SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES

Intellectual and Developmental Disabilities (IDD) program (formerly referred to as DD/ID)
(Effective Date February 1, 2015, updated 5/12/2021)

I. Service Description

This service standard applies to the program and services provided to children placed in residential programs approved by DCS as an Intellectual and Developmental Disabilities (IDD) program. This program provides highly structured, intensive services to children with intellectual and developmental disabilities, including autism spectrum disorders. These children and their families may also be affected by physical abuse, sexual abuse, emotional abuse, and/or neglect. It is expected that other behavioral/emotional issues will be addressed in the course of treating the abuse or neglect. In addition, counseling may be provided to address family or youth issues that resulted in the involvement of juvenile probation.

II. Service Delivery

Therapeutic Services

Residential providers will be expected to adopt and utilize evidence-based treatments that best suit the needs of children with developmental and intellectual disabilities. Providers may choose a range of evidence-based models, approaches and interventions; however, the most commonly accepted approaches with this population are behaviorally based.

Targeted Population

F) Responsibilities for Behavioral Health Services (from the 2021 residential providers contract)
"**1. (b)** any behavioral health services provided by the Contractor, its subcontractors or agents shall be provided in accordance with all Medicaid requirements (if the service is Medicaid billable), the Provider Manual and the most current version of DCS Service Standards for behavioral health services in a residential setting ("Service Standards") applicable at the time services are rendered."

The Center for Medicaid and Medicare Services (CMS Manual) states: "Intellectual Disability (AAIDD)(2013)** An individual is determined to have an intellectual disability based on the following three criteria: intellectual functioning level (IQ) is below 70-75; significant limitations exist in adaptive skill areas; and the condition is present from childhood (defined as age 18 or less)."

Due to the need to find the most appropriate placement for a child, when seeking residential treatment for a child with a Full Scale IQ below 70, referral sources should seek a placement with a program licensed for IDD. If a child has a Full Scale IQ between 70 and 75 but also has significant limitations in adaptive skill areas, consideration should be given as to the primary presenting treatment need and whether that need can be more effectively met in an IDD program, or another specialized licensed program with accommodation for differences/deficits in learning and literacy.

Population-Specific Competency

Residential providers will be expected to implement a comprehensive training program to ensure that all staff who work directly with the youth demonstrate population-specific competency (i.e., are competent to work with youth with IDD).

Qualified Intellectual Disabilities Professional (QIDP) *(formerly known as QDDP)*

Each child's active treatment program must be integrated, coordinated and monitored by a Qualified Intellectual Disabilities Professional (QIDP).
A QIDP is a person who has specialized training or one (1) year of experience in treating youth with IDD, and is one (1) of the following:

(1) A licensed psychologist.
(2) A licensed doctor of medicine or osteopathy.
(3) An educator with a degree in education from an accredited program.
(4) A social worker with a bachelor's or master's degree in social work from an accredited program.
(5) A person with a bachelor's or master's degree in a human services field other than social work and at least three (3) years of social work experience under the supervision of a qualified social worker or at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities.
(6) An occupational therapist who:
a) is a graduate of an occupational therapy curriculum accredited jointly by the council on medical education of the American Medical Association and the American Occupational Therapy Association;
b) is eligible for certification by the American Occupational Therapy Association under its requirements in effect on September 29, 1978; or
c) has two (2) years of appropriate experience as an occupational therapist and has achieved a satisfactory grade on the approved proficiency examination, except that such determinations of proficiency shall not apply with respect to persons initially licensed by the state or seeking initial qualifications as an occupational therapist after December 31, 1977.
(7) A speech pathologist or audiologist licensed pursuant to IC 25-35.6-3.
(8) A registered nurse licensed pursuant to IC 25-23-1-11.
(9) A therapeutic recreation specialist who is a graduate of an accredited program.
(10) A rehabilitative counselor who is certified by the Committee of Rehabilitation Counselor Certification.
(11) A physical therapist that is licensed pursuant to IC 25-27.
(12) A person with a master's degree in psychology from an accredited program.

The QIDP ensures:

- service design and delivery which provides each child with an appropriate active treatment program;
- that any discrepancies or conflicts between programmatic, medical, dietary and vocational aspects of the child's assessment and program are resolved; and
- a follow-up to recommendations for services, equipment or programs.

Comprehensive Functional Assessment

The facility must complete a developmentally based comprehensive functional assessment within 30 days of admission. The comprehensive functional assessment must yield data that is accurate, reflects the current status and needs of the individual, and can serve as a functional basis for an IPP to be developed.
The comprehensive functional assessment must address the child's:

- Physical development and health;
- Nutritional status;
- Sensorimotor development;
- Affective (emotional) development;
- Speech and language (communication) development;
- Auditory functioning;
- Cognitive development;
- Vocational development;
- Social Development; and
- Adaptive behaviors or independent living skills.

The functional assessment must also identify the child's:

- Specific developmental strengths, including child preferences;
- Specific functional and adaptive social skills the child needs to acquire;
- Presenting disabilities, and when possible their causes;
- Need for services; and
- Specific developmental and behavioral management needs.

