Frequently Asked ICAP Questions

Birth Date. I have one person on my caseload that does not have a certified birth certificate in their file. However, she does have a passport (but it is expired). We have been working on getting her an actual birth certificate for a while but the state in which she was born states that they don't have a record of her birth. Her family also says this is where she was born. Her Mom passed away a few months back but with visiting with her sister, she says they have always used their passports as their birth certificates since their birth certificates were destroyed in a fire at a young age. Would you count her expired passport as proof of her age for now? I will keep trying to get her birth certificate, but I really don't think we would have it back by the time of the review if she was pulled. To get a passport they had to present a valid birth certificate. An invalid passport will not work for validation of the ICAP.

Birth Date. I have a person that doesn't have their actual birth certificate on file. Their family has a lot of their records and when I requested a copy of their birth certificate, they sent me the certificate you get from the hospital to keep for your records. Would that count since the physician signs it and it has the date and time of birth? The family will need to go to any court house in SD and for a small fee obtain certified copy, or request via US mail or the internet through the state webpage under online services, vital records. If the person is born out of state, the state they were born in will need to be contacted. Dr signed will not take the place of a certified birth certificate.

B. Diagnostic Status

Where does the diagnosis of Prader Willi go on the ICAP? If there is a DSM diagnosis from a psychological/psychiatric evaluation, then the diagnosis can be recorded under #11. Mental Illness. It would only be recorded under #10. Physical Health problem if it met the definition of causing a chronic health problem in that there is clear documentation that it is causing health issues that need to have medical intervention, supervision and/or medication.
Do not mark it in the diagnostic section in more than one area.

The guidelines talk about someone who had a Baclofen pump for CP, and this can be marked in the #10. Physical Health. How about someone who is on oral Baclofen? If they have a diagnosis of CP with spasticity then whether it is oral or through a pump, it would be viewed the same.

We serve people who have a diagnosed seizure disorder, but seizures are controlled or addressed (not yet controlled) with a VNS implant, NOT medication. Where do we reflect this? #8 Epilepsy, viewing the implanted device as the anti-convulsant medication or under #10 Physical health problem? A VNS is not a medication so it would not be considered or recorded as a medication. It is however a means to control seizures. B. Diagnostic Status #8 could be marked if you have a documented diagnosis and the person sees the Neurologist at least annually. In addition, under H. Support Services #5 Specialized Medical Care would be marked if there is at least annual neurology follow-up/evaluations/calibration of the VNS.

Is the doctor's signature on the physical exam form which lists the diagnoses enough for documentation of diagnoses? A physical examination form alone is not always enough to determine if the Dr. assessed the person to arrive at a diagnosis. The concern with accepting that is that often staff writes a diagnosis on the form and the Dr. completes the form and signs without confirming that the diagnosis was correct or current.

Person has a baclofen pump for her CP. I marked CP on the Diagnostic Status. Then I would go to Medications and include baclofen....and I mark on Specialized nursing care under support services for the pump refills every three months? You would mark CP and that diagnosis could be either primary or

additional depends upon what you feel is primary diagnosis of all that meet the criteria. You would then mark #10 Physical health under additional diagnosis as that covers the pump. Then go to current medications and include it there under #2 for health problem. If the person goes to a neurologist or specialist to have the pump refilled, then it is 5. Specialized medical care in Section H Support Services.

I have a question on an individual ICAP. Section B, #10. He has Varicose Veins-lower extremities. He has doctor orders to wear ted hose daily due to him being hospitalized in the past for serious rupture. The ted hose is not listed on the MAR, but would we still be able to place this diagnosis under #10 and then write ted hose in Section C, #2? You could write the varicose veins in the diagnostic health area section B under number 10 physical health problem if he follows up annually with the physician about it and it is chronic and ongoing. We do not mark ted hose in the medication section though.

If someone uses a nutritional supplement, such as Ensure, which can be purchased over the counter, can physical health be marked as a diagnosis? It requires that we ask her to weigh, record the weight and help her to purchase the supplement when her weight drops below a certain point. Physical health can be marked as a secondary diagnosis if the person has a chronic ongoing health problem, they are receiving medical treatment (like at an annual physical) and/or taking medications to control, prevent, treat. This includes prescribed and over the counter medication. So, for the person taking Ensure; does the person have a reason to be taking that and are being followed by a Dr, say like malnutrition, lack of absorption of nutrients, etc. It should be more than a recommendation by the Dr to take a multi vitamin for good health as good practice. We could all go to our Drs and hear that annually. So, I would ask what the persons underlying condition is that we are checking her weight, recording the weight and helping her to purchase supplements when she becomes underweight? This could be one where it is a mental health problem (such as anorexia) but results into a medical problem (like malnourishment) and it would be both 10 and 11.

