some people are not putting the year on the data sheets and using them for the next yearly BASIS screening. These assessors also raised concerns that the statewide “need to be consistent” in how we score BASIS and track behavioral data (monthly behavior charts) may have a negative impact on the individual served (ignoring the good/focusing on the bad) as well as the environment (trash-landfill).
- SRS and many other CDDOs feel most comfortable having data to support the decisions we are making when scoring BASIS. Discussion on pros/cons of keeping behavioral data sheets. A pro to keeping data was being able to access data quickly in the event of an appeal. Appeals must occur within 90 days so some CDDOs keep data for 90 days while others keep it for up to one year. There are no established guidelines on collecting or saving BASIS behavioral data, it's at the local CDDO's discretion.
18. Is body piercing (ears, eyelids, nose, and lips) considered **self injurious**?
- The consensus of the group is “no”; body piercing is not considered a self-injury even if the person is piercing him or herself or being pierced by others who are not “professionally trained” to perform piercings.
19. Is eating large amounts of candy when diabetic considered **self injurious** behavior?
- If a person diagnosed as having diabetes chooses to eat candy they would be resisting supervision not injuring themselves.
20. **Verbal/Gestural Abuse** – can we add *intent* to this question. Such as person intentionally or deliberately directs the following behavior(s) towards another person: swearing, verbal threats, name calling, obscene gestures, gestures that indicate aggressive intent or threat. Some agencies argue that Tourette's syndrome should be captured here.
- The assessors felt that intent is already implied in the definition of Verbal/Gestural Abuse. The behavior must be intentional/ deliberate and the individual must intend to abuse others with their behavior.
21. **Property Damage** – If an individual urinates on his/her mattress every day how should behavior frequency for “Property Damage” be scored?
- 1st: would need to verify that urinating on the mattress is behavioral and not related to a medical condition.
 - 2nd: if it is happening deliberately, would probably need to be recorded on the behavior data tracking each time the person urinates on the mattress deliberately.
22. **Stealing** - current wording includes intentional, but should the person be aware of the consequences of their actions in order to be counted here? Webster's definition of deliberate includes: resulting from careful and thorough consideration.
- a. The BASIS assessor will need to ask follow up questions to determine intent in this situation. Intent and understanding consequences will need to be determined on a case by case basis.

Question #13 regarding “as a result of behavior problems.....;

23. **Carefully Structured** - Could we get a clarification on what "carefully" structured environment means? We are getting some plans that say, "We have to keep the noise level

down" or "we can't let him watch wrestling". Are these steps good enough if they are written in the PSP? Or should there be more?

- "Carefully structured" could include steps such as: can't watch certain television programs or read certain types of magazines due to the *fill in the blank* (ex: violent, sexual, etc.) content. Most importantly the "carefully structured" must be documented in the individual's person-centered plan.

24. **Supervised Time Out:** If the person goes to time-out voluntarily do we mark "yes" for this question?

- A voluntary act is not considered time out. A time out is an aversive consequence to a behavior.

Supervised Time Out – Does this assume a specific proximity to the person in time out? (Ex: send child to room to be alone, but parent or caregiver listens outside the door and are able to respond if child has a tantrum or begins breaking items. Agencies argue that simply being in the area and listening to person is a form of supervision, even though the person they are supervising is not visible.

- If the person is sent to their room and the caregiver or paid provider must stand outside the room to ensure safety this would likely meet criteria for supervised time out.

25. If an individual resists supervision and disrupts other's activities on a daily basis but all other behaviors in Question #12 did not occur in the past year, can the screener accept an answer of "YES" for **behaviors prevent individual from moving to a less restrictive setting**? Should we consider if the person places themselves or others in danger with their behaviors in order to count for the less restrictive question?

- The screener would likely be able to answer "yes" in this situation.

Do individualized justice plans count as a **behavior plan**?

- If the IJP follows the criteria for Question #13 "behavior management plan" then it could be considered a behavior management plan.

Question #15

26. **Making a bed** – Is making a bed as simple as pulling up sheets and a comforter/bedspread, or does it involve the more intricate process of putting on a fitted sheet, top sheet, pillow case, and comforter/bedspread? There appears to be differences in how various CDDOs are scoring this question based on their interpretation of making a bed.

Suggested guidance from SRS. We can discuss this further at the next meeting.

A "made bed" could look 10 different ways for 10 different consumers. Consideration needs to be given to what is the appropriate bedding for each person. Some people do not need or want fitted sheets and there is no reason to require that there be fitted sheets on the bed. Some folks want to have a blanket and/or a comforter, others don't. In general, the sheets, blankets, etc. should be pulled up and the pillow placed at the head of the bed. Let's don't hold persons with disabilities to a higher accountability level than we would hold ourselves.

27. **Microwave or Stove** use? Should we mark the highest ability to use **ONE** of these?
- If the person can use the microwave independently we would not need to consider how independently they use the stove. It's one or the other.
28. Providers are arguing that their consumers *typically* don't do anything for themselves. Due to behaviors the parents do the activities for them.
- Question is about ability and not willingness, this is already in guidelines.
29. **For Self Care #14 & Daily Living Skills # 15** can we remove the wording "typically" and change wording to the following? **"Indicate level that the individual could presently perform each activity from start to finish, if behaviors are NOT present"**.
- This section addresses whether or not the person is *PRESENTLY* capable of doing each category. Base answers on the person's ability and not their willingness/ unwillingness to engage in these activities. Unwillingness to complete these skills will be captured in the Behavior Section of the BASIS form. If the individual's situation does not allow them to do a task on their own, then estimate their ability to do this independently.

BASIS Child Assessment – Workgroup

Purpose of the BASIS Child Assessment: The Developmental Disability Profile (DDP) is inherently biased towards children. A non-disabled or disabled child between the ages of 5 and 10 would likely score "high" in behaviors and show the need for intense support in self-care simply because of their developmental stage. The child assessment was developed to bridge the gap between the child's natural developmental stage and the DDP.

Purpose of the Child Assessment Workgroup Tool: Like the interpretive guidelines for the BASIS assessment, the Child Assessment supplement can be used as a guide for assessors. The Child Assessment Supplement will be posted to the website and will be reviewed at the Quarterly Statewide Basis Meetings.

