South Dakota
Therap User Handbook

MARCH 2020

State of South Dakota
DIVISION OF DEVELOPMENTAL DISABILITIES

Table of Contents

Overview and Purpose

The Division of Developmental Disabilities (DDD) has contracted with Therap Services, Inc. to establish a statewide web-based information and technology (IT) system to meet the following outcomes:

- Transparency of information among all Individual Support Plan (ISP) Team members, particularly the participant and parents or guardian, as applicable;
- Documentation standards for Community Support Providers to improve access to information related to daily supports for all ISP Team members;
- Documentation standards for Case Management providers to promote clear expectations for and of all ISP Team members and increased efficiency for users accessing information across multiple providers;
- Improved outcomes for participants by creating system efficiencies.

All providers will have access to modules included in DDD's contract with Therap, as outlined below. Additional information regarding the functionality of each module is included in *Appendix A – SD Therap Modules*. All Providers are required to meet documentation as outlined in this guide.

Modules outlined throughout the Therap User Handbook include detail regarding whether the module is required and for whom: Case Managers, Community Support Providers, or both.

Module	Open to all Users?	Required - Community Support Provider	Required – Case Management Provider
Therap Basic			
Individual Data Form	Y	Yes	Yes
Emergency Data Form	Y	Yes	No
T-Logs	Y	Yes	Yes
Health Tracking	Y	Yes	Yes
General Event Record (GER)	Y	Yes – all incident reporting	Yes
GER Resolution	Y	Yes – Abuse, Neglect, Exploitation	Not available in CM account
Training Academy	N		
Secure Communications (SComms)	Y	Recommended for HIPAA compliant communication	Recommended for HIPAA compliant communication
ISP Programs/Data/Reports	Y	Required	Required
Behavior Plan/Data/Reports	N		
Individual Plan of Protective Oversight (IPOP)	N	Not required – by request	Not available in CM account
Case Notes	N	*Highly Recommended* - Shared Living Providers only	Documentation of billable and non-billable time
Time Tracking	N		
MAR Plus	N	Not Required – by request	Not available in CM account
Electronic MAR	N		
Mobile MAR	N		
First DataBank Drug Database			
Health Plus	N	Not Required – by request	Not available in CM account
Medication History	N		
Allergies	N		
Diagnoses	N		
Individual History	N		

Orders	N		
Consents & Authorizations	N		
Other Modules			
Employment History	Y	Not Required	Available as View Only
Training Management System	N	By Request	By Request
Personal Finance	N	By Request	Not available in CM account
E-CHAT (Comprehensive Health Assessment Tool)	N	Not Required – available by request	Not available in CM account
Health Passport	N		
Individual Care Plans	N		
GER and Demographic Business Intelligence	Y	Not Required	Not Required
1 GB Document Storage	Y	N/A	N/A
Individual Home Page	Y	N/A	N/A

Team Communication Modules

T-Logs:

T-Logs are used as one-way communication among team members to share information in a HIPAA compliant manner. Two types of T-logs can be created: Individual and Program Based.

<u>Individual T-Logs:</u> ***Required by DDD effective July 1, 2019 for Case Managers and Community Support Providers***
Designed to promote communication within provider organizations and within the ISP Team for participant-specific information. T-Logs provide a continuous, searchable record of team communication comparable to an electronic bulletin board in that T-Logs are most effective as *one-way communication*. Unread Individual T-logs appear in the users "To Do" tab. *The DDD has outlined the following "do's and don'ts" for the use of T-Logs:*

Do	Don't
Share brief updates re: changes to a person's schedule/routine *"Jo's schedule for work tomorrow has changed – she now works from 10 a.m. until 4 p.m. I assisted her to change her scheduled bus ride."*	Use to document provision of services in place of ISP data
Use T-Logs to share reminders – a change in medication time, an upcoming home visit, special instructions *"Bill is going to church on Christmas Eve with his sister. Please remind him of his new sweater and to comb his hair & shave. He will be picked up at 4:30 p.m."*	Write a detailed T-Log to summarize a person's entire day or the entire shift
Individual Health issues-updating nurse, team, etc. on change in health status, i.e. "Mary complained of a headache but didn't want to take ibuprofen – please monitor"	Use T-Logs to document administration of OTC meds instead of designated MAR

Each Community Support Provider shall determine internal standards for low, medium and high notification level of T-Logs. The use of the T-Log "Type" is also at the discretion of the CSP; however, standards should be established to promote consistency for Direct Support Professionals (DSPs) responsible for documenting as well as external team members' understanding and review.

