I AM
valued

I AM
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I AM
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A Guide to Using the I AM Assessment

New York State Edition

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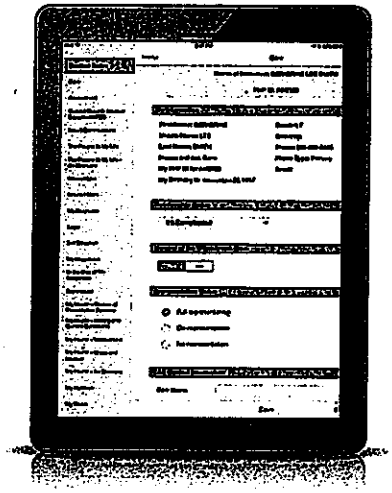
I AM represents the powerful voice of the person with IDD



I AM:

- Recommends specific services and support to address the hopes and dreams of persons with Intellectual and other Developmental Disabilities (IDD) as well as traditional health and safety requirements
- Aggregates all documented information that may be used as part of a comprehensive Life Plan: a list of detailed Goals and Actions for support and service providers to follow, as well as a printed summary of all content areas
- Delivers six in-depth narrative profiles, which represent the person's own story
- Offers a list of preferences and supportive routines for the person who cannot communicate their wishes
- Integrates the Council for Quality and Leadership's Personal Outcome Measures (CQL POMs)
- Has been reviewed and edited by CQL, national experts, state officials, families, and self advocates

SECTION 1: Introduction to I AM

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Even though a person may not speak, they must be heard.

What Is I AM?

I AM is a one-of-a-kind assessment tool that helps to gather and aggregate in-depth information about the practical needs and preferences of a person with IDD.

How Is I AM Used?

I AM documents a collection of information and conversations between the facilitator, the person with IDD, and his/her circle of support.

The information collected is used for support planning and integrates the actions of multiple providers to meet the needs and goals of each person.

Why Was I AM Developed?

I AM was developed to meet the demand for a person-centered interview process that encompasses the emotional and physical well-being of someone with IDD, down to the most granular detail.

In this way, the assessment acts as the voice of the individual with IDD, even if they cannot speak.

How Does the I AM Process Work?

The process moves the facilitator through 31 areas that assess the person's current status, and identifies Goals and Actions that are needed and/or desired by the person and his/her circle of support.

How Are Results Delivered?

I AM provides a list of specific goals and actions, six narrative vignettes, and other summary documents for support and service providers to follow.

Complete assessment results and summaries are delivered in PDF format. Results can be printed and also downloaded into an electronic record system.

The Council in Quality and Leadership and Personal Outcome Measures®

The Council in Quality and Leadership (CQL) has developed an interview process that determines whether a person feels supported and has a positive outcome using 21 indicators that range from health, safety, and relationships to goals and dreams. These indicators are called Personal Outcome Measures (POMs).

I AM integrates the CQL and POMs standards into its assessment tool to help ensure supports and services are truly person-centered and meet the highest standards of care.

Many providers and states require the use of the CQL POMs when filling out assessments. I AM provides a method for implementation of goals based on the CQL POMs. Goals in I AM link to one of the 21 POMs and have been reviewed by CQL staff.

For more information on the CQL and POMs, go to
https://c-q-l.org/the-cql-difference/personal-outcome-measures

What Are the Technical Requirements?

The I AM assessment tool is supported on an Apple® iPad® with other platforms to come.

SECTION 2: How to Use I AM

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How to Use I AM

Who Is I AM for?

I AM was specifically developed for persons with IDD. However, it can be used for anyone who is in need of a person-centered assessment that delivers a comprehensive plan of care.

Who Can Complete I AM?

The ultimate goal is to improve and enhance the quality of life for the person with IDD.

With this in mind, the facilitator should:

- be a skilled observer and interviewer
- be trained to use first-person language
- be able to move from general to specific insights
- document accurately and understand the characteristics and diagnoses of the person being assessed
- understand the programs available to the person in the area where they live

Most importantly, the facilitator must quickly develop a bond with the person and his/her circle of support.

Who Participates in the Assessment?

Three main groups are involved in I AM: the facilitator, the person to be assessed, and that individual's circle of support.

The circle of support includes:

- Family and friends
- Professional (paid) caretakers and healthcare workers
- Any other individual the person believes might be helpful and appropriate

Sometimes the person being assessed is not able to participate in the process in a meaningful way. In such a situation, it's even more important that participants know the person well and have their best interests at heart.