- A suggestion was made to change how we score "*not a problem*" from one (1) to zero (0). There will not be changes to the child assessment scoring at this time. Changes may be considered after the group that is reviewing assessments across all waivers issues their final report.
- A recommendation was made to change the last field of the Child Assessment from "SC Information" to "CDDO information". Sharon Vogel volunteered to *attempt* to change the last field in the children's assessment.
- In the BASIS Handbook the "SPECIAL INSTRUCTIONS" state that the Child Supplement may be completed before or after the DDP, but both must be completed.

The main thing to consider when observing and asking the parents questions about these different developmental abilities is the age of the child. A 5 or 6 year old may not be able to do as much as a 9 or 10 year old. Plus the severity of the child's disability will play into this as well.

- 1) **Ambulation and Mobility-** How well does the child get around.
 - a. At Home and School- Can they go up and down stairs and with how much supervision? Can they climb up on furniture? (Chairs and couches)
 - b. Parking Lots and Stores- Parking blocks maneuverability. How well do they get stuff off shelves and put them in shopping carts. How well can they help in stores.

- c. Playgrounds- Ability to climb steps, ladders, go down slides, holding onto hand rails. How well do they maneuver through the surface such as wood chips or sand compared to a concrete slab.
- 2) **Fine Motor**- How well can the child use the following?
- a. Pencils, pens, colors, markers, paint brush...
 - i. How well do they draw straight lines, circles and letters?
 - ii. Can they color in the lines?
 - b. Forks, spoons and cups
 - i. Does child hold these correctly?
 - ii. Is there excessive spillage?
- 3) **Receptive Communication**- How well does the child understand what is being said to them?
- a. Understand one step directions?
 - b. Understand two step directions?
 - c. How long does it take the child to react to what is being asked?
 - i. Do they know how to show they know their name?
 - ii. Do they know how to communicate their favorite ...
 - o Color
 - o Food
 - o Toy
 - o Book
 - o TV show
- 4) **Expressive Communication**- How well does the child ask and answer questions, with age taken into consideration.
- a. What is your name?
 - b. Where do you live?
 - c. What grade are you in school?
 - d. What is the dog's name?
 - e. What game would you like to play?
 - f. Why is it cold outside?
 - g. Why is it time to go to bed, it's still light outside?
 - h. Where does Santa Claus live and how does he fly?
- 5) **Self Care**- How independent is the child with ADL's with age and severity of disability taken into consideration? How efficiently is the ADL completed?
- a. Eating
 - b. Drinking
 - c. Dressing/undressing
 - d. Bathing
 - e. Hair care
 - f. Brushing teeth
- 6) **Vision without glasses.** Child may or may not have had a vision test depending on age.
- 7) **Hearing without aid.** Child may or may not have had a hearing test depending on age.
- 8) **Social Skills** - How well does the child do the following in school, home and community settings?
- a. Make eye contact.
 - b. Make friends.
 - c. Play with others.
 - d. Appropriately affectionate.
 - e. Share toys and other items.

f. Use appropriate language.

9) **Problem Behaviors-** Does the child display the following behaviors in school, home and community settings?

- a. Self-injurious.
- b. Aggressive verbally.
- c. Aggressive physically.
- d. Destructive to property.
- e. Resists supervision/defiant.
- f. Inattentive to directions and instructions.
- g. Constantly seeking attention.
- h. Impulsive actions.
- i. Elopement risk.
- j. Pyromania
- k. Sexually inappropriate to others.
- l. Threatens/teases/provokes others.
- m. Lies/steals/cheats.

10) **Emotional Problems** - (should these also be diagnosed by Dr. or counselor?) Are the following such that it interferes with the child's daily routines.

- a. Isolation from peers.
- b. High anxiety.
- c. Withdrawn from activities.
- d. Stereotypic behaviors.
- e. Depression.
- f. Angry/Sad/Violent.
- g. Mood Swings.
- h. Undeveloped Social Skills.

BASIS MEDICAL CONDITION DEFINITIONS AND EXAMPLES - QUESTION #3

Questions:

- **How will listing of accepted Medical Conditions be updated?**
- **Will the Registered Nurse verify condition and determine the correct category before the booklet is updated?**
- A Registered Nurse met with the workgroup to verify the medical conditions and provide medical professional input.

Please refer to the **BASIS – Assessment Section for Screeners** document for specific guidance when answering question #3 regarding medical conditions. This document serves as a guide to help further define the information contained in the **BASIS – Assessment Section for Screeners** document. Please also note that this is not an all-inclusive list. There is allowance for the screener to also complete research and consultation with appropriate persons to determine where and if a condition should be captured.

Chronic conditions: For the purpose of BASIS assessments, chronic conditions must be re-occurring & documented by a physician that the individual had (4) separate occurrences in the past twelve months. THIS STATEMENT IS STILL UNDER DEBATE BY THE GROUP.

The following language exists in previous minutes and training on BASIS and some would recommend this language be used on this form in place of the yellow highlighted section: To mark a medical condition “yes” at least one of the following criteria must be met: 1) A current condition; 2) Be on maintenance medication; 3) be receiving on-going medical

care with doctor reviewing treatment at least one time per year; 4) The condition requires on-going staff support. Otherwise, mark “no”. The following is a brief explanation/example of each category; when there is doubt about whether an individual has any of these, check the medical record or interview a medical professional.

Items highlighted in green are conditions in the BASIS manual that were not previously on this list, we need to determine if it needs to be added to the list or removed

RESPIRATORY

Including, But NOT Limited to the Following:

Words Relating To:

Bronchi – the airways that branch off the trachea

- Dyspnea – shortness of breath
- Pulmonary – pertaining to the lungs

Conditions:

- Adult Respiratory Distress Syndrome
- Allergies (not seasonal) – if the individual takes a year-round, **daily** medication
- Asthma
- Bronchiectasis
- Bronchitis (Chronic) - See requirements for chronic conditions
- Chronic Obstructive Pulmonary Disease (COPD)
- Cystic Fibrosis
- Emphysema
- Fibrosis
- Goodpasture's Syndrome
- Obstructive Dyspnea
- Pulmonary Edema
- Pulmonary Fibrosis
- Respiratory Conditions (Chronic) - See requirements for chronic conditions
- Respiratory Failure
- Restrictive Dyspnea or Obstructive Dyspnea – REMOVE – Placed in list alphabetically
- Sarcoidosis
- Sinusitis (Chronic) – See requirements for chronic conditions
- Sleep Apnea (Obstructive Type)
- Tuberculosis

Conditions that DON'T fit here:

- Seasonal allergies
- Acute or single occurrences of pneumonia, respiratory infections, etc.