We have a person with a diagnosis of pseudo seizures. Do we mark this under seizures or under diagnosis only? If the neurologist has assessed and determined the person has a diagnosis of seizures and the person is taking preventative medications or using a VNS, then it is recorded under seizure disorder. If a psychiatrist has assessed and diagnosed pseudo seizures, this is considered a mental health diagnosis. Sometimes people have both neurological seizures and pseudo seizures at the same time. Whatever gets documented as neurological seizures and reported to the neurologist as such, is what is used for the frequency of seizures in Section C # 4. Pseudo seizures are not considered when looking at documenting frequency of seizures in Section C # 4.

A person has strong background with Chemical Dependency; they have been clean and sober for several years and do attend AA. Can we still mark Chemical dependency for a diagnosis? Another person also had Chemical dependency but no longer attends AA but knows exactly how long they have been clean and sober, can this be marked? There needs to be a documented diagnosis of Chemical Dependency. Alcohol and Drug professionals tell us that the diagnosis is with the person forever so that would be an ongoing diagnosis.

I have an individual that was in a car accident when he was 5 years old. (Brain injury) On his psych. it says he has dementia NOS mild by history. In the past I have put as his primary diagnosis: Brain/neurological damage and then borderline intellectual functioning as additional. Should I now put as his primary #11- Mental illness due to the dementia NOS diagnosis? A primary diagnosis can never be mental illness. The diagnosis of Dementia NOS would be considered for category 4, Brain or neurological per the guidelines. It would be best to ensure there is some historical documentation in the central file stating information about the injury. The psych might have this in the content somewhere. The past documentation was correct including the BIF as additional in #13.

What documentation do we need to list a diagnosis or Autism? A qualified psychologist or psychiatrist is the preferred individuals to provide a diagnosis of Autism. In addition, social/medical history that provides a substantive historical path should be included in the diagnostic process. The important thing is that the person who conducted the testing or the evaluation to determine or rule out Autism, used valid test tools and has the qualifications to administer and conclude. The evaluation should indicate the type of test administered, what the results are and a conclusion of Autism being present or not and finally signed by a qualified professional.

We have some individuals who have been diagnosed with a hearing disorder; would we need to mark deafness in the diagnosis section? No. Deafness is only marked when the person has a diagnosis of Deafness or wears hearing aids and still has little or no useful hearing with the aids as documented by a professional. This item is cross-referenced with Section C. Item 3. Hearing. If you have scored this person a 3. Little to no useful hearing (even with hearing aid), based on documentation in the individual's medical records, then go ahead and mark 7. Deafness. A hearing disorder may be different than Deafness because a person could have a hearing disorder (perhaps has lost the ability to hear high frequency sounds) but is not considered deaf. On an individual basis, look for any supporting documentation in a person's medical records when determining the appropriate score on the ICAP.

If someone has a diagnosis of borderline intellectual functioning (full scale of 84 +/- 3 or 4), Attention Deficit Disorder and Oppositional Defiant Disorder, how would you recommend entering that into the ICAP? The ICAP would be marked #13 Borderline Intellectual Functioning as the primary and mental illness as a secondary.

I have a diagnosis of "Left spastic hemiparetic Cerebral Palsy from a perinatal right middle cerebral artery stroke. I have always listed the diagnosis on the ICAP as CP and brain or neurological damage. But now when reading the ICAP guide lines under brain or neuro damage it states …. brain damage due to injury, illness or stroke post natal. Since this occurred before birth can I list brain or neuro damage as an additional diagnosis? No, you cannot list it as brain or neurological for the reason you say as the Guidelines does not allow pre-natal neurological events to be recorded. The primary would capture the condition under CP. Assure to write this in the comment box though.

If someone uses a C-Pap machine, would physical health be listed as a secondary diagnosis? The use of a C-Pap machine would likely be for sleep apnea which would be a physical health problem and listed as a secondary diagnosis (sleep apnea), granted the documentation is available.

This individual has a diagnosis of High Cholesterol and was prescribed a medication for it, initially took it and then is choosing not to. His MD continues to recommend it and check at annual appointments but decided not to do any follow up labs etc since he isn't taking the med. So, is it OK to list a physical health problem with no medication in this case? Yes, if there is adequate documentation indicating this is a genuine condition that is chronic. The recommendation for meds as treatment, if not administered by person's choice does not cure the affliction.

We have an individual who has a diagnosis of mental illness but refuses all treatment. Do we mark that she has mental illness? If the person has a formal diagnosis of mental illness concluded and documented in an evaluation, it can be marked as an additional diagnosis even though the person is not taking medications. While typically there is a cross reference to current medications in the mood, anxiety, sleep or behavior category to the mental health diagnosis it is recognized that some people choose to not take medication, or the side effects are so severe there is a concern for causing more harm. The diagnosis is still present, regardless if the person chooses to or not to take medication to control the symptoms.

