FY22- Key Indicator Questions and Comments from Providers

General Discussion	
Reports of Findings	Reports will look different this year. There will be no "overall" score. Each service area compliance score will be reflected on the Report of Findings. This provides a better comparison as the system moves towards conflict-free case management and as the DDSN Network adds more private providers offering only one or two types of services.
Uploading Information	Alliant has returned to on-site Licensing Reviews and on-site Contract Compliance Reviews for samples of 15 or more records. Some information may still need to be uploaded or provided as a packet on the date of review. Please use the Review Prep Lists as your guide and ask about any additional information needed. Please do not upload more than necessary! Pay close attention to the documents requested by Alliant. Nothing more, nothing less.
Double-Jeopardy	During the annual review of the indicators, DDSN attempted to remove the possibility of being cited multiple times for the same issue.
Caseload Sample	**Why does it seem like seem like the review is concentrated on certain caseloads?** DDSN Response: The number of HASCI files pulled at your agency will be higher because there are not as many HASCI Case Management providers to spread out the statewide sample required by DHHS/CMS. Plus, most providers of HASCI Case Management have a small, targeted group of staff to provide that service. To have a statistically valid statewide sample, the number of HASCI files will always be higher among that select group of providers. DDSN IT runs a formula for pulling the samples, so our QM staff don't actually get involved in that process. The list is randomly generated, but sometimes the HASCI Caseloads can appeared skewed due to the concentration. We can use the substitution list IT pulls to spread out the HASCI files across those Case Managers, as needed.
Provider Qualifications and Training	
CMP 201-224 & CMP 301-312 EI 201-206 & EI 301-307 DS 201-207 & DS 301-309 EMP-201-208 & EMP 301-309 RH201-208 & RH-301-311	**We noted that all services areas now have training and hiring procedures embedded into the program areas instead of in one centralized location- the Admin. Standards. What is the reasoning for this? From this provider's perspective- this is a centralized activity completed by the agency HR Department. Keeping all requirements in one location is much easier for those staff members to ensure they are meeting all requirements. What is the value of de-centralizing systems?** **Moving staff qualifications and training out of the Administrative Indicator section will result in citations spread out over different sections. Having citations in different areas will require more Plans of Correction.** DDSN Response: The reorganization of the Key Indicators does not affect how the provider maintains this information. There is no de-centralizing of provider systems. The only change is in the placement of the indicators, which will assist in reporting needs for Waiver administration purposes. As staff qualifications and training requirements are measured for compliance, the results will be reported with the individual service type, instead of as a group with all services. By displaying the service area staff qualifications separately, this provides a better comparison across providers. Compliance among DSN Boards and Qualified providers can now be compared by discreet service type, rather than having all staff types (Residential, Day, and Case Management co-mingled in the Administrative section. Providers will not have "more" Plans of Corrections to complete as a result of moving the indicators. A Plan of Correction has always been required for each citation, so the number of POCs will not change. This is a reorganization of indicators, but they are not new indicators. The re-organization does not result in a work-load change.
Reference Checks	**We are having an issue getting reference checks back. We normally have this issue but after lots of harassing we get it. Now we have at least 6 new-hires that we're not able to get a reference for. Is DDSN considering any waivers for this requirement?**