CARDIOVASCULAR

Including, But NOT Limited to the Following:

Words Relating To:

- Arterial – pertaining to the arteries
- Coronary – pertaining to the heart
- Pericardium – a flexible, stretchable sac that envelops the heart
- Venous – pertaining to veins

Conditions:

- Angina
- Arteriosclerosis

- Artherosclerosis – accumulation of fatty material under the inner lining of the arterial wall
- Cardiomyopathy
- Coronary Artery Disease – fatty deposits accumulate in the cells lining the wall of a coronary artery and obstruct blood flow to the heart
- Defects
 - Atrial Septal Defect (ASD)
 - Ventricular Septal Defect (VSD)
- Diseases of the Heart Valves
 - Mitral Valve Disease
 - Mitral Valve Prolapse Changed HiLt from yellow to green
 - Tricuspid Atresia
- Heart Failure – Formerly known as Congestive Heart Failure
- High Cholesterol / Hyperlipidemia – Types Are As Follows:
 - Hypercholesterolemia
 - Hyperlipoproteinemia
 - Hypertriglyceridemia
- Hypertension – high blood pressure
- Hypotension – low blood pressure
- Murmur – Must be monitored by a physician at least annually.
- Pericarditis (Chronic) – inflammation of the pericardium sac - See requirements for chronic conditions
- Peripheral Arterial Diseases – affecting arteries other than the coronary arteries
 - Buerger's Disease
 - Raynaud's Disease/Raynaud's Phenomenon
- Pulmonary Stenosis

Conditions that DON'T fit here:

- Edema- can be caused by many things besides heart, such as kidneys or medications. May be captured in other areas, i.e. special healthcare procedures.
 - Shunts / Cardiovascular Shunt – Capture the cardiovascular condition that requires the shunt.
-

GASTRO-INTESTINAL

Including, But NOT Limited To The Following:

Words Relating To:

- Digestive System

Conditions:

- Achalasia – a nerve-related disorder causing interference with the rhythmic waves of contraction that propel food down the esophagus
- Cirrhosis of the Liver
- Constipation (Chronic) / Bowel Impaction (Chronic) - See requirements for chronic conditions
- Diarrhea (Chronic) - See requirements for chronic conditions
- Colitis / Ulcerative Colitis
- Crohn's Disease - chronic inflammation of the intestinal wall
- Diverticulosis (Chronic) - See requirements for chronic conditions
- Dysphagia – an awareness of difficulty in swallowing
- Encopresis – Capture the Gastro-Intestinal condition causing this, not the behavior.
- Esophageal Obstruction
- G-Tube – Must be due to a gastric related issue. (Ex. Do not count if due to throat cancer.) If no gastric conditions exist that require G-Tube, then capture in Question #6 – Special Health Care Procedures.

- Gastroesophageal Reflux Disease (GERD) / Acid Reflux – a back-flow of stomach contents into the esophagus
- Hepatitis B, Hepatitis C
- Hiatal Hernia – a protrusion of a portion of the stomach from its normal position in the abdomen through the diaphragm
- Irritable Bowel Syndrome (IBS)
- Liver Failure
- Malabsorption Syndromes
 - Celiac Disease
- Pancreatitis (Chronic) – inflammation of the pancreas - See requirements for chronic conditions
- **Ulcers** – well-defined round or oval sores where the lining of the stomach or duodenum has been eaten away by stomach acid and digestive juices

◦ Duodenal Ulcers - <i>alphabetized</i>	◦ Gastric Ulcers
◦ Esophageal Ulcers	◦ Marginal Ulcers
	◦ Peptic Ulcers

Conditions that DON'T fit here:

- Diverticulitis
 - Hepatitis A – This is a curable condition.
-

GENITO-URINARY

Including, But NOT Limited To The Following:

Words Relating To:

- Cysto – pertaining to the bladder
- Nephrotic – pertaining to the kidneys
- Pyelo – pertaining to the kidneys
- Renal – pertaining to the kidneys
- Urethers – tubes that lead from each kidney to the bladder
- Urethra – tube through which urine passes from bladder

Conditions:

- Alpert's Syndrome
- Bladder Infection (Chronic) - See requirements for chronic conditions
- Dysmenorrhea
- Incontinence- Capture the Kidney / Bladder Condition causing the condition and not the behavior.
 - Enuresis (Bedwetting) –Capture the Kidney / Bladder Condition causing the condition and not the behavior.
- Kidney infection (Chronic) - See requirements for chronic conditions
- Medullary Cystic Disease
- Nephrotic Syndrome (Chronic)- See requirements for chronic conditions
- Neurogenic Bladder (loss of normal bladder function caused by damage to part of the nervous system)
- Polycystic Kidney Disease
- Renal Failure – a decline in the kidney's ability to clear the blood of toxic substances, leading to an accumulation of metabolic waste products in the blood.
- Renal Tubular Acidosis (RTA)
- Urinary Tract Infection (UTI) Chronic - See requirements for chronic conditions

Conditions that DON'T fit here:

- Anemia
- Gall Stones

- Having only one kidney
- Hyperuricemia

Item for Discussion: Counting diabetes- group feels that if we count in genito-urinary, we also need to count endocrine/other conditions such as thyroid gland disorders and pituitary gland disorders.