Preparing for the I AM Assessment

When preparing for the I AM assessment, it's important to:

- Understand how the person communicates and identify all participants
- Identify all those who will participant in the assessment
- Gather all medical and health-related records including:
  - — The individual's diagnosis
  - — Date of most recent physical

— Date of most recent dental exam

— Date of flu shot and other vaccinations

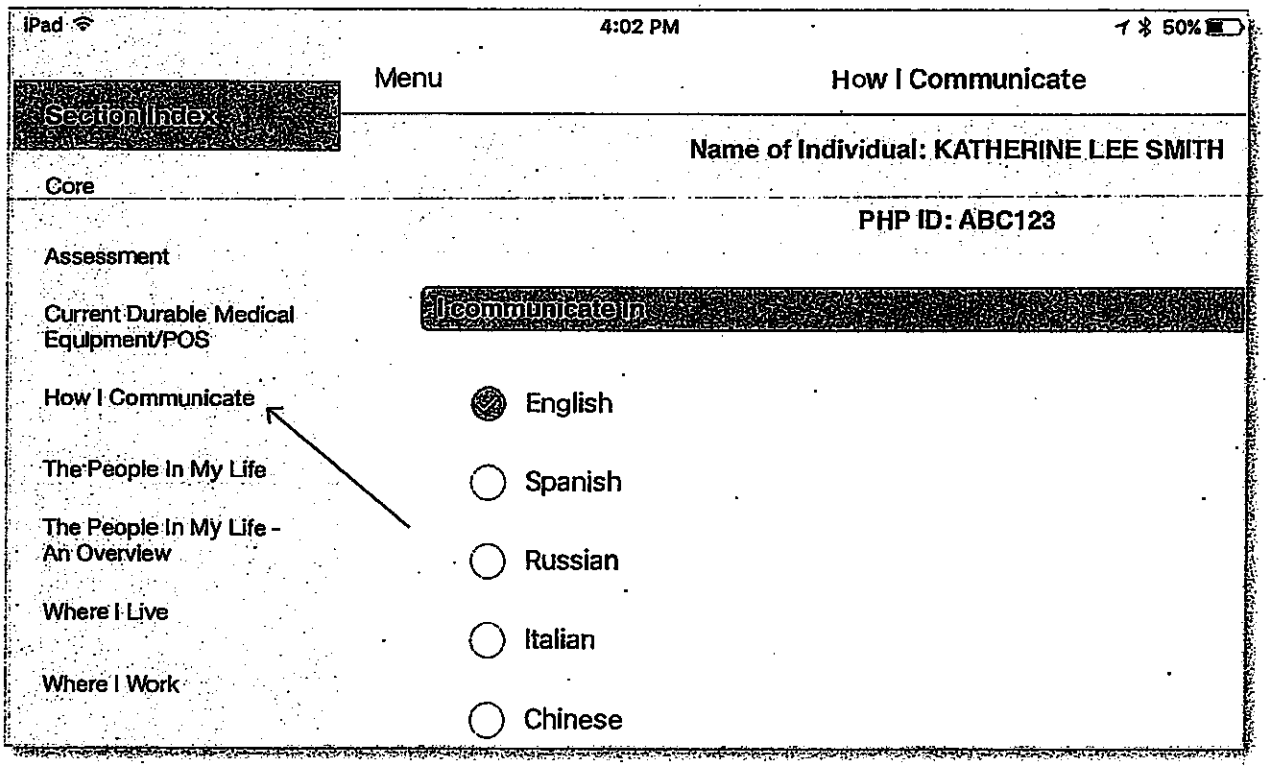
— List of allergies

— List of medications

If available, gather any additional reviews, evaluations, habitation plans, and previous assessments that could be relevant and helpful.

Getting Started

There is no exact right or wrong way of doing I AM. However, it is recommended that the facilitator begin with the **How I Communicate** section, as this information will be useful throughout the process. It is important to establish a way to communicate with the individual so that their responses to your questions are understood and documented with accuracy.



*Click on **How I Communicate** in gray menu bar on left to bring up section.*

I AM was developed with flexibility in mind. The facilitator can move freely through the application and complete sections as the conversation evolves in a way that is natural and supports the individual's needs.

A full listing and description of all sections is here.

The Use of Logic

I AM uses logic to determine which questions appear based on how previous questions are answered. Community health standards are used to facilitate this logic.

For instance:

— Questions that only pertain to a female (i.e., date of last mammogram) will not appear for a male, and vice versa

— Some questions will vary based on whether a person lives in a certified residence or at home

Question and answer formats vary depending on the type of information needed. In questions where a choice is required, the facilitator can choose "other" and enter a specific response in a free-form text field.

SECTION 3: Elements of the Assessment

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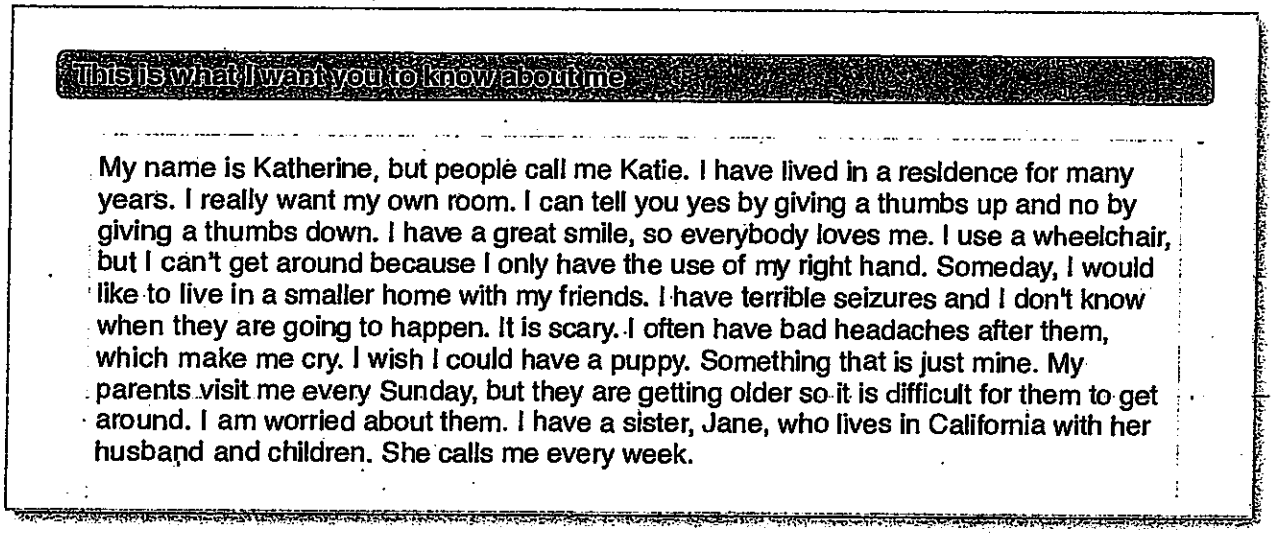
The 6 Narrative Profiles