On the ICAP where would Fragile X put placed, and what kind of documentation would I need to show that someone is diagnosed with that? It would be noted in the Comment Section. Fragile X is a genetic condition and may be diagnosed by a Medical doctor rather than a psychologist. Typically, the person with Fragile X has an ID which then would be recorded in number 9 as the primary.

We have a student who has a moderate IQ level and autism (quite severe symptoms). Would the Moderate IQ be considered primary? When a person has two diagnoses that can be a primary diagnosis on the ICAP, mark the diagnosis that justifies the person receiving DD services. So, if the Autism is mild and the ID is severe, mark #9, if the Autism is severe and the ID is mild, mark Autism. In this situation either #9 or Autism could be the primary and neither would be wrong. Don't forget to document the one that is not primary in the additional diagnostic section.

Can you confirm Tuberous Scoloris goes under Brain/Neuro on the ICAP? Yes, Tuberous/Sclerosis goes under Brain/Neurological on the ICAP.

Where does Tourette's get marked on the ICAP? Tourette's is classified as a mental illness and marked as such on the ICAP.

If someone is on Birth Control and it is marked under Health for current medication, do you mark it as a Physical Health Problem under Diagnostic Status? No, you do not mark Physical Health Problem when someone is on Birth Control.

Would a diagnosis of Turner Syndrome go in 13 Other? Since there is no category to capture this disorder, and many other disorders, this would be indicated by writing Turner Syndrome in the comments box. This is how we capture other diagnostic information that does not fit any of the 13 categories. Nothing other than BIF or psychiatric care as a result of allowing a monthly or more required care by a nurse or physician would go in number 13 Other.

I have a question about Adjustment Disorder. Would this be captured under mental illness or situational mental health? According to the DSM, Adjustment Disorder begins within 3 months of onset of a stressor and lasts **no longer than 6 months** after the stressor or consequences have ceased. Given this information, I would advise you to mark it as 12: Situational mental health problem where we define in the ICAP Guidelines as follows: **12. Situational Mental Health Problem: Person has a diagnosis of a mental health problem that is expected to last less than one year, i.e., depression due to death in the family.**
NOTE: When 11. Mental Illness is marked do not mark 12. Situational Mental Health Problem.
However, if this person also has a Mental Illness diagnosis (PICA, psychosis, schizophrenia, Bi-polar, ADD, ADHD, oppositional defiant disorder, obsessive compulsive disorder, reactive attachment disorder, personality disorder, depression, post-traumatic stress disorder) and has 11: Mental Illness marked on the ICAP, then you **would not** mark 12: Situational Mental Health Problem. See the note from the ICAP Guidelines above.

We have a young woman taking Premarin for hormones following a (ovarian cancer) hysterectomy. She sees an oncologist every 6 months but is not currently being treated for cancer. Should we mark both 10. Health problem cancer and medications 2 for health problem or just medications 2 for health problem without the cancer as an additional? Yes, mark both 10: Physical Health Problems as an Additional Diagnosed Condition because she is still under the care of an Oncologist on a regular basis and under Current Medications mark 2: For health problem.

Brain Damage- When a person has alpha wave abnormality due to static encephalopathy, does that meet the criteria for brain or neuro damage? No.

We have a person who is seeing a neurologist and is being treated with Topamax for possible seizures. The formal diagnosis of seizures has not been made. Do we mark on diagnosis that he has seizures since he is being treated for them possibly happening? I would **not** suggest it is written in the diagnostic section as seizures until a diagnosis is made. You could mark this down as medication for health and note that there is a possibility of seizures and a formal diagnosis is being explored.

C. Functional Limitations and Needed Assistance

C1 – A person has a psychological evaluation that says his full-scale IQ is 62, which puts him in the mild level of intellectual disability. However, the evaluation states "This examiner feels there is a tendency for the WAIS-R to overestimate intellectual functioning and would suggest that the person functions adaptively and vocationally more like an individual who has a moderately intellectual disability, than he does like an individual who has a mild intellectual disability." Should his level be scored as mild or moderate? In situations like this we would take the written words from the examiner's summary of his findings versus the IQ score of 62 on the report. It should be scored as Moderate. Qualified professionals reserve the right to determine a final diagnosis based on all factors, not just the full-scale IQ score.

C4 - I have an individual who has seizures. She had 3 in December, none in November 3 in October. I don't know what to do in this situation as she missed a full month of having no seizures. Frequency of Seizures is an item on the ICAP where you can go back an entire year. In this case since she didn't have any seizures the month of November, go back and look at seizure logs to determine how many she had each month for the past year. If there is only that one month (November) when she didn't have any but all other months, she had multiple, it would be accurate marking 3. Monthly Seizures. If it turns out there are several months during the past year that she was seizure free, then the item would have to be scored 2. Less than monthly seizures.