NEOPLASTIC DISEASE

Including, But NOT Limited to the Following:

Words Relating To:

- Benign – abnormal tissue growth that does not spread to other tissue
- Cysts – a closed sac-like structure filled with air or fluid that is not part of the normal tissue
- Malignant – abnormal tissue growth that does spread to other tissue, and other parts of the body
- Metastasis – movement of cells from one part of the body to another
- Neoplasm – Uncontrolled and progressive growth. Found anywhere in body or on the skin.
- Neoplastic – adjective form of neoplasm

Conditions:

- Angiofibroma- a type of tumor
- Cancers / Carcinomas including :
 - Kaposi's Sarcoma
 - Lymphoma's (Hodgkin's and non-Hodgkin's)
 - Of the body to include: every organ, eye, ear, jaw, lips, tonsils, skin and bones.
- Cysts
- Fibroid Tumors
 - Leiomyoma - Uterine Fibroid (Benign Neoplasm)
- Leukemia
- Polyps – must be diagnosed as a neoplastic disease by a physician
- Syringomyelia – Cyst within the spinal cord
- Teratoma
- Tuberous Sclerosis
- Tumors – both benign and malignant

Conditions that DON'T fit here:

- Acne
 - Boils
 - Lupus
 - Mole Mapping
-

NEUROLOGICAL DISEASE

Including, But NOT Limited to the Following:

Words Relating To:

- Central Nervous System – comprises the brain and spinal cord
- Cerebro – pertaining to the brain
- Peripheral Nervous System – the network of nerves that connects the brain and spinal cord to the rest of the body

Conditions:

- Alzheimer's Disease or Alzheimer's type symptoms* – formerly Organic Brain Syndrome
- Bell's Palsy – damage to the 7th cranial nerve which to the facial nerve
- Cerebral Aneurysm

- Cerebral Heterotopia – Brain Malformation
- Chari Malformation
- Charcot-Marie-Tooth Disorder – an inherited neurological disease
- Creutzfeldt-Jakob Disease – a degenerative and fatal brain disorder
- Dementia/ dementia with Alzheimer’s like symptoms*– if not caused by meds or other conditions
- Encephalopathy - If there is damage to brain and neurological function
- Guillain-Barre Syndrome
- Head Injuries / Traumatic brain injury (TBI) – If there is damage to brain and neurological function
- Huntington’s Disease
- Hydrocephalus - If there is damage to brain and neurological function
- Lou Gehrig’s or ALS (Amyotrophic Lateral Sclerosis)
- Microcephaly - If there is damage to brain and neurological function
- Macrocephaly – If there is damage to brain and neurological function
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Narcolepsy – a chronic neurological disorder caused by the brains inability to regulate the sleep-wake cycles normally
- Parkinson’s Disease
- Sleep Apnea – Central Type
- Stroke – also called Cerebrovascular Accident or CVA
- Tourette’s Syndrome
- Transient Ischemic Attacks (TIA’s) – small strokes
- Williams Syndrome

*Alzheimer’s disease cannot be definitively diagnosed until after death, many doctors will instead diagnose Alzheimer’s type symptoms or Dementia with Alzheimer’s type symptoms

Conditions that DON’T fit here:

- Cerebral Palsy – Capture in Section 18 (Page 1) of the BASIS Assessment
- Fibromyalgia
- Hemiparesis – Capture in Section 18 (Page 1) of the BASIS Assessment
- Hemiplegia – Capture in Section 18 (Page 1) of the BASIS Assessment
- Insomnia
- Prader-Willi Syndrome - Capture in Section 18 (Page 1) of the BASIS Assessment
- Seizures - Capture in Section 18 (Page 1) of the BASIS Assessment
- Shunts / Brain Shunts – Capture the Neurological Condition that requires the shunt
- Scoliosis
- West Nile Virus

ITEM FOR DISCUSSION: Should the following be counted in Neurological if there is documented damage to the brain and neurological function?

- Encephalitis / Encephalopathy- Caused by infectious agent, alters brain function / structure
- Hydrocephaly / Hydrocephalus (Water on the brain)
- Macrocephaly (Abnormally large head)
- Megocephaly (large brain formation)
- Megalencephaly (enlarged brain)
- Microcephaly - is a neurodevelopmental disorder (Small head & small brain formation)

**OTHER DISEASES / CONDITIONS THAT ARE NOT CAPTURED
IN MEDICAL CONDITIONS (SECTION #3) OF THE BASIS ASSESSMENT**

Discussions have been held regarding the items listed below and this is a running list.

- Acne
 - Acute or single occurrences of pneumonia, respiratory infections, etc.
 - Allergies – Seasonal
 - Anemia – Anemic (Chronic) – requiring on-going treatment
 - Boils on skin surface
 - Bone and Joint Disorders
 - Rheumatoid Arthritis
 - Osteoarthritis
 - Osteoporosis
 - Systemic Lupus Erythematosus
 - Sclerodema
 - Sjogren’s Syndrome
 - Fibromyalgia
 - Cellulitis
 - Cerebral Palsy – Capture in Section 18 (Page 1) of the BASIS Assessment
 - Diverticulitis
 - Edema- can be caused by many things besides heart, such as kidneys or medications. May be captured in other areas, i.e. special healthcare procedures.
 - Endocrine Disorders
 - Thyroid Gland Disorders
 - Pituitary Gland Disorders
 - Fibromyalgia
 - G-Tube – Must be due to a gastric related issue. (Ex. Do not count if due to throat cancer.) If no gastric conditions exist that require G-Tube then capture in Question #6 – Special Health Care Procedures.
 - Gall Stones
 - Gout
 - HIV / AIDS
 - Hemiparesis – Capture in Section 18 (Page 1) of the BASIS Assessment
 - Hemiplegia – Capture in Section 18 (Page 1) of the BASIS Assessment
 - Hepatitis A – This is a curable condition.
 - Hyperuricemia
 - Insomnia
 - Kidney – having only one kidney
 - Lupus - Skin Condition
 - Mole Mapping
 - Prader-Willi Syndrome - Capture in Section 18 (Page 1) of the BASIS Assessment
 - Pre-Diabetes
 - Psoriasis
 - Scoliosis
 - Seizures - Capture in Section 18 (Page 1) of the BASIS Assessment
 - Shunts / Brain Shunt / Cardiovascular Shunt – Capture the condition that requires the shunt.
 - West Nile Virus
-

Still need to be addressed:

- Should the definition for chronic condition continue to be part of the medical clarification?
- Debate on whether or not we can alter the BASIS manual. Can we add to that list, take away from that list?
- Other items on the list that haven’t been discussed
- “Identified Disability” need clarification on how/why things get marked here.

Feedback from last roundtable:

- Migraines- can count if meets chronic criteria
- Hydrocephalus- ask questions from guidelines to determine if it meets criteria.

Next meeting date/time: August 6th, 2009 – 9:00 a.m.

STATEWIDE BASIS COMMITTEE

Meeting Minutes

1/29

(DIXIE WILLIAMS)

January 19, 2009 0900hrs. Meeting was called to a close at 1200hrs

Present: All CDDO's were present

Next meeting: April 30, 2009, 0900hrs, (meeting will be via phone, Greg W. will send notification with call-in information)

Minutes taken by: Brandi Loudermilk, SPE Coordinator Sedgwick County CDDO

I. Announcements / Roll

There were no formal announcements to be discussed at this time. The official roll was taken by Greg Wintle, all CDDO areas were present.