These narratives appear throughout the assessment as open-text fields, encouraging the person to describe in detail how they feel about many aspects of their life. This information will contribute to the individual's Life Plan.

The narratives are meant to be written in first-person language using the voice of the individual. The exception is the My Health - Medications section, which is to be completed by the facilitator or care manager.



A narrative in the Assessment Section

Helpful Hints for Completing the 6 Narrative Profiles:

- The mode of communication should be established in the How I Communicate section of I AM
- The facilitator should make every attempt to have the individual respond in their own words
- If the individual can speak but is having difficulty responding, some gentle prompting or framing of the questions may help
- If the person cannot speak, ask questions that can be answered with "yes" or "no," or by blinking or nodding
- Consider the possibility that the individual may want to have some of their feelings represented by pictures
- Family and other members of the circle of support can assist for a member who does not communicate fully

For more helpful information on completing the narratives, go here.

Stratification

Information gathered during the assessment for the sections **In the Way of My Happiness** and **My Health - History and Current Conditions** will help determine the individual's level of care. This process is called Stratification.

There are three levels of Stratification: **High, Medium,** and **Low.** Examples of input that may increase the level of Stratification:

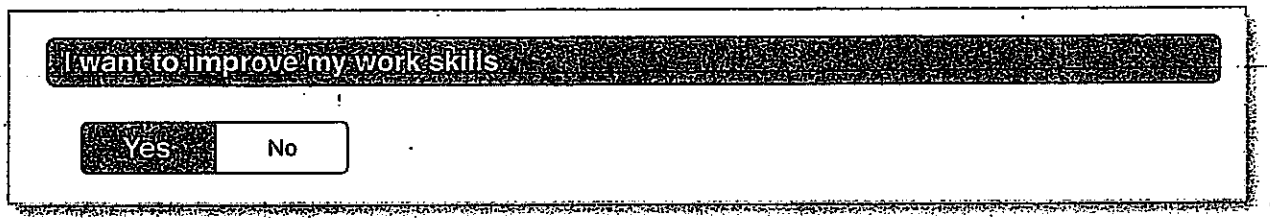
Behavioral: Aggressive behavior that has led to an arrest.

Health: End-stage renal disease or a current diagnosis of cancer.

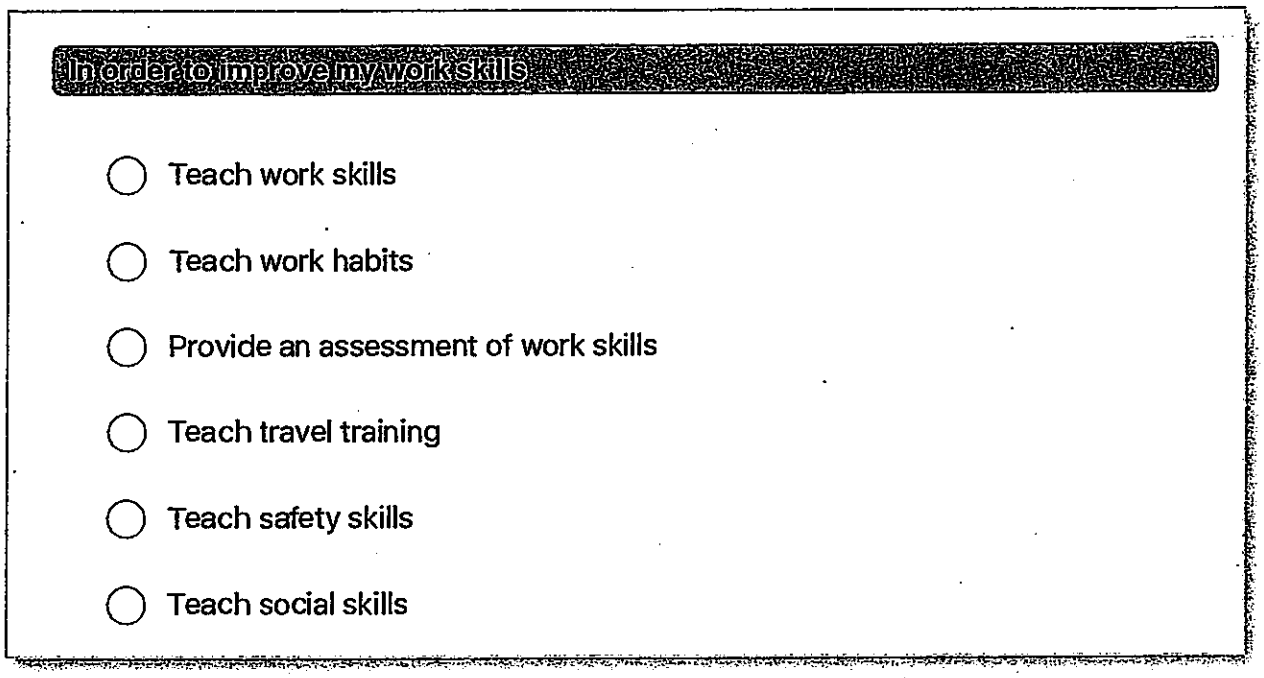
For more details on Stratification, go here.