We have a person with a diagnosis of PKU and on a specialized diet which does cause some limitations with activities in the community. Can we mark few or slight limitations under health? A PKU diet is not a health limitation. The only activity it may limit is eating out and that is a social activity. Reduced calorie diets or diabetic diets are not considered health limitations on the ICAP.

C6 - Required Direct Care by Nurse or Physician:

Can I count visits to the Chiropractor and Psychologist when determining what to mark on C. Required Care by Nurse or Physician, item #6? No, Chiropractors and Psychologist visits/care are not considered to be required care by a nurse or physician.

Can finger pricks for diabetes count as required care if the nurse does them. Blood sugars (finger pricks) can be a delegated task to a DSP, so do not count as Required Care by Nurse or Physician

I have a person who is receiving a lot of speech therapy (3-4x/week). We are trying to determine if this would qualify for weekly nursing care since it is lasting more than 3 months. Can you let me know so we can score it accordingly? No. Speech therapy is not included under nursing care. Speech therapy is addressed under H. Support Services #9 Therapies.

I am working on Required Care by nurse or physician. The person has appointments or labs etc in every month with exception of one month. Of course, some months – there are multiple entries. (This does not include routine dental, vision, annual physical) Do I mark less than monthly or monthly as meets 11 of 12 months? Since this person has required care for every month but one and multiple in other months not counting the routine visits, I would allow required nursing to be marked monthly. One would expect to see a

physical health problem or other condition in the diagnostic area as well as medications treating the condition reflecting the required care.

C7 - Current Medication(s):

Are PRN medications listed in a category? PRN medications are not recorded in a category unless the use of the PRN medication is occurring on a regular basis, i.e., daily or weekly for 3 months.

Do Exelon, Aricept and Namenda, medications to slow the progression of Dementia, go under "meds for mood, etc." or under "meds for health"? The medications slow down the progress of the disease so the meds should go under health and not mood, behavior, etc.

Does each individual medication that the person takes need to be listed under Current Medications?
Answer: Not unless you want to list them. Only the category needs to be marked that corresponds to the reason the person is taking the medication. The medications can be written in the comment box if so desired.

How does listing the correct category of medication help me in making sure all additional diagnoses are marked under B. Additional Diagnosed Conditions?
Answer: When medications are cross checked with the reason the person is taking the medication. Example: If you marked Current Medications, item #4 for seizure control there should be a corresponding seizure disorder marked in B. Diagnostic Status, item #8.

In the ICAP: What category does the Depo Provera shot go under in the current medications section? (this is for a male sex offender) If there is a diagnosis for pedophilia and/or a problem behavior specific to sexual issues it goes under #3 behavior as there is no other category for it and it is usually the psychiatrist that prescribes it and it is not prescribed due to a physical health problem or birth control.

I have an individual that has a formal diagnosis of Fragile X but takes a medication for his mood, behavior, and anxiety. There is no formal diagnosis for mental illness, so when I mark the medication on #3 it does not reflect the diagnosis for # 11 (mental illness). What do I need to do? If the medication is prescribed for mood, behavior, and anxiety that it where it needs to be documented under Medication. You should have documentation that this is what the medication is for. Did the doctor write on the prescription or on the contact form what it is for? If not. I recommend that you get something from him/her.

Someone has GERD, they take Prolisec (which has become OTC). The person is prescribed this and takes it daily. Can it be put in down for health (#2) instead of other (5). Same thing for chronic constipation- it is health related, but most drugs have become OTC? Even though the medication formally was a prescribed medication, since it is now an over the counter it would go under #5 Other. Continue to document these conditions under #10 Physical Health Problem.

We have participants supported that do not live in residential but rather with their families. The families take care of all the specialist appointments and administer medications. We are concerned as the families are not providing us with documentation about what medications are being taken and what was ordered or decided in out-of-town specialist visits. How does this apply to the ICAP? Do we just enter the old info we have, or do we need to be getting the documentation from the parents? If the parents refuse or just delay, then what are we to do? It is best practice to educate the parents on the importance of sharing information allowing you to keep care of their son or daughter's health while they are receiving services in the best way possible. This includes the current medication(s) they are taking and the diagnostic and physicians notes from appointments. In the educational system, in order to receive educational services, the parents are required to submit this information so it should not be unfamiliar to anyone. If an emergency were to happen,

the first thing emergency responders will want to know in order to successfully treat a person is what their conditions are and what medications they are taking. Staff play a vital role in observation of medication side effects too. For staff to be alert it is best they know what to look for. It is not recommended to use old information in the medication category. It is up to each agency to use their agency policy for refusal of sharing pertinent information. Continue to educate the parents and discover why they are not sharing this information. Sometimes people don't understand the importance.