<u>Professional Documentation & Interpretation:</u>
CSP training and ongoing coaching for DSPs regarding objective, professional documentation is a fundamental component of orientation and professional development.
It is imperative that Case Managers are cognizant of DSPs' role in documenting, and the varying levels of experience in professional documentation and correct terminology. Additional follow up by the Case Manager is warranted in the event an entry may be interpreted as abusive, neglectful, exploitative, restrictive, or punitive. Follow up may include, but is not limited to:

- Contact with CSP management/supervisor for further detail;
- Contact with CSP management/supervisor regarding actions taken/planned;
- Report to DDD as a CIR; and
- Contact to guardian or family regarding situation.

Program Based T-Logs: ***Not Required by DDD***

Designed to promote communication for non-participant specific information, such as issues which impact all people within a setting or are pertinent to a location or general information for staff working within the department or location. The DDD has outlined examples below which include, but are not limited to, ways in which a provider may choose to use Program Based T-Logs. Examples are as follows:

- Maintenance Requests
- Technology Requests
- Dept. to Dept. communication

Secure Communications (SComm): ***Not Required by DDD***

Case Management and Community Support Providers will determine internal protocol for use.

SComm facilitates the exchange of information among users in an agency or across different agencies in a secure, HIPAA compliant way. Using SComm, staff members within an agency can exchange messages on administrative or individual care related issues. Users can also contact and communicate with Therap Customer Support regarding PHI sensitive issues.

SComm behaves as an email account within Therap; therefore, after an employee leaves the organization and the account is deactivated, there is no permanent record or log of conversation or follow up regarding participant-specific issues shared via SComm. The module also includes features like Compose, Reply, Reply to All and Forward. Internal reports (e.g. ISP, Individual Data and others within the Therap system) as well as external documents (e.g. Word and Excel among others) may be attached to an SComm message.

Two types of SComm exist: General Information and Individual Specific. Examples of when to use each type include, but are not limited to, the following:

- General Information: An overnight staff person prepared breakfast, completed laundry, etc. and sends an SComm to notify team members.

- Individual Specific: sending a message to just one or a smaller group of people to share or request information which doesn't warrant inclusion of all team members.

Multi-Provider SComm:

Multi-Provider SComm allows messages to be sent between multiple providers who support the same individual. To access and use this feature, the "Multi-Provider SComms" Privilege must be selected. Once enabled, the user can send an SComm to users in other organizations who also have the designated Privilege. In most cases, middle managers and those in leadership roles within an organization are granted access to Multi-Provider SComms.

Storage Modules

Individual Document Storage: ***Required by DDD effective April 1, 2019***

Allows users to store various external documents pertaining to an individual and ISP Team to view them from one convenient place. It helps to convey different information pertaining to an individual like Admission Order, Authorization, Consultant Report, Discharge Order, Lab Result, Referral Document, Financial statements/ledgers, etc. to agencies providing services to the individual in a HIPAA compliant way.

For participants who request specific information pertaining to him/her NOT be stored in the Therap system, such as past abuse, trauma or sensitive health information, the team should take all necessary measures to respect the participant's request for privacy.

- What is the nature of the information requested to keep private?
- Will the participant consider granting access to the information on a case by case basis by signing a release of information?
- Does the participant want to share the information with team members after a designated period of time?
    - Example: Diagnosis of cancer and the participant wishes to tell team members on his/own terms, after gathering more information regarding the prognosis, or after determining a course of treatment.
- Will preventing or restricting access to the information reduce team members' ability to effectively support a person?
    - Example: if a person has experienced past trauma or abuse, how will information about potential triggers, specific supports, and preventative measures be shared with team members? Has the person considered acknowledging past abuse, neglect, exploitation within the plan without disclosing details?
- Does preventing or restricting access to the information increase risk of others contracting a communicable disease?
- How will precautions to prevent the spread of communicable disease be communicated with team members?