Goals and Actions

Goals appear throughout I AM in white type within a blue bar. When a Goal is chosen, a window opens with multiple Actions that may support the achievement of the Goal. If an appropriate Goal is not present, you may choose "other" and enter the appropriate Goal in the narrative box.



Actions appear throughout I AM in black type within a blue bar.



- One or more Actions can be chosen and assigned to different providers or caregivers
- If an appropriate Action is not present, you may choose "other" and enter the appropriate Action in the narrative box

An Action has one of four functions. Actions 1 and 2 represent a single service. Actions 3 and 4 represent ongoing services. Action functions have been predetermined. Actions with an asterisk (*) are care management tasks. The three other Action functions are assigned to providers and are specified once they enter the care coordination system. Actions are described below:

Action 1: Care Management Task
This task identifies an Action to be implemented by the care management team.
Example: Schedule a doctor's appointment.

Action 2: Provider Task
This is a one-time task assigned to a provider.
Example: Complete a psychological assessment.

Action 3: Supports
These are ongoing services provided to an individual.
Example: Provide supervision when in the bathroom.

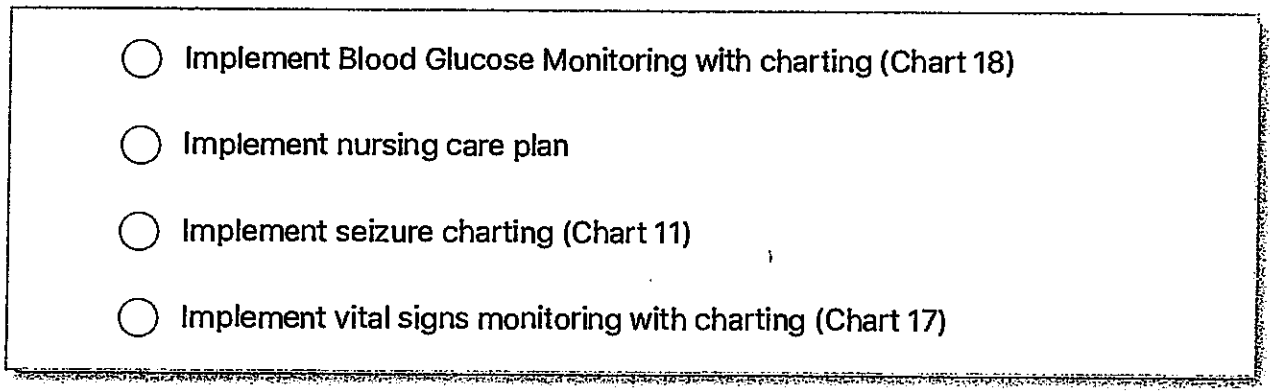
Action 4: Goals
Goals represent an Action that is intended to bring the individual to a greater level of independence.
Example: Teach to use public transportation.

Observation Charts

The Action sections contain 20 Observation Charts. These Charts are completed when the care management team needs to document and monitor specific actions and responses. Some examples of Charts include ongoing behavioral concerns, sleep log, food and fluid intake, and seizure records.

- The Charts were developed by groups of clinicians and specialists
- They may be used in their present form or edited to meet provider or state-specific requirements