II. Discussion

Meeting was called to order and items discussed were as follows:

Agenda Items for January 2009 Conference Call

General:

Is Down Syndrome considered its own Identified Disability or is it considered as a MR diagnosis. If someone has Down Syndrome we have been marking that they have MR and just writing to the side on the hard copy that they have Down Syndrome. Some do not have an MR diagnosis or Full Scale IQ to determine where their intellectual assessment would fall: mild, moderate, severe, or profound. If MR is marked BASIS will not let you put undetermined. Where should Down Syndrome be counted on the Information Section question #18, MR or other identified disability?

ANSWER - If an individual is diagnosed with Down Syndrome, the information section question #18 should be marked as other. Down Syndrome is considered to be its own identified disability.

Is there some way that we can get an updated list for Gatekeeping purposes to show CDDO contact people. (Who to call for courtesy Basis – who to send information to for Gatekeeping) ?

ANSWER – Mieke Ellwood will take the lead on this issue and get all needed information from CDDO directors. After a contact list is comprised Mieke will send the list to all individuals on Greg Wintle's Statewide Basis Committee contact list.

Child Assessment:

At the bottom of this form it asks for Service Coordinators Name (CM). In Johnson County the BASIS Assessors complete these forms. Would it be appropriate for the Assessor to list their name in that area, instead of the Case Managers name?

ANSWER – The assessors name should go on the bottom of the form instead of the TCM name. Greg Wintle will try to find an electronic copy of the form and make the necessary changes. Effective immediately, it is okay to put the assessors name and title on the bottom of the page.

Information Section:

Day Programs –

7 & # 8 of this section – Can we add the wording “**Wages Paid**” to the description for this one. Since it is not listed, we are having discussions with Case Managers that believe that volunteer work should be counted here as well.

ANSWER – After a group discussion, it was decided that there is not a need to change the wording. The minutes have now been documented to verify that competitive employment has the same meaning as “wages paid”. Volunteer work should be listed as “other” and will not be included in #7 and #8 under question #17 in the information section.

Assessment Section:

Question 3:

Can migraines be counted as a neurological disease on question #3? The Case Manager who asked me about this asserts that it should be counted if diagnosed as a disease and a neurologist is seen for the condition.

ANSWER – After a group discussion, it was decided that Mieke Ellwood would take this issue to the Medical Conditions Small Workgroup and report back to our group. This issue will be discussed at a later meeting.

Where are other screeners counting Hydrocephalus? Neurological disease or Identified Disability?

ANSWER- After a group discussion, it was decided that Mieke Ellwood would take this issue to the Medical Conditions Small Workgroup and report back to our group. This issue will be discussed at a later meeting. Current guidelines will stand until there is other information given to change that. Hydrocephalus is on the list of neurological diseases that was given to all areas during a past meeting and should be marked as neurological disease until further notice.

Question 12:

First, for question 12, does the behavior have to be intentional (example: person puts his hands in his pants/grabs self, but not intentionally sexually inappropriate, does that count?)

ANSWER – Regardless of intent, if the behavior is of a sexually inappropriate nature, beyond socially appropriate and requires staff support, it should be marked as sexually inappropriate behavior.

In Shawnee County we have had the question come up in regards to running and wandering away when they can only walk with the assistance of another person.

ANSWER – Following posting procedures, the guidelines will be modified to reflect the change voted and agreed on. The change will read as follows to assist in answering the above question; “Running/Wandering away – repeatedly and deliberately or inadvertently leaving program area, group activity or living area and requires staff support to insure the persons health and safety.”

How should behaviors be tracked for individuals that live alone and have only minimal staff support or if the behavior was not observed by staff or family, but a roommate (consumer) reports that a behavior occurred over a weekend?

ANSWER – Consumer self reporting is okay to use as a form of tracking data. If the behavior is self reported to the TCM or any other staff by the consumer, it must be tracked in the form of an incident report or some other form of data tracking. It is also okay to track calls or reports from community partners or anyone else that can provide accurate information regarding the consumers behavior observed.

How are CDDO's completing BASIS one month ahead, since we need to collect and calculate the past 12 months of behavior tracking data ? Example: If the birth month is in December do you request behavior tracking data from Dec 1st thru Nov 30th.

ANSWER – Twelve months of data is used to complete the assessment using the 12 calendar months prior to the month that the assessment is completed.

Question 13:

One-on-one supervision. Should we request documentation? Or do we accept verbal report that it is being done?

ANSWER – Documentation should be requested and turned in before the assessment, at the time of assessment or turned in according to the time frame that your particular CDDO requires all information regarding assessments to be turned in. Current guidelines are as follows and should be followed to be considered one-on-one supervision:

- **Because of behavior problems, the individual requires one-on-one supervision for many program activities**. - Consider the following information when answering the last item. One-on-one supervision is one individual being provided direct services by ONE staff person who has no other responsibilities except to be with, support and provide direct care support and services to that individual.

Many is defined as:

- (a) consisting of, or amount to, a large but indefinite number
- (b) a large number of persons or things. Use your judgment, but typically 50% of the waking hours is a reasonable amount

The new guidelines do not state that physical intervention on question 13 has to be documented to count. I have had it come up a couple of times where staff were body blocking but not documenting it. They wanted it to count, because the new guidelines don't specifically state that they have to show documentation and it isn't in the minutes anywhere.

ANSWER – After much discussion, we the committee did not come to a clear consensus on this issue. All committee members will discuss this issue with staff and other area assessors and we will re-visit this issue at the next roundtable meeting.

III. Workgroup updates

Medical Conditions Small Workgroup –

- Mieke Ellwood reported that this group will meet Tuesday February 3, 2009 and will have information to present at next meeting.

Child Assessment Small Workgroup –

- Paul Heidrick reported that his workgroup will have more information to report at the next meeting. More information to follow will include amending the current form in some areas as well as more detailed guidelines.
- There was a question as to whether or not the point system could be reversed for “don’t know” and “no problem”. Changes will be brought to SRS for approval.

ADDITIONAL QUESTIONS DISCUSSED -

1. Please clearly define for us what the difference is between a Neurological Condition & a Neurological Disease. This is something that certain service providers question at every Basis Mtg.