	DDSN Response: Directive 406-04-DD continues to require the provider's attempt to obtain reference checks. The hiring agency should document all attempts to solicit the reference checks, whether by phone, email, or regular mail. As long as the attempts are documented, the provider will not be cited for the lack of response from the requested entity.
Crisis Management for EI Staff EI 104	**Why are EIs required to spend 2 days in Crisis Management training when it does not seem applicable to them?** DDSN Response: Providers must determine appropriateness of curriculum used. Providers are encouraged to use a curriculum designed with young children in mind to address common issues such as hairpulling, biting, and eloping, and de-escalating difficult family situations. This may not require an in-person, 2-day training, based on the needs of EI Staff. For curricula that is not on SCDDSN's currently approved list, included with 567-04-DD, an Exception must be approved prior to use. Some providers may choose to have a different curriculum for EIs versus the curriculum in place for other providers. While there is a cost due to the purchase of an additional training option, the provider may find a savings associated with the reduction in training time and opportunities for billable service hours.
Administrative Compliance Indicators	
Review of GERs during RM Meetings A-107	**We have some concerns regarding "review trends of all the GERS." In order to ensure we are capturing accurate information this would mean an agency of our size would be sorting through and reviewing thousands of GERS in the course of a Quarter to find trends and then completing follow up on the high risk categories. If we are reading too much into this, please let me know (we have attempted this a couple of ways, but there was no easy way to go about this).** DDSN Response: Providers may utilize summary reports currently available in Therap to track/trend GERs within their agency. In particular, the Business Intelligence tool in Therap can be very useful for tracking/trending GERs by type and location. If your agency does not currently have the Business Intelligence tool available, you should request access through DDSN IT/Helpdesk.
Med Tech Quarterly Oversight AI-112	**Are interventions such as ZOOM, blast emails, other mass communication tools still acceptable to address this quarterly oversight indicator? What is the purpose of supporting evidence to show the indicator is being met? Are providers being asked to prove the content is acceptable? Please elaborate on the purpose of this indicator in the context of an ever-changing staffing pattern in programs.** DDSN Response: The follow-up resulting from oversight activity can be coordinated through various communication tools, based on the needs identified by the person responsible for oversight. The findings from the quarterly oversight may be communicated/addressed via electronic communication in some cases, while other findings may require in-person instruction. The purpose of the oversight is to ensure staff remain knowledgeable about their responsibilities as a Med Tech and any concerns are addressed timely.
Residential Habilitation Compliance Indictors	
Initial Assessment RH-302	**It is impossible to complete a full and accurate comprehensive residential assessment based on 2nd hand information- which is what this indicator is asking for. Is there some type of idea of what DSN considers to be a comprehensive residential assessment able to be completed solely off of information obtained by others prior to admission? Could that doc be shared with providers? Of course, basic information needs to be obtained prior to service delivery but that is very different from a full and comprehensive assessment. Would appreciate additional detail for this indicator of what is expected.** DDSN Response: DDSN has not required all providers to use a uniform assessment tool. This Key Indicator is based on currently approved Residential Habilitation Standards.
Comprehensive Functional Assessment RH-402	**Noted in the review guidance that significant differences are listed as the benchmark. Please clarify what DSN defines as significant- would assume by this that issues such as clerical errors, dates not updated would not trigger citations but not updating when a goal is met, or a skill is lost would be what is being sought with this indicator.** DDSN Response: Clerical errors will not result in a citation.
Residential Plan RH-503 & 504	**Noted in the guidance in these two indicators some overlapping information. Verifying that if 604 is cited- this won't create a situation where 605 is automatically cited as well.** DDSN Response: The Key Indicators are based on currently approved Residential Habilitation Standards. 503 requires that the type and frequency of care needed by the person is addressed in the Plan. 504 requires that the type and frequency of the person's supervision needs are addressed in the Plan. The indicators will be reviewed separately.
Residential Plan	**Guidance indicates fewer than three training objectives may be established if people are "experiencing significant health issues/treatments…". It would be helpful to have clarification if very high degrees of**

RH-506	**either physical or intellectual disabilities would qualify as reasons for having fewer than three training objectives.** DDSN Response: At this time DDSN is not considering additional modifications to this standard based on the person's baseline physical and/or mental health status.
Residential Monitoring RH-707	**In every other residential/day training element, monitoring is required quarterly- why is this required monthly?** DDSN Response: This Key Indicator is based on currently approved Residential Habilitation Standards.
Behavior Support RH-701-713	**Where in the indicators does it give how problem behaviors are defined? There doesn't seem to be any place that discusses the behavioral goal and replacement behavior that is to be monitored.** DDSN Response: The indicators are not intended to be the sole source document for information about behavior support. Please refer to source documents for the indicators for additional information.
Behavior Support RH-708	**Understand that this is not a new indicator but continue to feel it necessary to state that the progress on a behavioral goal is also subject to the individual's participation. This indicator puts 100% of the responsibility for documented progress on the provider. Often change for the sake of change occurs on plans- DSP staff can't keep up. Note: they are not trained therapists- this continues to be a bit ambitious.** DDSN Response: Thank you for your feedback. This Key Indicator is based on currently approved Residential Habilitation Standards.
Behavior Support RH-708	**Can RBTs complete the Fidelity Checks?** DDSN Response: The standard indicates that at least 50% of fidelity checks must be completed by the plan author. RBTs are not considered plan authors, therefore they would only be able to complete 50% of the checks required by this standard.
Behavior Guidelines	**How will Behavior Support Guidelines be reviewed? Do we need the same level of documentation required for BSPs?** DDSN Response: DDSN has not specified the content of behavioral guidelines, only that there should be some brief historical data regarding an individual's diagnosis and general techniques for staff if symptoms are displayed. If the person has a diagnosis listed and a formal Behavior Support Plan is not warranted, Guidelines to address targeted behaviors and simple guidance for staff on what to do if behaviors are displayed may be documented. Guidelines are probably no more than a paragraph or so, depending upon the needs of the individual. These really are not meant at all for anyone with serious or significant behaviors.
PDRs with Private Psychiatrist	**PDRs- Private Psychiatrists are refusing to complete documentation for PDR. The person has the right to choose their psychiatrist.** DDSN Response: Providers should have a form to document Psychotropic Drug Review. This needs to be completed by the coordinator or whoever is responsible for ensuring the PDR is completed. The form should include targeted behaviors, discussion of the behaviors occurring, the effectiveness of the BSP, effectiveness of the meds, and any recommendations for change in the meds or the BSP, etc…. All of this can be documented by the coordinator/residential staff. All the psychiatrist has to do is write any order changes and sign the form. The residential staff should be completing all documentation of discussion from the PDR and just getting the MD to sign.
Residential CI/ Event Reporting RH-901	**Why is the obviously Administrative function moved into the programs? Also, MAR reviews are included in the QA indicators as well as in the licensing standards (3.9). Why in both locations? This sets up the ability to be cited in different reviews for the same issue. Admin systems should be reviewed as such- not fragmented into departmental reviews.** DDSN Response: The QIO Reviewers will continue to identify reporting issues that may be discovered during the individual file review. It is important to have timely, accurate reporting of adverse incidents/events to ensure appropriate response and identify changes in service needs. The individual file review may present information that was not evident at the Administrative Indicator level. The indicator will support increasing CMS incident management reporting requirements.
Visitors	**What are the new HCBS requirements for visitors in residential settings?** DDSN Response: It really depends on what is detailed in the person's plan. Other factors may be at play, such as if a person has a legal guardian. For provider owned or controlled residential settings, the regulation states (as it pertains to visitors): *(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:* *(D) Individuals are able to have visitors of their choosing at any time.*