C9 and C10 Mobility

Individual lacks any safety skills whatsoever, and we staff him 1:1 to ensure his safety as he will wander all over and moves very quickly. How do I mark this for mobility assistance needed…can I put staff assist in C-9 and the 10-4? He doesn't use any devices, but never goes anywhere alone. He would not be able to have mobility marked other than Walks (with or without aids) in number 9. Number 10 would be **none**. The assistance you are providing is based on behavior rather than function in the lower extremities. Behavioral concerns will be indicated in the behavioral area of the ICAP.

Does a white cane qualify as a cane as defined in option #2? If the person is using the white cane to physically walk from point A. to point B. the majority of the time the white cane would qualify as a needed assistive device for mobility.

I support someone who *can* walk without assistance. However, he often uses his wheelchair with staff pushing him due to being too tired to walk following seizures (monthly seizures). Several times weekly, he simply chooses to use his wheelchair instead of walking (more behavioral— "plays possum" acting tired to try and avoid undesired things, but often perks up as soon as something desired is offered). I'm debating over marking his mobility assistance needed as "none" since he *can* walk without assistance, but so frequently chooses to use his wheelchair instead. What would you recommend? We are measuring functional limitations and needed assistance and would be indicating the way the person gets from point A to point B the majority of the time throughout a typical day. If the person can walk but is using the wheelchair to escape undesired tasks it would not be considered as needed for functional assistance. You may want to indicate the avoidance use of the wheelchair as a problem behavior if intervention occurs when it happens.

Individual uses a wheelchair and she is not able to move the wheelchair on her own. She is not in the wheelchair all day long. She can walk and will, at times, walk without staff assistance short distances, although we try not to let this happen because it is not safe for her to walk without staff assistance. Under #10 Mobility Assistance Needed, I know I should mark 2, needs assistive devices. Should I mark a 3 for occasionally needs help or 4 for always needs help? Mobility means movement from point A to point B. Mobility is measured by a typical day. In the big picture of the typical day, you must determine how much help does the individual need from another person to get from point A to point B. If she has a history of falls, cannot transfer in and out of her wheelchair safely or walk safely without assistance from another person this should be a 4.

Person has a doctor's order for orthotics on his feet. Without those in place his mobility would be hampered. Could we capture under Mobility Assistance (device)? No, orthotics would not be counted as an assistive device.

50+ male who has stopped walking. Unknown as to why -- CT scan completed - negative findings; currently using a wheelchair to get from point A and B. When not in a wheelchair two staff assist him with moving around. He is not walking independently, looking at Mobility Assistance -- device/all. Mark 2. Needs assistive devices for C.10. This gentleman not walking independently and needing assistance from

two staff when not in his wheelchair and moving around, I would advise you to also mark 4. Always needs help of another person.

D. Adaptive Behaviors

The person I am scoring knows how to do tasks but won't do them unless prompted or told to do them. How do I score that? If a prompt is required for a person to complete the task and they and do it well when prompted, mark a 2, does well. If the person does the task when prompted, but not all the time and/or the task is done poorly, mark a 1.

D1- Motor Skills

#3 Sits alone for 30 seconds with head and back head straight and steady. How can be scored a 3 if the person does not hold perfectly still or have straight posture? This is a developmental skill of an infant who is learning to sit up. As with any infant learning this skill other people are close by to prevent the infant from falling to the side, front, back. The infant is not perfectly still nor having straight posture in learning this developmental skill. For adults, this item does then not require that the person sit perfectly still or have correct posture. This item focuses on whether the person can support his/her upper body in a sitting position for thirty seconds. If the person receives a score of 3 on Motor Skills, Item #4, stands for at least five seconds, the person would most probably have mastered the skill of sitting alone for thirty seconds.

D3 – Personal Living Skills

#10 Uses the toilet including removing and replacing clothing, with no more than one accident a month. A person can use the toilet and replace clothing well, however, for the past year he has been having BM accidents more than monthly. This appears to be behaviorally based-using his accidents to avoid something and will laugh about them. Should this item be scored a 3 since he does have the skills and his accidents are more behaviorally based than developmentally based, or should it be scored as a 0 since he does have more than one accident a month? If you are certain he is having no accidents and all his incidents are purposeful, then it would be scored a 1 or a 2. This would also be recorded as problem behavior. If he has an incident of incontinence (bladder or bowel) more than one time a month which is not related to behavioral reasons than it would be a 0.

#11 Closes the bathroom door when appropriate. If a person cannot close the door because of their disability but they cognitively know that it is what should be done is that a 3? Would the person assure someone helped him close the bathroom door? If so, how often? This would determine his score of a 1 or a 2. If the person is aware that the door needs to be closed for privacy and asks someone to close the door for him almost all the time, the score would be a 2. If he asks for assistance closing the door some of the time the score would be a 1. The score would not be a 3.

