Public Respondent	Feedback	DDSD Response
Survey Monkey	Responsible party and frequency of update is very helpful.	Thank you
Survey monkey	Many issues have already been brought up at the Feedback Forum. A few of my concerns are: Why does CIHS need all the documentation that a FL home book needs? CIHS is an intermittent, non-intensive service. I would suggest that ISP, TASS, MERPs and HCPs and PBSP be included. Logs kept at the Agency, but not required for the home book. The requirement to keep the Medicaid and the SS cards in the agency file are a violation of the Privacy Act. Documentation of Guardian status will not be required for the agency file? LOC will not be required in the agency file? Written notice of annual ISP meeting not required in agency file? What is the difference between Data Tracking for Action Plans and Progress notes? The first one is monthly and is required for the home? Is this the monthly home visit form? And will it now need to be included in the home book? And what is the difference between a Progress Note and a Daily Contact Log? Semi Annual Reports.	Please refer to the Provider Documentation and Client Records chapter, the Provider Reporting Requirements chapter and the Client File Matrix. DDSD completed a substantial review of the Client File Matrix.
Survey monkey	It should clearly state that while other Reports are due 14 days prior to the ISP, the Nursing report is a true Semi annual and is based on the ISP date, not the ISP meeting date. Is it necessary to have the PAs for nursing, therapies and BSCs in the LCA home book? What value does that provide the FLP or in-home staff? Also, why at the CCSG and CIE Group service sites? This seems unnecessary.	Please refer to the Provider Documentation and Client Records chapter, the Provider Reporting Requirements chapter and the Client File Matrix. DDSD completed a substantial review of the Client File Matrix.
survey monkey	The eCHAT section #7 states: Timely completion, entry and approval of an e-CHAT in Therap must be: within no more than 3 business days of admission or transfer to a new provider agency, or two weeks following the initial ISP or transition meeting, whichever comes first. at least 14 calendar days but no more than 45 calendar days prior to the annual ISP meeting. In order to reflect the individual's current condition, within 3 business days of a significant change of health status (change of condition) and upon return from any hospitalization or sub-acute stay. Budget problems with the above: 1. Often nursing budgets have not been approved by admission date/start date. Reasons for this include: 1. Case Manager did not submit nursing on the budget at least 30 days prior to admission date/start date. Therefore a resubmission cannot take place for 30 days following the first submission date. Often budgets aren't approved going back to the client's start date when submitted late by CM. We do not get paid for work we have done.	DDSD has made clarifications through the standards that address this comment. Please refer to the Provider Documentation and Client Records chapter, the Provider Reporting Requirements chapter, the Transitions chapter, the Available Services and Individual Budget Development chapter, regarding working with the Regional Office in special circumstances, and the ISP chapter.
survey monkey	.2. Case Managers do not schedule a transition meeting at least 30 days before the admission/start date. Therefore, they aren't able to submit the budget until less than 30 days before admission/start date. Nursing budgets are not approved by start date. Therefore if we complete the assessments according to the Standards time line we do not get paid.	DDSD has made clarifications through the standards that address this comment. Please refer to the Provider Documentation and Client Records chapter, the Provider Reporting Requirements chapter, the Transitions chapter, the Available Services and Individual Budget Development chapter, regarding working with the Regional Office in special circumstances, and the ISP chapter.
survey monkey	3. Transition meetings are to take place 30 days before the start date. How can nurses complete their assessments 2 weeks after the transition meetings and hope to get paid since this is before the agency start date? Budgets don't become active until the agency start date. We have had multiple incidents of not being able to recoup money for initial nursing assessments when done according to the Standards because of the above reasons. Agencies should not have to provide nursing services for free for these required services.	DDSD has made clarifications through the standards that address this comment. Please refer to the Provider Documentation and Client Records chapter, the Provider Reporting Requirements chapter, the Transitions chapter, the Available Services and Individual Budget Development chapter, regarding working with the Regional Office in special circumstances, and the ISP chapter.
survey monkey	Page 1: Timely Distribution and Sharing of Records Sub line 2: Because of the changes made to when ISP meetings need to be held, the requirement of a semi annual report and then another report 14 days prior to the annual IDT, we would recommend utilizing one Summary report that would be submitted 14 days prior to the IDT. There is at most 2 months worth of data that is generated in addition to a semi-annual report A summary report would provide a more complete review of what the individual has accomplished during the current ISP year while removing a burdensome requirement on providers. Sub line 3: The requirement for current providers to transfer one year of medical records is burdensome when the information is available on the Therap system. If a transfer of services has been approved, why isn't the receiving agency simply provided limited access to Therap so that they can review the documents in question.	Sub line 2: DDSD made a decision to keep reporting requirement for "semi-annual" reports the same, being due 190 days after the start of an ISP year and two weeks prior to the ISP meeting. Sub line 3: The following language exists in the revised standards related to transferring medical records. "1. The Case Manager will share the current Individual Data Form (IDF) with the new Agency. 2. The receiving agency must accept a referral from the Case Manager following Therap referral procedures to access the electronic record. 3. The existing or discharging agency must provide the complete medical record for the past year, including any paper documents (via hard copy or fax) and documents contained in Therap via secure electronic communication. The record must be delivered prior to the Transition Meeting. 4. The person may not be discharged to the new agency until the record transfer is complete. "
survey monkey	Page2: Time Distribution Sub line 3: Please clarify time lines for Case Management to distribute the ISP to members of the IDT. Please also clarify process if an ISP is not approved by the Outside Review in a timely manner. Should the unapproved ISP be distributed?	Once the approved ISP is available, the Case Manager distributes it to all IDT members for which the individual requests to receive a copy, DDSD RO, and all DD Waiver providers with a SFOC, within 14 days of the approval.