At least annually, the comprehensive functional assessment of each child must be reviewed by the interdisciplinary team for its relevancy and updated, as needed.

Treatment Plan/Individual Program Plan (IPP)

An initial treatment plan for each child, which must be completed within 7 days of admission, must address the child's immediate needs and meet the requirements of 465 IAC 2. Subsequently, within 30 days of admission the Treatment Plan must be updated to meet the requirements of an Individual Program Plan (IPP).

The IPP must include opportunities for the child's choice and self-management and must identify:

- the discrete, measurable, criteria based objectives the child is to achieve;
- and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed.
- The IPP must be directed toward the acquisition of the behaviors necessary for the child to function with as much self-determination and independence as possible.
- The IPP must state the specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment and the planned sequence for dealing with those objectives.
- These objectives must be stated separately, in terms of a single behavioral outcome;
- Be assigned projected completion dates;
- Be expressed in behavioral terms that provide measurable indices of performance;

- Be organized to reflect a developmental progression appropriate to the child; and
- Be assigned priorities.
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Until it has been demonstrated that the child is developmentally incapable of acquiring these skills, the IPP must also include, for those children who lack them, training in skills essential for privacy and independence including, but not limited to:

- toilet training
- personal hygiene
- dental hygiene
- self-feeding
- bathing,
- dressing
- grooming
- communication of basic needs
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Prior to implementation, each objective on the IPP shall have a written training program designed to facilitate the child's achievement of each objective. Objectives may be implemented based on priority. Each written training program must specify:

- The methods to be used;
- The schedule for use of the method;
- The person(s) responsible for implementing the program;
- The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
- The inappropriate client behavior(s), if applicable;
- Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

Except for those facets of the Individual Program Plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

The individual program plan must be periodically reviewed, at least by the QIDP, and revised as necessary in situations in which the client has successfully completed an objective or objectives identified in the individual program plan, is regressing or losing skills already gained; is failing to progress toward identified objectives after reasonable efforts have been made or is being considered for training towards new objectives.

The IPP must also identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The IPP must also include generalization of skill training to the community when safe and appropriate.

Intensive Behavioral Intervention

Intensive behavioral intervention (IBI) services shall be provided to children placed in residential programs approved by DCS as an Intellectual and Developmental Disabilities (IDD) program when the children exhibit behaviors that decrease the child's quality of life, independence and meaningful participation in the community. Generally, IBI services address manifestations that are amenable to

change in response to specific, carefully programmed, constructive interactions with the environment. IBI services are a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of the child's treatment needs. The primary goal of IBI services is to reduce behavioral excesses, such as tantrums and acting out behaviors, and to increase or teach replacement behaviors that have social value for the child and increase the child's access to their community. Program goals are accomplished by the application of research based interventions.

Behavior Support Plans

IBI services that are provided to a child shall be described in a Behavioral Support Plan (BSP). The BSP is developed based upon the belief that all behavior has purpose and meaning for the individual. This belief requires a BSP that is the result of a careful and deliberative process conducted by qualified persons. The BSP is a component of the IPP. The BSP will suffice for the requirement for goals for "any specialized services, such as counseling" required for the Treatment Plan by 465 IAC 2.

To develop the BSP, the agency shall obtain information potentially associated with the unwanted behavior from assessments of the child including but not limited to:

- medical/health assessments;
- meaningful day assessments;
- environmental assessments;
- psychiatric assessments;
- other assessments such as speech and language when communication difficulties play a role, as indicated for the individual.

Also, as a part of the development of the BSP, the agency shall perform a functional behavior assessment utilizing:

- a review of records including information from all assessments;
- interviews with knowledgeable informants; and
- direct observation of the child.

The functional behavior assessment shall be reviewed annually at minimum and be either updated to accurately reflect the hypothesized cause or function of the individual's behavior or confirmed that the assessment continues to accurately reflect the function of the individual's behavior.

A Behavioral Support Plan shall include:

- identifying information for the child;
- operational definition for alternate or replacement behaviors to be increased or taught;
- alternate or replacement behavior objectives;
- data collection instruction for alternate or replacement behaviors to be increased or taught;
- operational definition for targeted behaviors to be decreased;
- data collection instructions for targeted behaviors to be decreased;
- pro-active or preventative strategies;
- re-active or de-escalation strategies;
- identification and signature of the author; and

- when indicated, the signature of the child, the child's legal guardian and the signature of the referral source.

If the BSP incorporates restrictive interventions, the BSP must have approval of the legal guardian/ referral source prior to implementation. Use of restrictive interventions in a BSP shall be in compliance with 465 IAC 2.

The facility shall monitor the BSP and adjust and readjust the individual's environment and BSP as necessary in attempts to minimize the unwanted behavior. The BSP shall be assessed by the facility on a regular basis, with at minimum monthly reports to the legal guardian or referral source of progress.

All persons working with the child shall implement the child's BSP. The facility shall provide competency based training on the child's BSP to all persons working with the child prior to these persons beginning to work with the child.