#12 Dresses self completely and neatly. A person can dress herself fully, but not well. She can slide her shoes on without her AFO, but with her AFO, she needs assistance with both her AFO and her shoes. Would this be scored a 1 or a 0 since she can't put her shoe on over the AFO? A score of 1 is appropriate as the 1 indicates does, but not well. Using the AFO and her shoes are only a part of her getting dressed.

#16 Mixes and cooks simple foods. This person can get ingredients out, mix them together, do simple cooking tasks on the stove such as flipping and stirring. She does need assistance setting the temperature on the stove/oven, determining when food is done cooking and with reading a recipe. Would this be scored a 0 or a 1? Since she can do some preparation towards the skill of cooking to include mixing, stirring and combining items it would be scored a 1. A 0 would indicate she cannot do anything in this area.

D4 – Community Living Skills

#4 Stays in an unfenced yard for ten minutes without wandering away. We are serving a young man who has restrictions preventing him from going out in the yard without supervision to assure he does not leave the yard and become a danger to the community. If there was not the restrictive concern, the skill would be performed at a score of 3. But because he has the restrictive concern, he is not allowed outside without supervision. Would this be a zero? This would likely be scored a 1 or a 2. Is the skill too difficult or unsafe for the person, or beyond their current skill level? No, he has the skill, then it is not a zero (safety for the community is the concern with this situation) Has the person mastered the skill needing no assistance or help or supervision? No, he requires supervision. Then it's not 3. A problem behavior may also be seen in the problem behavior section if this person has committed a serious crime requiring the level of supervision received.

#8 Crosses nearby residential streets, roads and unmarked intersections alone. The same young man in #4 can cross the street alone safely, however, he does not go out in the community alone due to restrictions. Would this be scored a zero since he is not performing the skill? This would likely be scored a 1 or a 2. The person has the skill so it would not be scored a zero. The person is not performing the skill without assistance or supervision so it would not be a 3. A problem behavior may also be seen in the problem behavior section if this person has committed a serious crime requiring the level of supervision received.

E – Problem Behaviors

We have a person who has a behavior of impulse spending and has a restriction currently in place, so the behavior does not occur. Not sure how to answer frequency question. Guidelines say we need to document actual occurrence, but due to restriction it is currently not happening. Under E. Problem Behavior - Scoring: If a highly structured environment or the use of medications has reduced the frequency or severity of the behavior being rated, do not rate the behavior based on what would happen if the supports were to be removed. Rate the behavior according to how often the behavior presents itself. If the person continues to have a restriction and/or a PBS plan in place to prevent this behavior it would be assumed the behavior is still happening and it can be marked as less than monthly.

We have a couple of people with some self stimulatory behaviors that we are not sure how to document under behaviors. If these are related to a diagnosis i.e. pervasive developmental disorder can they be listed under behaviors? The diagnosis does not determine if a behavior can be documented or not. If staff is not intervening to stop or redirect the self-stimulatory behavior when it occurs, then it is not considered a problem behavior and therefore is not recorded on the ICAP.

Where is the most appropriate Problem Behavior category for AWOL if we already have Uncooperative Behavior used for something else? You need to determine which behavior, the AWOL or the other already indicated in the Uncooperative Behavior section, is the worse behavior and use that one. We can't document behavior in another category if there is something already in that category. If you were to hand the ICAP over to the next provider, which behavior would be the one you wanted them to be aware of most importantly?

Under the hurtful to self category if a person stays out in the sun purposely to get burned (has had to go to doctor for second degree burns for doing this) would this go here? Hurtful to self-category requires intentional harm to one's self and as a result requires immediate intervention. Most people who sunburn don't purposely go into the sun to get burned therefore it is difficult to indicate this as a problem behavior without further documented history of the happenings to justify placing it under hurtful to self. You would need to assure staff is doing everything they can to prevent it and know that the choice to stay in the sun is for purposely getting burned with a result of hurting one's self intentionally, rather than lack of knowing the consequences

until it is too late. Perhaps if staff is trying to prevent this behavior unsuccessfully, it may better be placed in Uncooperative Behavior category.

Under uncooperative behavior (tantrums) which behavior do you use as primary problem? Documenting a combined behavior episode in any category is described as combined behavior episode or tantrum in the primary problem description. Then, in parenthesis describe the components of the episode from beginning to end. An example would be, in Uncooperative behavior the primary problem is *combined behavioral episode* (refusing directives, screaming, verbal abuse, hitting, destruction to property, and/or other components that have been observed in the past). The severity is based on the worst behavior in the episode that has ever happened, even if it rarely happens due to good de-escalation strategies. Count the frequency by how many times the person refused directives, even if the other components of the behavioral episode did not occur.

Under Hurtful to self they have listed - Drives while intoxicated... Does this go there? From what I am reading on the guidelines it does not fit there but I don't see that it would fit somewhere else either. This would be breaking the law and documented in uncooperative behavior.