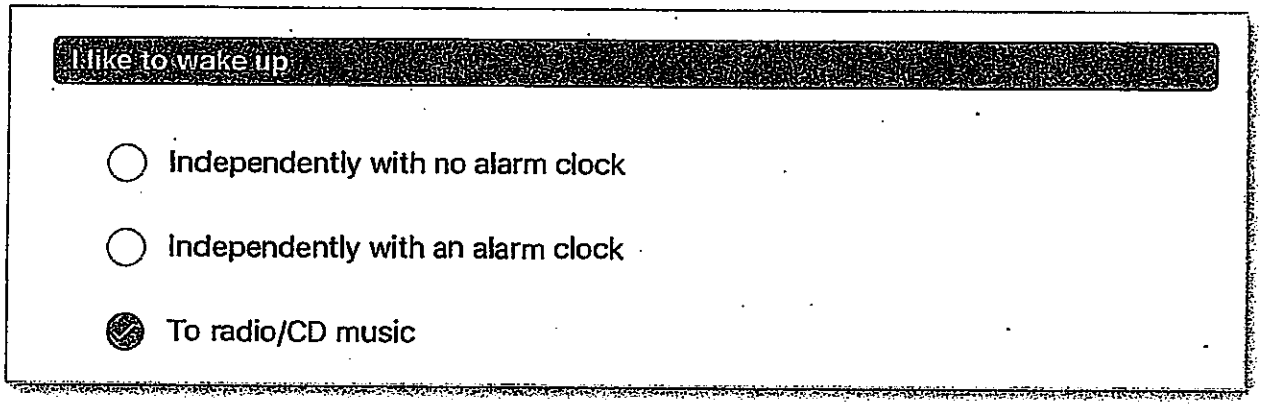
The full list of Observation Charts are here.



Sample of how Charts are indicated in Action sections (black type within a blue bar).

Supportive Routines

This section offers a series of Supportive Routines (represented in yellow type within a blue bar) that promote a quality of life that is the right of each person.



They represent the work of Dr. Thomas Pomeranz, a nationally recognized authority, trainer, clinician, and consultant in the field of services for people with disabilities. For more information on Dr. Pomeranz go to www.universallifestiles.com

Supportive Routines are used when the individual does not have freedom to make choices in their everyday life. Here are some examples:

- Preference of a shower or bath and at what time of day
- How, when, and what to eat
- Preference to sit in the front passenger seat when in a car
- Attend religious services
- Having some quiet time with a cup of tea after work

Supportive Routines are found in many sections throughout I AM. When chosen, they will generate a list in the Summary section and should be implemented by all members of the circle of support by choosing to follow Supportive Routines in the My Happiness section.

If Supportive Routines need to be determined, go to the My Happiness section, scroll down to the Action heading "In order to meet my goal provide the following," and select "Determine Supportive Routines."

SECTION 4: Creating an Assessment

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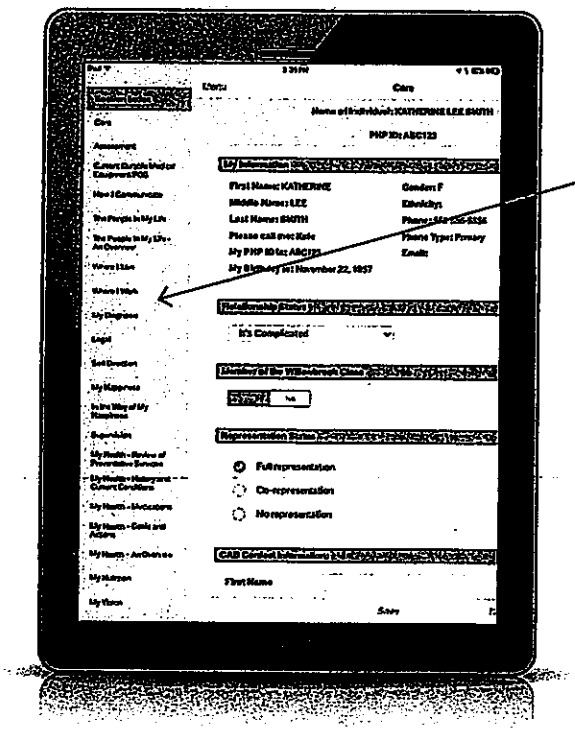
Content Sections

I AM contains 31 Content Sections. Each section begins with a review of the current status of the individual and continues with a series of Goals and Actions that the person and his/her circle of support may choose in developing a Life Plan.



You can find the 31 Content Sections in the gray menu bar on left.

Section	Description
Core	Collects current demographic information about the individual, including: • Name, address, birthday, and nickname • Relationship status • Representations status • CAB contact information
Assessment	Notes the date and details the reasons for the assessment and whether the individual participated. • Includes the first narrative profile "This is what I want you to know about me" • Describes, in the words of the individual, what they believe is the most important information for others to know about them

Section	Description
Current Durable Medical Equipment (DME) and Prosthetics/Orthotics Supplies (POS)	Details DME and POS the individual currently uses to assist in daily life. DME/POS is divided into categories such as self-care, eating/drinking, medical, and mobility • Information on DME can be collected in specific sections as well as at the end of the assessment
How I Communicate	Includes preferred language, mode of communication, hearing ability, how much is understood, and how the individual expresses pain. • Allows the facilitator to document words/signs/gestures used and what they mean for those with limited communication abilities • Facilitator can choose actions that help the individual communicate better • This section should be completed early in the assessment so that the individual's mode of communication is established and implemented throughout
The People in My Life	Compiles information about all service providers and natural support persons in the individual's life. • Allows for the documentation of contact information as well as the service provided • Defines the nature of the relationship of all contacts including family member, legal guardian, member of the interdisciplinary team, and emergency contact
The People in My Life - An Overview	Provides a space for the individual to describe the important relationships in his or her life. • As much as possible, this section should be completed in the person's own words
Where I Live	Documents the individual's living situation: With a residential provider, family, or other. • Uses language specific to state and federal agencies to define the type of residence, so that moves to a more integrated setting can be documented • Explores whether the individual is happy with their living situation, and sets goals, time frames, and actions if a move is desired • Details whether the individual lives in an environmentally safe setting • Concludes with a narrative that describes how the person feels about where they live