	The regulation also states – in that same section: *(F) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*
Key Assessments	**How should we document Key Assessments/ Access to keys?** DDSN Response: The statement "*any modification to these additional requirements for provider-owned or controlled home and community-based residential settings must be supported by a specific assessed need, justified in the person-centered plan*" in the Residential Habilitation Standards, is basically a direct quote from CMS. The CMS requirement actually goes farther than the Standards by saying the following (some of the points don't seem applicable to the issue of keys): *"The following requirements must be documented in the person-centered service plan:* *• Identify a specific and individualized assessed need.* *• Document the positive interventions and supports used prior to any modifications to the person-centered service plan.* *• Document less intrusive methods of meeting the need that have been tried but did not work.* *• Include a clear description of the condition that is directly proportionate to the specific assessed need.* *• Include regular collection and review of data to measure the ongoing effectiveness of the modification.* *• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.* *• Include the informed consent of the individual.* *• Include an assurance that interventions and supports will cause no harm to the individual."* The statement in the Standards, "*reviewed by the human rights committee*" was added by DDSN based on Directive 535-02: "Human Rights Committee". As you know, the HRC is responsible for safeguarding and protecting the rights of those who are not fully able to exercise their rights, ensure people are treated with dignity and respect in full recognition of their rights. Regarding the issue of keys, it seems that the right to be recognized is that the person is a renter with a lease and therefore has the right to have access to their home (rented space) and ability to secure their personal space/ belongings within their home. There will be different scenarios based on the abilities of the person; the requirement for the HRC approval would depend on the scenario. Generally: If someone is assessed to completely able to understand the pros and cons of having a key and assessed to be able to manage having one, considers his/her own circumstances in light of the pros and cons, then decides not to have one. In that situation, the person is fully able to exercise his/her right to a key but has made an informed choice not to have one - no HRC needed. The "outcome" of that would be that when anyone asks him/her about it, he/she indicates that he/she knows he can have a key but have chosen not to have one, can get one if he/she decides differently, etc. If someone is assessed to completely able to understand the pros and cons of having a key and assessed to be able to manage having one, considers his/her own circumstances in light of the pros and cons, then decides a key is wanted, but is denied one by the provider – It's not clear that the HRC should approve or that HRC approval would help; the expectation would be that a key be provided. If someone is assessed to be unable to fully understand the pros and cons of having a key but assessed to be able to fully manage having one, it seems the provider would have two choices: 1. give the key and train on understanding the pros and cons until he/she can exercise right to possibly decline, or 2. not give the key, train, and get HRC approval. NOTE: If assessed to be unable to understand, the provider can't say that the person is fully able to decline. If the declination is not informed and voluntary, then HRC approval is necessary. If someone is assessed to be able to fully understand, but assessed to be unable to fully manage, it seems the provider would again have two choices: 1. train on managing, not give the key until he/she learns to do so or declines, and get HRC approval, or 2. give the key and train. **Providers would be wise to have a policy about charging for replacement keys.*