From the Dictionary of Developmental Disabilities:

A disease is: Literally, "without ease" or "uncomfortable." A failure of an organism to adequately adapt to stress, resulting in a disturbance in structure or function. A disease is a definite entity with a (usually) single cause (even if unknown) and recognizable signs & symptoms from which it can be diagnosed.

From Tabers:

A disease is: A **Condition** (added for emphasis) marked by subjective complaints, a specific history, and clinical signs, symptoms, and laboratory or radiographic findings. The concepts of disease & illness differ in that disease is usually tangible or measurable, whereas illness (and associated pain, suffering, and distress) is highly individual and personal. Thus a person may have a serious but symptom free disease (e.g. hypertension) without any illness. Conversely, a person may be extremely ill (e.g. with PTSD) but have no obvious evidence of disease.

Examples to consider: Encephalopathy, hemiplegia, Neurodermatitis, Hydrocephalus

Some service providers are arguing that anything related to neurological system should count because the definition of **disease** includes the word **condition**.

ANSWER – Stating that a disease is a condition is taking the definition completely out of context.

2. Please discuss what "receiving ongoing medical care with the doctor reviewing treatment at least one time per year" means specifically.

What is ongoing medical treatment. Recently a service provider was struggling to provide documentation of treatment for medical conditions they wanted to count. It seemed to the screener these fell more into the category of "medical history." Now the provider has developed a generic form where they fill in all of the individuals medical information from their records & are having the doctor sign it prior to the basis assessment. The form says "The following is a list of the persons current * active diagnosis's. Then at the bottom of the form in very small print it says * Active* defined as a disease currently being treated by Primary Pysician & Healthcare Team for the identified individual. It seems the provider does not want to provide documentation of the specific treatment being provided.

Does there have to be a specific medical treatment or does "montioring" of past medical issue suffice?

ANSWER – The current guidelines are clear and will stand. The guidelines are as follows:

MEDICAL CONDITIONS – Indicate 1-Yes or 2-No for each of the following:

To mark a medical condition „Yes“ at least one of the following criteria must be met: 1) be a current condition, 2) be on maintenance medication(s), 3) be receiving on-going medical care with doctor reviewing treatment at least one time per year, 4) the condition requires on-going staff support. Otherwise, mark „No“. The following is a brief explanation/example of each category; when there is doubt about whether an individual has any of these, check the medical record or interview a medical professional.

Documentation should be available that the person has been receiving on-going medical treatment as part of a treatment plan prescribed by a physician.

IV. Additional information discussed

- If an individual has a medical condition that does not allow them to attend services due to extreme cold or extremely hot weather, can that be marked as yes on the assessment as missing a total of 2 weeks of regular activities (#6). It can be marked as yes if they missed 14 calendar days due to the medical condition and actual medical problems.
- There was a question as to if we were going to cut out using the manual and only use meeting minutes. The response was; section 2 of the manual is current and currently being used. Minutes are updates to the manual.
- Greg Wintle reminded all CDDO's that they need to pass information to all providers when there is a change. When information is posted to the SRS website it is official and listed according to posting dates and implementation dates.
- During the meeting Greg Wintle sent out a copy of the current guidelines with minutes included. The guidelines are attached.
- Next meeting date and time: April 30th, 2009 @ 0900hrs

Meeting adjourned at 1200hrs

Statewide BASIS Assessment Committee
Regular Meeting Minutes
July 30, 2008, 1:00 p.m.

Greg Wintle from SRS welcomed all. Introductions were made around the room. Greg referred all to Appendix F of the CDDO contract which created the committee and lays out its charges. Copies were available.

1. The first item of business on the Agenda was to select a Chair. Greg opened the floor to nominations. Linda P. nominated Paul H. There was also a nomination for Mieke E. Dixie moved to close nominations. Votes were tallied with two votes per CDDO. Voting was tied 22-22. Paul and Mieke elected to Co-Chair jointly and moved to the front table.
2. Next on the Agenda was to decide on "minute-keeper" responsibilities. Greg asked for a volunteer to take minutes currently and for ideas on how to decide on who takes them for future meetings. Cowley County volunteered for the day. After discussion and considering DPOK took them at the previous Roundtable, the minutes will be taken by the agencies on list in order, starting with Cowley County and working upwards. Therefore, Cottonwood will be responsible for minutes at the next meeting.
3. Next on the Agenda was to review the BASIS Assessment Section for screeners document. Greg gave a quick review of the document stating that the one Committee Member received for the meeting was reviewed at a BASIS Roundtable in 2007 and includes information from a training held in 2006 and also some additional information taken from the minutes of previous Roundtable discussions.

Mieke suggested all look at 1.b. of Appendix F which discusses the posting of information. She stated this was an important tool which should be posted on the website, readily available for all.

There was a brief discussion on why the new manual was not currently available yet. Greg answered there were some delays as they are waiting for the new BASIS program to be completed but he would see this Assessment Section guidelines be posted as a separate document. There was a question on why the April Roundtable Minutes were not yet available on the website. Greg answered he had been unable to get them posted to date.

The Committee discussed where and when this document should be posted. As Appendix F refers to a 30-day review period Greg suggested it be posted with a "revision" or "posting" date and an "implementation" date. All agreed. It was also agreed everyone felt all of the information should be posted in one place on the website. Greg said they may remove the Roundtable link and put all posted information with the manual.

There was also a discussion on the difference between the minutes from the Roundtables and the Assessment Section guidelines. Greg said some of the information from the minutes was incorporated into the Assessment guidelines but not all. All agreed the Assessment guidelines are instructional and the minutes considered as a resource for odd-occurring issues and are considered “appendixes” to the manual itself.

Mieke recapped Agenda item saying all agreed Assessment Section guidelines will be used by all, they will be posted all together on the website and will include a “posting” and “implementation” date. Greg asked all to give SRS time to get website updated.

4. The next Agenda item was a review of the BASIS General Guidelines. Greg gave its history saying a couple years previously, the contract stated General Guidelines needed to be addressed and it was created. He said there was a small group formed from the BASIS Roundtable participants who worked on its creation and it was then approved at a Roundtable in July of 2007. He said the intent was to incorporate them into the manual as many thought there should be more structure in the process of completing an assessment. As it is final form it was discussed and agreed by all it too will be posted on the website with the other information. There was one question asking if the appeal and special assessment section still reflected current procedure. Greg stated it did.
5. The next item was to develop criteria for committee action. There was a lengthy discussion by the committee on this topic. Many expressed they thought this committee was going to take the place of the Roundtable, and therefore the small and odd issues the Roundtable previously discussed amongst themselves would be incorporated into the Committee meetings. Others felt there should be two separate groups even though the members of both would basically be the same.