Section	Description
Where I Work	Provides information on the individual's employment status. • Includes name, address, and phone number of organization • Allows the individual an opportunity to describe their work life and indicate what changes, if any, they'd like to make along with specific goals and actions for achieving those changes
My Diagnosis	Allows the facilitator to document all of the individual's known diagnoses using ICD-10 coding designations.
Legal	Explains the individual's ability to make their own decisions on legal issues related to their life and health. • Notes whether the individual has existing legal documents including a will, advance directive, health care proxy, and special needs trust • Notes whether the individual would like to acquire or update legal documents
Self Direction	All states are moving to allow individuals to self direct as many of their services as possible, with or without the assistance of their families • Documents the participation and/or potential interest in OPWDD and DOH Self Direction • Programs can be made state-specific
My Happiness	A series of questions that help define specific personal goals and wishes, as well as the general mood and feelings of the individual. Insights from CQL POMs are helpful to this process. • Goals range from basic (I want to be able to turn my television on and off) to complex (I want to join a group, have an intimate relationship, see family and friends more often) • Goals generate a series of Actions that support implementation
In the Way of My Happiness	Details behaviors that interfere with the individual's happiness and the happiness of others. Provides Goals and a series of Actions that are recommended to address challenging behaviors and provide a more meaningful life. • Information gathered contributes to the recommended stratification level • Notes suggestions about what cues the behavior, what ends the behavior, and what positive behavior might replace the disruptive one • Documents the consequences and whether a support plan and restrictive limitations/consequences are included

Section	Description
In the Way of My Happiness (continued)	• Charts may be recommended to document intervention strategies • On the recommendation of self-advocates, this section includes a narrative box in which the individual can describe, in their own words, why he or she has challenges
Supervision	Documents the individual's need for supervision in various situations: At home, in the community, and overnight. • Provides a variety of options for levels of supervision and offers charts to document any necessary supervision
My Health - Review of Preventative Services	The first of five sections which document and develop a plan for health care. • Documents dates of all standard medical/dental services and current tests using community-standard criteria • Logic determines whether age- or gender-related questions are shown
My Health - History and Current Conditions	Details a list of medical conditions with additional information requested for certain conditions such as cancer, bedsores, allergies, seizures, surgeries, and fractures. • Documents any emergency room visits and hospitalizations • Information gathered contributes to the recommended stratification level
My Health - Medications	Documents all current medication. • Details what assistance the person needs to take their medications • Documents known side effects • Develops a plan for medication oversight if needed
My Health - Goals and Actions	Uses the information from the three prior My Health sections to define Goals and Actions that will help develop a comprehensive health care plan.
My Health - An Overview	A summation of all information relevant to the person's health care. • Only narrative section that is not written using the individual's own words (but should use first-person language) • Recommended to be completed/reviewed by a health care professional for individuals with complex needs in the health care area

Section	Description
My Nutrition	Details all things related to the individual's nutritional needs and preferences. • BMI, food allergies, diet, food and liquid consistency, and supervision or assistance during eating • Provides comprehensive eating guidelines that may be included in the individual's Life Plan
My Vision	Documents the individual's eye care status, last vision exam, and Actions necessary to maintain healthy vision.
My Mobility	Describes how the person moves, and what he/she needs to get from place to place. • Includes use of wheelchair, walkers, and other transport devices • Documents the number and reason for falls and provides for Goals and Actions to improve and or facilitate safe movement
Toileting	Determines the need for supervision, training and/or support of the individual.
My Skill Matrix - Personal Hygiene	Reviews 13 specific areas that make up personal hygiene. • Recommendations can be made for general hygiene support, or for any of the 13 specific areas • Goals can be identified for specific areas of improvement
My Skill Matrix - Daily Living	Reviews 13 specific areas that make up activities of daily living. • As with hygiene, recommendations can be made for general support, or for any of the 13 specific areas • Goals can be identified for specific areas of improvement
Supportive Routines for Personal Hygiene Skills and Activities of Daily Living (PHS ADLS)	Details how the individual would like to be supported when completing personal hygiene and activities of daily living.
Safety Plans	Identifies what is needed by the individual in case of emergency/evacuation or when calling for help. • Describes level of independence, need for assistance, and any need for DME/POS • This section is mandatory even if the person is independent

Section	Description
Reasonable Accommodations	Helps determine whether the individual needs reasonable accommodations to feel comfortable and safe in a variety of situations. • Examples: translation services, avoiding crowds, bathroom needs, use of an elevator versus an escalator
Durable Medical Equipment/POS Summary	Summarizes all the individual's current DME/POS equipment and what needs to be ordered for their use. • If DME/POS was noted in another section it will be recorded here • Ability to edit or complete information related to DME/POS is allowed here, but not in the Assessment Summaries
Preferences	Documents the individual's likes and dislikes across several categories, including: • Personal care items such as shampoo, perfume, and toothpaste • Music, sports, clothing, and environment Can note staff preference for specific tasks (male/female or specific caregiver). • To define preferences, go to the My Happiness section, scroll down to the Action heading "In order to meet my goal provide the following" and select "Determine preferences" • To implement a plan to follow certain preferences, go to the My Happiness section, scroll down to the Action heading "In order to meet my goal provide the following" and select "Follow preference guidelines"
Notes	Provides a free-form text area for the facilitator to record notes and reminders. • This section will not print or be transferred electronically to the final version

SECTION 5: Assessment Summaries

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Assessment Summaries

Assessment summaries are based on the content that has been input throughout the I AM process.