I support someone that is self-abusive—he hits himself quite hard. It is frequent, 1-6 days out of the week he will hit himself. Usually the situation only takes one staff person, but there have been at least 3 times this past year where he has hurt himself requiring medical attention because staff could not keep him safe, and twice where physical intervention was needed to keep him safe. During these times, he meets all criteria for #3 Very Serious. However, when he is hitting himself and it doesn't progress as far, it would only fall into the category of #2 Moderately Serious. What Intensity level should I use for this situation? You could use either intensity. The key with this situation is the frequency. If you use the higher severity you would need to assure you reflect the frequency of the times the behavior rose to that level. Using moderate, you could reflect the frequency of 1-6 times a week. If this was a behavior that contained several typical components that escalate in a similar manner each time it occurred, it may be viewed as a combination behavior.

We support a lady whose extreme verbal aggression toward others requires her to live alone. In the Problem Behavior section, it states that in order to be #4, you must have 24-hour staffing. Given the severity of the situation, and the fact that we could not serve her anywhere else, she needs 1:1 staffing, services are in jeopardy, and CIR has been done for this, I think that she should fall into the #4 category even though the 24-hour supervision category is not met. The behavior severity would be scored based on the severity where all bullets are met. In order to meet all the bullets in severity level 4, her behavior would need to be a grave and immediate threat to her life or the life of others. It does not appear that anyone's life is in danger.

I have one individual who lives on her own and has supported living assist. A main concern is non compliance with medical advice RE: morbid obesity and resultant conditions: diabetes, asthma, sleep apnea, etc. She will take medications and will use her C-PAP. She does go to the doctor often – somewhat of a hypochondriac. However, she will not or doesn't or isn't able to do the bigger things that have been asked of her: diet, exercise. Finds excuses to not go to the pool to water walk or even take short walks in the 'hood'. Has been seeing nutritionist from hospital etc but doesn't change her eating habits. The other issue is not providing our agency/nurse with information about medical appointments or medications. Kind of feels like it is her business – not ours. Is this indicative of uncooperative behavior? We must decide if what we're doing about it is managing problem behavior or trying to manage behavior or providing encouragement to exercise or eat appropriately as a service all should receive. Has the lack of follow through caused her any medical problems she needed to get immediate medical follow up for? Hardly anyone follows their Dr advice to the letter so it must be decided based on the level of support required, based on her needs for the resulting medical issues of not following her diet, etc. I would be looking at immediate needs

rather than long term. I wouldn't count the not providing medical information to the staff as a behavior but would continue to educate her on the necessity of sharing that information for quality care.

I have a person supported on my caseload that has two tubes. One is a j-tube for his feedings and the other is a g-tube for draining his stomach. He tends to pull at these tubes. He has a mitt on to prevent him from pulling at them which is a restriction, but he has several times each day that staff can take the mitt off while he is in the living room or dining room area. He can never be left alone in his room with the mitt off because they wouldn't be able to see if he pulled at the tubes. I want to mark this as a moderate behavior because when he does pull them out, this is a big health issue since he must go to the hospital to have it replaced and if it is his j-tube that is his source of nutrition and his only way to get medications. The only thing I am not sure of is…because we have done such a good job watching him and with the mitt on, he hasn't actually pulled the tubes out in the last year but he still either tries to scratch at them or pull them on just about a daily basis when his mitt is off (generally when he is taking his bath). Staff obviously redirects this every time it happens or put his mitt back on, but they don't document each time that he scratched or pulled at the tubes unless he pulls them out. Can I still mark this as moderate? This can be marked in the severity category that meets all the bulleted criteria.

Someone had been at SDDC for many years and had a severe PICA behavior. She has had surgery in the past to remove items. She has been at her current provider for 5 years and has not had any PICA issues in the past year. Should this be considered Hurtful to Self yet? If supports and/or strategies are being provided to assure it does not happen again, because it may happen if you don't, then yes. However, I would move this to the unusual or repetitive category. The frequency would be less than monthly. The severity would be scored by matching the bullets in the appropriate severity category based on the intensity of your support.

Cluster Behaviors – Would a cluster of refusals, hitting, kicking and pinching be in hurtful to others? You can cluster the behavior episode in any category that behaviors are demonstrated. However; you can only select one category and whichever category you select you need to gauge the frequency on how many times that behavior you have categorized it under, has happened. Typically, the beginning stage of a behavior cluster happens more frequently than the next stages of the cluster, therefore hitting usually does not happen at as high of frequency as the uncooperative refusals does. Marking this in uncooperative would allow the frequency to reflect the number of times staff intervene to stop this cluster from escalating. We would mark the severity based on the most severe stage i.e., hitting, kicking, pinching. It would be acceptable to indicate this behavior cluster in hurtful to others, but the frequency could only be marked when hitting, kicking or pinching occur.