Public Respondent	Feedback	DDSD Response
AADCP	Page 2: Client Records Please clarify language "shall be maintained in the location(s) where it is needed to perform". An individual in Community Integrated Employment may only see staff at their place of employment. Does this require that a client record be kept at the place of employment?	Please refer to the Client File Matrix. Select documents for CIE are to be maintained with the DSP when providing services.
AADCP	Page 3: Health Tracker While not absolutely imperative, it would make sense to title this section as Health Tracking or Health Tracking Report which is the name assigned within the Therap system. The use of a word or phrase that is not part of the system can be confusing to new providers. Sub line 3: Height/weight: We would request that gathering of this data not be required of the secondary provider agencies. If an individual utilizes a Community Integrated Employment provider, where would that provider collect the data? Sub line 5: Please establish time lines for this section of data collection. Is this required by end of shift, end of the week, etc.	The title of "Health Tracker" will remain. A hierarchy of the responsible parties for tasks such as weights (note these may be further defined in the plans) has been incorporated. Creating timelines for data collection would be too prescriptive, based on the example given: weights are typically taken at the same time of day in the same manner for consistency.
AADCP	Page 4: Health Track(in) Sub line 6: Again, if an individual only utilizes Community Integrated Employment services, is the providing agency required to collect immunization records and enter them into Therap? What if the family/guardian refuses to share this information?	Please refer to the hierarchy of primary providers responsible for the Health Tracker in the Provider Documentation and Client Records chapter.
AADCP	Page 4: Health Passport Sub line 1: This sentence implies that direct support staff must keep these documents with them at all times which has implications for HIPAA. Sub line 2: In an emergency, should this document be allowed to follow the individual to the hospital as soon as possible.	Therap is accessible electronically to obtain a health passport when remote if paperwork is not available. Primary and secondary providers will assure that the current Health Passport and Physician Consultation form, accompanies each individual whenever they are taken by the provider to a medical appointment, urgent care; emergency room, or are admitted to a hospital or nursing home.
AADCP	Page 4: Electronic Comprehensive Health Assessment Tool (e-CHAT) Sub line 2: Remove the word robust. Board of nursing requirements already dictates to nursing personnel the scope of their work. The term robust is too indeterminate and is open to subjective opinion.	The term "robust" is intended to define an in-depth and complete assessment and will remain.
AADCP	Page 5: e-CHAT Sub line 7.a: requires that e-CHAT be completed made within two weeks of the initial ISP or transition meeting. If this meeting is held 6 weeks prior to services being started (or longer), does this requirement still hold? Sub line 7.b: we would request clarification of what is acceptable if the date of the ISP is changed due to unforeseen circumstances and now the date of the e-CHAT is 46 days prior to the date of the IDT meeting?	1- We will review agency admission documentation requirements. 2- The current requirements state that the assessment will be completed no more than 45 days before and no less than 14 days before the ISP planning meeting. Keep in mind, the date time frame is based on the meeting date: not the service start date. The actual ISP effective date never changes. 3- If the ISP meeting date is moved up, it will push the eCHAT date out of compliance: that is more than 46 days before the meeting date. 4- Although meeting date changes may need to occur, every effort should be made to keep with the scheduled date as much as possible and clearly notify all members if the meeting dates needs to change. 5- If the meeting date does change and the eCHAT is over 45 days , the nurse may: a. Copy and save as draft b. Adjust the date c. Make note in comment section (usually part 29) about ISP meeting date change. d. Sign and approve.
AADCP	Page 5: Requirements for maintaining complete client records Sub line 4: We would recommend that Jackson class files be transferred to the safe keeping of DDSD/DOH when the individual is deceased or permanently discharged from the waiver (i.e. moved out of state).	LMB will work with OGC to determine whether providers are required to keep Jackson records indefinitely.

Public Respondent	Feedback	DDSD Response
AADCP	Required Client File Contents by Provider Type When asked to define the term "Service Delivery Site", it was indicated that this section was originally meant to apply to Living Care Arrangements and then "on site" Customized Community Supports – Group and Community Integrated Employment – Group. We request that the matrix take into consideration that on site group activities will be limited under the state's transition to the CMS Final Rule. What documents, if any, will be required to be available to these services when they are in the community? In regards to the Medicaid Card, Medicare Card and Social Security Card, are copies of these documents acceptable for the administrative file? In the Human Rights and Settings section, please clarify exactly what is meant by under development for each document and when those documents would be available for review. In the Person Centered Planning section, requirement for IDT minutes does not specify whose minutes? Should these be the minutes generated by the Case Manager only or each individual agency's minutes. In the Individual Service Plan Section, we suggest removing ISP Assessment Checklist as a required document. We do not see how this document improves the quality of life of an individual and of what value it would have to anyone but the person creating it. In the Data Tracking Section: it requires that data tracking for current month and previous year be available. This data may not be applicable to the current ISP and could be purged from the client record without any ill effects on the quality of service for the individual.	The Client Files Matrix details select documents DSPs carry when providing service in the community. Copies of cards are appropriate for the administrative file. The Human Rights chapter has been completed and any new forms will be available prior to implementation.
7/18/17 Forum	Budget – RFI letters – does agency need copy?	Provider agencies need copies of the approved budgets.