All of these summary areas are compiled to develop a Life Plan that addresses the comprehensive needs and wishes of the person.

Summaries can be printed in PDF format or transferred/downloaded/integrated into an electronic data recording system.

Sections of the Assessment Summary:

Profile Summary

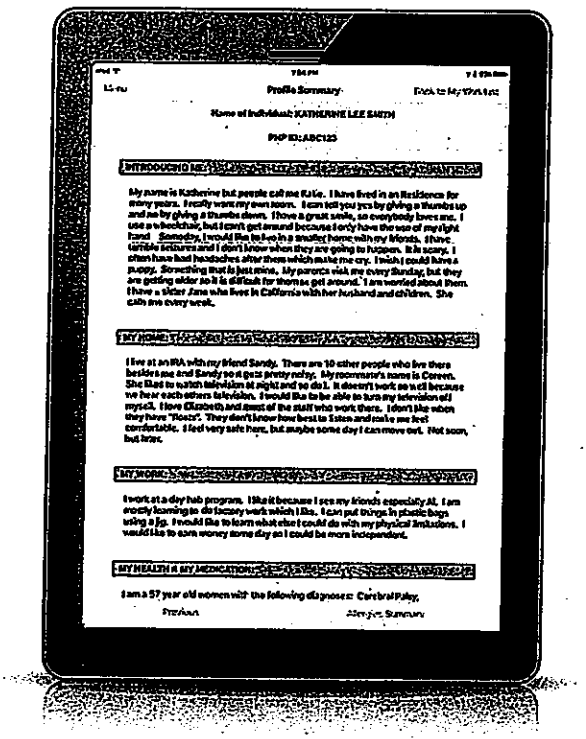
Organizes and displays information gathered from the 6 Narrative Profiles.

Sections include:

- Introducing Me
- My Home
- My Work
- My Health & My Medication
- My Relationships
- My Happiness

The Profile Summary gives a detailed, first-person snapshot of the individual using their voice and from their perspective.

For helpful information about how to create a powerful and valuable profile, go here.



The Profile Summary

Allergies Summary

Summarizes information collected throughout the assessment for the following allergies:

- Food
- Environment
- Products
- Medical

Durable Medical Equipment (DME) and Prosthetics/Orthotics Supplies (POS)

A comprehensive list of all DME/POS the individual currently uses and needs.

- Organized by content section
- May be used as a property list and to authorize new equipment

Supportive Routines

Compiles all suggested Supportive Routines chosen for the individual in one convenient place.

To implement a Supportive Routine:

- Go to the My Happiness section, scroll down to the Action heading "In order to meet my goal provide the following" and select "Follow supportive routines guidelines."
- The Action will be recorded into the POMs section to be assigned to relevant providers and caregivers

Preference Summary

Documents all of the individual's likes and dislikes as in the Preferences section.

Goals and Actions Summary

Summaries for Goals and Actions are divided into two preview sections: Personal Outcome Measures (POMs) and Individual Protective Oversight Plan (IPOP).

POMs Preview

POMs represent the person's dreams for their life including: My Human Security, My Community, My Relationships, My Choices, and My Goals.

The summary combines the Goals and Actions chosen from three sections: **Where I Live**, **Where I Work**, and **My Happiness**.

- First line: represents the CQL POM which has been attached to the Goal
- Second line: records the Goal/Valued Outcome
- Following lines: represent the Action or Actions to be implemented to achieve the Goal
- There may be more than one Goal and corresponding Action under a POM

IPOP Preview

Defines the Actions that are needed to keep the person healthy and safe.

- Includes health care, nutrition, medication management, supervision, evacuation, and personal hygiene
- Represents the Goals and Actions from all the other sections of the assessment
- Not attached to POMs
- Can be assigned to providers or used by everyone in the circle of support

SECTION 6: Appendices

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Helpful Hints for Completing the 6 Narrative Profiles

The Profiles are intended to create a narrative about the person. It should be told in the person's own words.

The exception is the My Health - Medications section, which is to be completed by the facilitator or care manager.

The facilitator or care manager will also get personal information through the person-centered planning process, made up of assessments and record reviews.

Keep in mind:

- The profile is updated at each Life Plan meeting to reflect the person's current needs and desires
- The profile is not intended to be a static history of the person's life

> The facilitator/care manager should make every attempt to have the person respond in their own words. The profile is meant to represent their story—the core of the person-centered paradigm.

Establishing Communication

The mode of communication should be established in the communication section. If the person cannot speak, ask questions that can be answered with "yes" or "no." If necessary, the person may communicate by blinking, nodding, etc.