I support a person that has gastric issues and passes gas a lot. It is not on purpose, but the smell is very bad, and others are offended by it, whether it is on purpose or not. So, here is the question. What if it affects the person in the sense that it changes their ability to go places? For instance, if she is having one of those days, we are not going to support her to go out to eat at a restaurant or to another place where many people will be. We don't feel it is in her interest as far as dignity is concerned etc. What would your answer be for that? It is affecting her ability to participate in the community, but it is not a behavior (purposeful). Someone who has no control over bodily functions which may offend people is not indicated as a problem behavior in the maladaptive behavior section of the ICAP. This person has no way of controlling the gas, does not do it on purpose and doesn't appear to gain anything from it. There is no way to stop this behavior when it happens, redirect it when it happens or intervene with it when it happens as there is no intent behind this behavior nor any positive behavior replacement to teach. This person's adaptive behavior would likely be capturing control limitations as well as perhaps health conditions/medications marked elsewhere on the ICAP and would not be considered a problem behavior. In a situation like this I would recommend consulting with the physician for gastric treatment or assessment.

F – Residential

Someone living in a dorm during the week, home on weekends, dorm has many supports and (supervision and meals provided in commons area with other students). How do you list residential placement on page 10 of the ICAP? #1-with parents, #12-other, #5-room & board without personal care since that is not provided? Breaks and summer is at home full time. Other and indicate this as post-secondary educational service receiving campus residential supports.

G – Daytime Program

I have someone who comes in to do janitorial in the afternoon for an hour three days a week and is paid minimum wage. She has a rocky employment history and is job seeking again. She does not volunteer. What do I put for Daytime program under G.? If she is not working any more than the 3 hours a week, and she is not participating in any other activities it would be marked as #1. *No formal daily program outside the home.* The majority of this person's daytime hours are spent in no formal daily program outside the home.

H – Support Services

Specialized diets for support services, pg. 11 the guidelines talk about highly restricted diets as needed due to disorders or problem behaviors. If someone has a restricted diet due to diabetes, can this be counted? No. Per ICAP Guidelines under Support Services #8. Specialized Nutritional or Dietary Services: These services would not include routine annual assessment of dietary needs such as weight and relationship of certain foods with medication; reduction diet; increased servings diet; Low-cholesterol diet or diabetic diet.

We mark a physical health problem for the people who are on oxygen, usually as COPD. Can it be put under Specialized Nursing Care, since the oxygen administration supports are primarily completed by direct support professionals? We do have to contact the oxygen companies who supply the oxygen each month and they do an assessment (with our input) on each person about monitoring the person's health and evaluating their current health situation. We were just wondering if this would fit under "Section H", like other services that require similar evaluations. You would not put it in any category. The person has a physical health problem (example of COPD) that coincides with the reason for the O2 and the problem is already listed in additional diagnostic section. Administration of oxygen is not considered a medication or a specialized nursing service.

Where do we reflect that a person has regular care from an audiologist? #9 Therapies or #5 Medical?
H. Support Services does not address services from an audiologist since the services provided are commonly repair or calibration of a hearing aid or for a hearing test. Support Services does not address services from an optometrist or dentist. Services from an audiologist would not be recorded under Support Services at this time. Problems with Vision and Hearing are recorded under C. Functional Limitations and B. Diagnostic Status if there is a documented diagnosis. #9 Therapies-Occupational, Physical or Speech are specific to those areas and must be for the treatment of an on-going condition provided to a person by an occupational therapist, physical therapist, or speech therapist on a regularly scheduled (on at least monthly) basis. This does not include seeing any of these therapists for evaluation purposes only.
#5 Specialized Medical Care is also specific to the definition listed under H. Support Services.

For Specialized Nutritional Services can it be marked if someone has modified food consistency such as ground or pureed? Yes, if there is an initial evaluation, such as a swallow study or other type of evaluation that identifies the need for ground or pureed food.

Can we count Depo shots as specialized nursing in section H? No. The Depo would not be considered specialized because it birth control and is elective. Injections for treatment of a medical condition would be considered specialized.

11. Specialized Transportation Services - I support a person who uses paratransit but doesn't use adaptive equipment – she was found to NOT be a candidate for public transportation due to safety concerns (she is very vulnerable to strangers). Do they have to use a mobility aide or just ride paratransit or project car to be allowed specialized transportation services?? In order to be able to mark this section the person is required to have a physical limitation preventing them from being able to ride in a vehicle that is not equipped with a lift.

If a person does not have access to their food due to binge eating staff assist with access to and portioning food and snacks, and this is part of an approved Human Rights plan, can you mark Specialized Nutritional or Dietary Services? Yes. If the monitoring meets the criteria in number 8 of the ICAP Guidelines from Section H Support Services.