Some felt by having only the Committee discuss what would be considered Roundtable items it would not give Affiliates or other agency screeners a chance to participate, when others felt each CDDO could gather questions, comments, and suggestions in-house, and bring them to the Committee meetings, then provide their own training afterward.

Also up for discussion was the method of meeting choice; either by teleconference, physical meetings, or a combination of both. Other suggestions up for consideration: time block for meetings, how often meetings needed to be held, how and when to gather agenda items and decide which “group” should handle them, and the role of both the Committee and BASIS Roundtable group.

After a break, Mieke broke down the following for Committee approval:

1. The next quarterly meeting would have a three-hour time block and be conducted by conference call.

All agreed to this format for the next meeting.

2. Criteria would be as follows:

- a. The Statewide BASIS Assessment Committee would handle all items pertaining to any changes, amendments, or additions to the state-wide Assessment Section guidelines.
- b. Anything considered discussion or not requiring any change would be considered items for the Roundtable.

All agreed to these criteria.

3. Decide whether to:
 - a. Have two separate groups: one Roundtable and then the Committee.
Or,
 - b. Incorporate the Roundtable discussions into the Committee by adding it as a line item and inviting anyone who wishes to participate to join at that time.

Janet made a motion to incorporate the Roundtable discussions into the committee by adding it as a line item to the agenda. Cindy seconded. All voting members voted by hand. Majority approved the motion.

Dates and times were discussed for the next quarterly meeting. It was set for Thursday, October 30, 2008, from 9:00 a.m. to 12:00 p.m. by teleconference. Mieke stated teleconference and agenda instructions will be sent out prior to this date. All agreed each agenda items would be sent in ahead of time and Greg, Paul, and Mieke would determine where they would be placed on the agenda; either for Committee action, or Roundtable discussion.

6. Next on the Agenda was discussion on an issue presented to Carrie by one of her Affiliates. They felt there should be more health related questions to address those on oxygen, respirators, and other such items. She explained currently there is only the option of "yes" or "no" on the questions asking if those providing care need training for specific health care procedures, but if someone utilizes more than one specialized equipment, there is no additional weight added to the BASIS. After discussion it was agreed the BASIS could not address everything and if there is needed cost of additional staff the service provider should ask for Extraordinary Funding.

After discussing other health issues such as there being nothing to address skin issues, there was a brief conversation of 1.b. of Appendix F which talks about the Committee looking at other level of care determination practices, assessments and the efforts of those working on the Systems Transformation Grant. It was agreed these were all issues to look at and it was decided an update on those working on the Systems Transformation Grant would be added as an agenda item to each subsequent meeting.

Greg was asked if the new BASIS addressed the Child's Assessment or if any interpretive guidelines were available for it. He answered it was discussed by the BASIS Enhancement Committee but only that it needed to be completed and entered in the system. He said he is not aware of anyone appealing the outcome of one but if the group

feels it needs to be addressed, we can add it to a later agenda. This will be done. All agreed documentation should be used to complete the form and when in doubt, always answer with the higher score.

7. The last item on the agenda was from Ben for the group to discuss Syringomyelia and determine whether it should be addressed as neurological or neoplastic. After discussion it was agreed it could only be marked under one which should be neurological.

Greg asked if anyone had any other items to discuss. They did and are as follows:

Dixie asked how West Nile Virus should be addressed on BASIS as they have two individuals with it who are both experiencing neurological problems and seeing a neurologist who has yet to give a specific diagnosis. After discussion and input from one member who had a horse who had contracted the disease, it was agreed West Nile is a virus that would eventually go away and any changes to the level of care would be addressed in various sections of the BASIS. It was also agreed neurological probably should not be marked until an actual diagnosis was given by the doctor. More information may be brought to the next meeting.

Someone asked about strokes and whether they should be marked neurological or cardiovascular. It was agreed to mark it under neurological as long it met the requirements of a medical condition which included on-going monitoring and medication.

There was a brief discussion on whether a condition had to be degenerative to be marked under neurological. Previously the Roundtable had decided it did.

Penny asked if everyone counted adaptive utensils under the question asking about special health care procedures. All stated they did as the manual states they can be included. The need for utensils to be included here was brought up and it was decided this could be added to an agenda for the Committee to review.

Someone asked if "Bi-Weekly" would be added as a frequency for behaviors as many are more than weekly but less than monthly. Most agreed they err on the side of the consumer, giving a higher frequency when it is close. Greg said they should be answered in accordance to which frequency's criteria the data meets so if it is less than weekly but more than monthly, it meets the criteria to answer monthly and should be answered accordingly.

Someone said their case manager's have asked who is responsible for documenting behavior data for those who get case management only. Most said they have their case manager's document what they see and count self reported documentation if they have it but all agreed most under those circumstances will not have significant behaviors to begin with.

Reminder: The next meeting is scheduled for October 30, 2008, at 9:00 a.m. by teleconference. Meeting adjourned.

Recorded by: Darcie Darby, Cowley County Developmental Services, Inc.

BASIS Roundtable Meeting Minutes

Provided by DPOK, Inc.

January 20, 2008 10:00am – 12:00pm

Attendance: Greg Wintle, HCP, and all Community Developmental Disability Organizations with exception of New Beginnings.

Agenda:

- List of discussion topics submitted by CDDOs, emailed to participants on January 28, 2008.
- Document "General Guidelines for BASIS Assessors" to be added to new BASIS Manual.
- If time, additional questions/comments/suggestions.

DISCUSSION: CDDO submitted topics with Roundtable discussion outcome as follows:

1. Does Incontinence count under Genito-Urinary? It could be considered behavioral or as a daily living skill that requires lots of support, but is it ever acceptable to be captured under #3?

Workgroup decision: In order to count under Genito-Urinary, there must be a documented medical condition.

2. Should Tourette's Syndrome be counted under #18 Identified Disabilities, or under #3 Neurological Condition?

Workgroup decision: Should be counted under #3 Neurological Condition.