Agency Document Storage: *Not Required by DDD*

Agency Document Storage allows users to store various documents and view them from one convenient place. Therap currently offers three types of documents to be shared via Agency Document Storage: Operating Guidelines, Policies and Procedures and Training Materials. Providers may use the module at their discretion to reduce the administrative burden of repeatedly sharing documents via email with staff members and/or DDD. Examples of such documents include, but are not limited to:

- Policies and Procedures
- Accessible formats of annual participant and guardian training
    - Abuse, Neglect & Exploitation
    - Grievance
- User guides for employee access
- Provider internal forms for employee access
- Organizational charts and contact information
- Instructional manuals for equipment – Hoyer Lifts, etc.

Participant Information & Person-Centered Planning

Participant/Guardian Access Policy: Per ARSD 46:11:08:02, a copy of the participant's record shall be in a format accessible to the participant. If abbreviations, acronyms, or jargon are used, a key shall be provided. In addition, it is the Division of Developmental Disabilities' position that the participant, participant's parent, if the participant is under 18 years of age, or the participant's guardian has the right to access information in the participant's record.

DDD strongly recommends providers develop and implement policy regarding the process by which the parties above may request access to a participant's record. A written policy offers protection to interested parties in the event the provider disapproves access to either general or specific information in the participant file. It is recommended that any policy developed includes the following:

- A designated person within the provider organization, either by name or title, to whom the request may be submitted;
- The process by which the provider will establish access and grant permission to view, submit and/or correspond with ISP Team members based on the following criteria:
    - Scope of legal decision-making authority of the requestor (Ex. a Conservator would be granted access to financial records only);
    - If the requestor has no legal authority to access information, a release of information signed by the participant and/or any substitute decision-maker which authorizes access to the requestor and details the type and scope of information to be shared;
        - *Best Practice: Private conversation, away from requesting party, with participant regarding his/her consent to release information to the requestor, including type and scope of information.*
    - ISP Team agreement that the requestor's access to participant information would not be detrimental to the participant's physical, mental, or emotional well-being;
        - If the ISP team determines access would to be detrimental and thereby denies access, the requestor may file a grievance with the provider or file a complaint with the DDD.
- Provisions which outline criteria for restricting or removing access based on the requestor's abuse or misuse of information.

Granting Access to Participant Information:

Case Manager	Community Support Provider	Authorized to View:
Individual Data Form Individual Support Plan • Personal Focus Worksheet • ISP Agenda • Individual Support Plan ISP Monitoring Team Meeting Notes Eligibility documentation General Event Reports written by Case Manager	Individual Data Form General Event Records T-Logs Rights Restriction(s) & Restoration Plan(s) • Related due process documents Behavior Support Plan Implementation of goals & daily supports Health Records – appointments, results, medications	• Participant • Guardian • Parent, if the participant is under 18 years of age • Others as designated by the participant and/or guardian through a release of information

Participant Record Requirements:

The participant record is made up of many components within Therap. Pertinent information is housed in various modules, each designed for ease in finding, downloading and printing information. Per ARSD 46:11:08:02, the participant's record shall include data as outlined in the Required Information column, as follows:

Required Information (ARSD 46:11:08:02)	**Therap Location:**
Participant's full name	Individual Data Form-Identification Data *While most digits of the Social Security Number are de-identified, caution should be exercised regarding access to SSN, which when combined with other identifying personal information such as DOB, address, etc., increases risk of the participant being a victim of identify fraud.*
Participant's Social Security Number (SSN)	
Date of Home and Community Based service eligibility	
Address of the participant at the time of entry into the division's service system and current address and phone number	
A summary of health insurance, financial support, and entitlements	Individual Data Form - Insurance
Any identification of family, guardian, conservator, or other interested persons, including current addresses and telephone numbers	Individual Data Form – Individual Contacts • Note type of guardianship if applicable • Attach legal documents to Individual Data Form
Status of legal capacity	
Identity of the party responsible for managing the participant's funds	
Any provider of services or supports including any subcontractors during the past two years	Individual Data Form AND Individual Support Plan
Any employment history, including a list of employers, dates of employment, and any position held	Employment History
Current assessment reports	Document Storage – Folder 3 Assessments
Critical Incident Reports	General Event Records – High Notification
Quarterly assessments pursuant to 46:11:05:05.01 and	Individual Home Page (anticipated by April 1, 2020)
Participant's current ISP	Personal Focus Worksheet, ISP Agenda, and Individual Support Plan

Individual Data Form (Core IDF): In addition to the required information above, the following information shall be included in the Individual Data Form, which is designed to help users maintain essential demographic information. Users are able to attach two photographs to this module as well as scanned documents and store them in a HIPAA compliant manner.

- Title
- First Name/Last Name (Required)
- Date of Birth
- Social Security Number
- Medicaid Number (Required)
- Race
- Ethnicity
- Residential Address
- Mailing Address
- County of Residence
- County of Service Delivery
- Email
- Phone Number

Individual Service Plan:

Information gathered for initial and annual planning purposes is written by the Case Manager and housed in the Case Management provider's Therap account, and at this time is searchable through the CSP Therap account. DDD is currently working with Therap implementation specialists and programmers to streamline access to this information for all team members through the Individual Home Page.

The Individual Service Plan, as defined in ARSD 46:11:01:01, is comprised of three separate modules in the Therap system, which include the Personal Focus Worksheet, the ISP Agenda, and the Individual Support Plan.

The Personal Focus Worksheet is a questionnaire designed to provide a summary of the information gathered through assessments. Questions are framed from the participant's perspective as well as the perspective of others who know and care about the participant. Any items noted on the Personal Focus Worksheet which may require further discussion can be linked to the ISP Agenda.

The ISP Agenda lists topics for discussion, a review of current and past action plans, enabling the team to more effectively evaluate progress. In addition, the ISP Agenda contains questions which must be addressed by ISP Teams per ARSD 46:11. The ISP Agenda acts as the literal agenda and houses meeting minutes for the ISP initial or annual meeting and is intended to guide the ISP Meeting conversation and result in more detailed action plans to assist the participant to achieve his or her identified goals, which are then included in the Individual Support Plan.

The Individual Support Plan includes each of the following sections. See Standardized ISP Guide for detailed guidance.

- What is most important to the participant – *summary of what was learned through completion of assessments, PCT Discovery tools and skills, or Charting the LifeCourse tools. See Standardized ISP Guide for additional information.*
- Risks (such as seizures or falls) and related protocols. *CSPs must provide the Case Manager with documents outlined below, as they are developed by the CSP for implementation purposes but must to attached to the ISP by the Case Manager.*
    - The risk section should capture risk related to medical conditions, supervision, legal issues, behavioral concerns, rights restrictions, safe environment, and healthy living. Attachments for the risk section shall include (but are not limited to):
        - *Participant-specific* protocols-seizure, suicide, choking, falls, run-away, etc. as listed in the Risk Type dropdown menu
        - Due process – Human Rights Committee (HRC) and/or Behavior Support Committee (BSC) signatures reflecting approval or disapproval of:
            - Rights Restrictions – at least annually
            - Behavior Support Plan – at least every six months
            - Emergency Rights Restrictions – whenever implemented, review by a quorum of the HRC
        - Functional Analysis addressing root cause of behavior
        - Documentation of positive approaches implemented prior to approving and implementing more restrictive procedures
- Professional services used by the participant (physicians, therapists, etc.)
- Service Supports – outlines the typical weekly schedule as well as type, scope, duration and frequency requirements for specific services provided to the participant.