Consider the possibility that the person may want to have some of their feelings represented by pictures.

Family and other members of the circle of support should be able to help tell the story for a person who does not communicate fully.

Advice for Gathering Information

If the person can speak, but is having difficulty responding, some gentle prompting or reframing of the questions may help. For example:

Introducing Me: (This is what I want you to know about me)

If the person doesn't respond, the facilitator could prompt them with the following:

- What do you want to tell me about yourself?
- What do you want me to know about you?
- What do you want to say?
- Who are you?
- What is important to you?
- Are you happy/sad? Feel good/bad?

- What are your dreams?
- What worries you?

Remember to include important religious and/or cultural beliefs and how they can be addressed by the care management team and providers.

My Home: (Free-form text about home)

- Tell me about where you live/your home?
- Is it nice?
- Do you like it? Not like it?
- Do you want to move?
- Are you happy there?
- Is it clean?
- Do you have enough room?
- Who do you live with?
- Are the people nice?
- Do you like your bedroom?
- Do you like your neighborhood?
- Would you like to change where you live?

My Work: (Let me tell you about my work)

- What do you do?
- Do you like it? Not like it?
- What kind of work do you like to do?
- Do you want to do something else?
- Do you get paid?
- Do you want to make more money?
- Who do you work with?
- Are the people nice?
- Do you need help?
- Do you want a new job?
- Do you want to change where you work?

My Health & My Medication: (My Health - An Overview is free-form text added by the facilitator/care manager from records.)

This section is the only one that generally does not include input from the person with IDD. The majority of information will come from the person's medical record and program charts.

Questions that you may ask the person include:

- How do you feel?
- Do you feel good?
- Do you feel sick?
- Does anything hurt you right now?
- Are you OK?

My Relationships: (Things I want you to know about the people in my life)

- What/who makes you happy?
- Who makes you sad/mad?
- Who do you like to be with?
- Who is your favorite person?
- Who are your friends? Girlfriends/boyfriends?
- Who is nice to you?
- Tell me about your family/friends.
- Would you like to develop some other relationships (i.e., friends, girl/boyfriend, neighbors, etc.)?
- Who can you depend on to help you?
- Who do you help?

My Happiness: (This is what I have to say about how I act and how I feel)

This section was requested by self-advocates to allow individuals to respond to their own behavioral issues.

- How do you feel now?
- What do you like?
- What don't you like?
- What/who makes you happy?
- What makes you sad?
- Who are you?
- Tell me what makes you laugh?
- What things do you like to do?
- Who do you like to be with?
- How can I make you happy?

- How can I make you laugh?
- Do you feel good?
- Who is nice to you?
- What makes you mad, frustrated, angry, and sad?
- What helps to make you feel better?

A Note on Reasonable Accommodations

Reasonable accommodations help ensure that persons can attend, participate in, and be comfortable in the following situations:

- Appointments (including doctor and dentist visits)
- At home and work
- During recreational or entertainment-based activities
- At religious services
- At any other event important to the person

The care manager and the interdisciplinary treatment team are tasked with developing plans to ensure reasonable accommodations; the provider implements these plans.

Please note: Accommodation is not solely about wheelchair accessibility. A person may not like crowds, may be sensitive to noise, may be visually impaired, or may experience anxiety. Once the assessment is completed, all of these characteristics will be known and should be added to the profile in the "Introducing Me" section.

Stratification Menu

Section	Response	Strat Level
In the Way of My Happiness	Behavior support plan with PRN medications	Moderate
In the Way of My Happiness	Behavior support plan with restrictive interventions	Moderate
In the Way of My Happiness	Behavior support plan with mechanical restraints	Moderate
In the Way of My Happiness	Behavior support plan with time out	Moderate
In the Way of My Happiness	Behavior support plan with rights restrictions	Moderate
In the Way of My Happiness	Behavior support plan with other [free text]	Moderate
In the Way of My Happiness	Get in trouble with those around me	Moderate
In the Way of My Happiness	Get arrested	High
In the Way of My Happiness	Have needed the police to intervene	High
In the Way of My Happiness	Have needed to go to the hospital	Moderate
In the Way of My Happiness	Have needed to get admitted to an inpatient psychiatric unit	High
In the Way of My Happiness	Have needed to go for respite	Moderate
My Health - History and Current Conditions	I currently have Decubiti—Stage 4 (skin breakdown)	High
My Health - History and Current Conditions	I currently have ESRD	High
My Health - History and Current Conditions	I currently have uncontrolled seizures	High
My Health - History and Current Conditions	I am currently being treated for cancer	Moderate
My Health - History and Current Conditions	I have been hospitalized this many times in the past year: 2	Moderate
My Health - History and Current Conditions	I have been hospitalized this many times in the past year: 3	High
My Health - History and Current Conditions	I have been hospitalized this many times in the past year: 4 or more	High
My Health - History and Current Conditions	I have had this many ER visits in the past year: 3	Moderate
My Health - History and Current Conditions	I have had this many ER visits in the past year: 4 or more	High
My Health - Medications	I take 6 or more medications	High
	The member currently has 3-5 active conditions	Moderate
	The member currently has more than 6 active conditions	High

Observation Charts

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