3. Can Prader-Willi be captured under Neurological Conditions?

Workgroup decision: Agreed to capture on Information page under #18 Identified Disabilities and any associated behavioral issues would be addressed within the assessment.

4. Does Fibromyalgia count as a Neurological Condition?

Workgroup decision: Agreed this would NOT be captured as Neurological Condition.

5. Can Shunts be counter under #3 and #6?

Workgroup decision: Would not be counted on assessment page under #3 “Medical Conditions” as is part of the treatment for a condition and not a condition itself. Could be captured on assessment page under #6 “Medical Consequences” if medical issues as a result of the shunt arise.

6. October roundtable minutes not appearing on the website:

- a) How would people who didn't attend know what was discussed?
- b) We would like to have had some mention of the discussion about advising participants at each screening (for CDDOs not currently doing this) after an agreed upon date (1/1/08 was discussed) that documentation pertaining to behavior frequency in questions #12 would be required at the next annual assessment.
- c) Having rotating note takers at each roundtable to capture items discussed for purposes of submitting to you for inclusion on the website.

Workgroup decision: The October roundtable minutes did not appear on the website because that meeting was a review of the BASIS Manual thus any outcomes of that meeting would be part of the manual. The importance of having each and every meeting documented was discussed and thus (for items a & c above), the decision was made to rotate minutes takers alphabetically. These minutes would then be forwarded to Greg W. for inclusion on the website. DPOK, Inc. volunteered for this round, thus it was decided to start alphabetically with them.

For item b above, regarding behavior frequency data for assessment question #12, the consensus was that for any CDDO that did not already collect data, or implement a process for collecting data, they would start immediately notifying ALL participants at an individual's BASIS meeting that frequency documentation for each question in #12 would need to be presented for the following year's BASIS assessment and every year thereafter.

7. Issue of some CDDOs not releasing BASIS screenings to other CDDOs.

Workgroup decision: This appears to be an isolated incident that needs to be worked out between the CDDOs involved. Other CDDOs report not having this issue.

8. The individual being screened has started demonstrating some very unusual behaviors, most notably storing urine in soda bottles (as far as they know not injecting). Staff were wondering where that would fit in BASIS? The only way I could think to mark it was to count the amount of assistance needed for toileting as supervision. I would like input from other screeners as to how they would count this type of behavior.

Workgroup decision: Not addressed through assistance needed for toileting, but rather as part of behavior questions in #12 – resists supervision.

9. I know we've discussed the issue of Thyroid before, but as I do the BASIS, there are so many individuals with this problem that it seems like we really do need to be able to show it on the medical section. Since endocrinologists are the specialists that treat both diabetes and thyroid, could we put thyroid as a Genito-urinary problem?

Workgroup decision: NO – Thyroid would not be counted as a Genito-Urinary condition.

10. #6 on the assessment. Presently requires special diet planned by a dietitian etc. It seems all our agencies now have a form signed annually by a dietitian that lists standard nutritional guidelines but will add a statement such as low sodium or high calorie, etc. I know I have asked this before and was told "you can mark yes if it takes more support for that persons diet than normal". I just wanted to know how others were handling the whole diet thing and what kind of documentation they were requiring.

Workgroup decision: After much discussion there was no resolve. Many CDDOs have decided to stop battling over this one, and accept as long as documentation exists to support. Discussed that this should also be described in the individual's person-centered support plan. Greg was going to discuss with Margaret, who is an RN, as well as other HCP staff to ask for input.

11. Regarding behavior tracking data/forms... what are the consequences for providing false information? Should the tracking forms have a place for a signature/date which states the following or something similar:
12. "I certify that by signing this document, the data tracking that is listed above is true and accurate and in accordance with the Behavior Tracking Guidelines. I understand that any false information that is reported on this form will be considered fraudulent and is subject to ANY and ALL Federal, State & Local Medicaid Fraud Laws".

Workgroup decision: *There was encouragement in general to check an individual's person centered support plan to see if data is consistent with information contained in the plan. Outside of that it was felt that we were not prepared to address this at this time.*

13. Must a Neurological condition be degenerative in order to be counted?

Workgroup decision: *This issue was tabled. Greg offered that we would discuss further in a future meeting if someone wanted to look at the conditions currently listed to see if this was currently the case.*

14. Why is Diabetes counted under Genito-Urinary? Research via the web from Wikipedia & the American Diabetes Association suggests that it does not fall in the category. Diabetes & Thyroid condition are both caused by the endocrine system which is not listed as an option under Medical Condition.

Workgroup decision: *For unknown reasons, Diabetes has always been captured under Genito-Urinary as stated in the BASIS Manual. For many reasons, it was agreed upon to leave it as it is and count Diabetes under Genito-Urinary condition.*

15. If a person is color blind, then would you capture that as an impairment under vision? If so, to what degree, Mild...?

Workgroup decision: *Agreement that there are additional questions that need to be asked to determine the level of impairment IF indeed it causes some kind of impairment.*

16. If a parent stocks a pill box, but the consumer lives alone and taken his medication from the pill box daily without assistance or reminders then would this be counted as _____ for level of support regarding medications. This scenario is similar to the medication bubble pack, which we now count as "Independent" regarding level of support.

Workgroup decision: *Consensus was that the scenario as described would be "Independent", just like the bubble pack.*

DOCUMENT REVIEW "General Guidelines for BASIS Assessors":

Greg explained that much of this document was designed to meet contract language, and once complete, it will become part of the new BASIS Manual. There were no objections to accepting it as is and BASIS assessors are to have with them and implement immediately if haven't done so already.

ADDITIONAL QUESTIONS/COMMENTS/SUGGESTIONS:

1. Polyps – An individual is wanting to count this as Neoplastic?

Workgroup Decision: Polyps is NOT neoplastic unless specifically diagnosed as such by a physician.

2. Scenario presented of an individual that lives in own apartment/home. This individual takes food and hides it, removes screws from cabinet doors to get inside, is self-abusive. Question is if stealing ones own food (since he lives alone) could be counted under assessment question #12 related to behavior "steals".

Workgroup Decision: The food stealing for this particular scenario would be captured under "resists supervision" and NOT "steals".

Next Meeting Date: **Conference Call**
Thursday, April 24, 2008 @ 10:00AM

Next Meeting Minutes Taker: **Flinthills**
DSNWK gets a BYE for helping with recent minutes.