	If assessed to be unable to understand and unable to manage, then HRC review and approval is required.
Physical Accessibility	**What are the requirements for physical accessibility in residential settings? Does the home have to have more than one ramp?** DDSN Response: The Center for Medicaid and Medicare (CMS) has issued requirements for Home and Community Based Settings (HCBS). These requirements apply to many DDSN programs and have been incorporated into a variety of standards and tools in order to provide evidence of implementation. These new rules require an adjustment of philosophy and a commitment to person centered planning/thinking. Central to this philosophy shift is ensuring that a person's environment is one that is fully physically accessible. This means that the person can fully experience all the benefits of their home with a focus on safety, choice and autonomy. DDSN recognizes the practical physical site and budgetary challenges such a shift will require. To that end, DDSN is providing the below clarification of the licensing standard related to physical accessibility of the setting. Standard Clarification 2.15: The setting is physically accessible. DDSN expects that providers are assessing the physical accessibility of settings, acknowledging the need for improvement, and putting plans in place to become compliant. The requirements for accessibility accommodations for mobility related adaptations such as full egress from all exits to the home, lips in doorways, narrow hallways/doorways etc. must be implemented per the guidance in this standard. Providers have limited flexibility with the full implementation of mobility accommodations due to their direct connection to health and safety protections. The requirements for accessibility accommodations such as appliances, counter heights, and furniture must be implemented in consideration of the assessment and person-centered planning process. The decision to make an accessibly change in the home for these types of items, must include consideration of the abilities of the person and their interest to have accommodations put in place in their home. Assessments must include documentation of the discussion with the person about their interests in accessibility changes at their home. For example: if a person has an interest to learn to prepare meals, the provider needs to assess the person's needs in that area. Then provider can create a plan that describes how to move towards adding accessibility options to the home to meet that need/desire. However, if the person does not express any interest in learning to prepare meals, the provider needs to document the outcome of that discussion in the assessment and no further plan would be needed and no modifications to the home would be necessary. When a setting has people living at it that are assessed to have different accessibility desires and needs, the provider will work with the people in the home to create a plan to fairly balance accommodations. What must a setting do in order to ensure physical accessibility? At a minimum, the setting must comply with existing requirements under federal, state, and local law (e.g., fire safety codes, the Fair Housing Act and the Americans with Disabilities Act (ADA), if applicable). In addition, the setting must ensure that people can come and go from the setting and have visitors at times of their choosing. The setting also must ensure that people have unrestricted access to all common areas of setting (e.g., the kitchen, living room, laundry room, deck, yard etc.). In order to ensure that all parts of the setting that are normally available to people are accessible to people with disabilities, the setting may need to provide widened doorways, laundry machines with front (not top) access, cabinets and counters at a non-standard height, ramps, or other accommodations. In considering whether a setting meets the accessibility requirements, the DDSN will consider the following factors suggested by CMS: · Do people have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in the shared areas? · Are there gates, Velcro strips, locked doors, or other barriers preventing entrance to or exit from certain areas of the setting? · Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to overcome the obstruction? · For people who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheelchairs, viable exits for emergencies, etc.? · Are appliances accessible (e.g. the washer/dryer are front loading for individuals in wheelchairs)?

	· Are tables and chairs at a convenient height and location so that people can access and use the furniture comfortably? Where immediate achievement of all of the above standards—or prompt achievement of these standards as new needs arise—would entail a significant capital expense (e.g., buying new laundry appliances or adjusting counter heights), providers may wait to incur the expense until the affected part of the setting is rebuilt/remodeled/replaced. This delay is not allowed for new settings and does not authorize any provider to delay compliance with the Fair Housing Act, the ADA, or any other existing law. In cases where the provider would incur a significant capital expense to bring a setting up to standard for any reason, providers must show evidence of an assessment of the setting and plan to bring the setting up to accessibility standards. The plan must align with the assessed needs of each person in the home and be documented via the person-centered planning process. Exceptions for this standard may be made in cases where the provider does not own the setting and has limitations for which environmental modifications are permissible. In those cases, it would be expected that the assessment of the setting would acknowledge these limitations and determine if the setting remains appropriate for the persons served in the setting.

Citations for non-compliance	**If the HCBS Setting Rule does not require compliance until March 2023, why is my agency being cited now?**
	
	DDSN Response: DDSN and DHHS have already made a number of decisions, based on provider documentation, that certain settings have been determined compliant with the settings rule are expected to maintain compliance. If a provider is now suggesting that a setting is not or will not be compliant with the settings rule until March 2023, then DDSN will need to notify SCDHHS and the provider will need to do the following:
	
	• develop a compliance transition plan that details the actions to be taken to achieve full compliance by Dec. 30, 2022.
	  ○ This plan must be submitted to DDSN no later than October 1, 2021.
	  ○ DDSN may only approve plans that are judged to be thorough and sufficient to ensure full compliance. Each provider must have an approved plan by November 1, 2021.
	• submit to DDSN a quarterly report detailing the implementation / completion of the actions included in their compliance transition plan.
	• no later than November 1, 2022, must submit to DDSN new evidence for each setting that proves full compliance with the settings rule.
	  • Evidence may be submitted at any time prior to November 1, 2022.