- Acton Plans for Employment or Alternative to Employment (ATE) and any other goals identified by the participant and team
- Discussion Record serves as a place to document other supports needed and wanted by the participant, team discussion related to the participant's life
- External attachments may be added to the ISP, such as attendance and signature sheets from team meeting(s)

For detailed instructions regarding how to complete each component of the Individual Service Plan, please refer to the Person-Centered Planning section.

ISP Monitoring:

Quarterly Monitoring is written by the Case Manager and housed in the Case Management provider's Therap account. The CM is responsible for sharing the Quarterly Monitoring document with the participant, the guardian, any authorized family members or other parties, and the CSP. The document is downloaded to a PDF form and sent to these parties through ***secure email or Therap SComm***. The CSP is responsible for storing the Quarterly Monitoring form in Document Storage for each participant to promote accessibility for all team members. *DDD is currently working with Therap implementation specialists and programmers to streamline access to this information for all team members.*

Participant Health & Safety

Health Tracking: ***Required for Community Support Providers effective April 1, 2019***

The Health Tracking module allows users to efficiently track different types of health data, a flexible way to record and follow up on medical issues and create detailed reports. DDD requires the following information to be documented within Health Tracking.

Health Tracking section	Required Content	Meets DDD requirements for:
DDD requires documentation in the following "sub-modules" for all participants:		
Appointments	Annual Exams – medical, dental, vision, chronic conditions, specialist follow up Consults Reason for appointment and any description of specific symptoms Comments – appointment results & findings Can attach medical visit summary document	Medical/Dental assessments Dental assessments Other clinical assessments Preventative Health
Immunization	Required per SD Immunization guidelines/requirements: Diphtheria, pertussis and tetanus containing vaccine Poliovirus vaccine Measles, mumps, and rubella vaccine (MMR or MMRV) Varicella Vaccine Tdap (11+) Meningococcal vaccine (11+) Recommended: Hib Hepatitis A Hepatitis B	Medical History Preventative Health

	HPV Annual influenza Pneumococcal	
Lab Test Result	Upcoming labs Lab results & comments Can attach related physician's order	Medication Management ISP Monitoring - Medical
Medication History	Link medication to diagnosis Attach physician's order for medication (sedation for medical/dental) Lab results for medication management	ISP Monitoring – Medical Medication Management Meds for Procedures
Documentation for the following "sub-modules" is required only as applicable to individual participant's support needs and team determination of documentation warranted:		
Height/Weight		
Infection Tracking		
Intake/Elimination		
Menses		
Respiratory Treatment		
Seizures		
Skin/Wound		
Vital Signs		

Medication Administration Record: *Not required by DDD*

Use of Therap Med Administration Record (MAR) is NOT required; however, if the MAR in Therap is not used, CSPs shall upload current physician's orders at least monthly (if changes in medication type or dosage occurred during that month) to enable all ISP Team members access to currently prescribed medications. Medication changes may also be documented more frequently in the following locations:

- Individual Document Storage;
- Medical Appointment Results;
- T-Logs;
- Medical History;

Health Plus: *Not Required by DDD*

Medication History: Contains a list of an individuals' current medications, including Home Medications, Review of medications and Reconciliations. Users will be able to navigate to corresponding modules from the individual's Medication Profile page.

Allergies: Enables users to document an individual's allergy information in detail. This information is used to determine if the medications in the individual's Medication History forms have any interactions with the individual's active allergies. Providers with access to the First DataBank will be able to view the Drug-Allergy interaction along with the Drug-Drug interaction information available for the individuals.

Diagnoses: Contains an individual's diagnosis record. Users may add, delete, and resolve diagnoses for an individual.

Individual History: Enables users to access and record historical information for individuals they support. Users can keep track of complaints, history of illnesses, reviews, status, etc. while accessing necessary medical information from one form.

Orders: Allows users to place orders for individuals' various requirements including medical equipment, diagnostic tests, medical supplies, nursing orders, nutrition, and food services.

Consents & Authorizations: Allows users to record, view, and print various Consent forms. Administrators can define Consent Types and upload Consent Templates for the agency.

Care Plan: Allows agencies and care providers to better document individualized Care Plans. As care requirements and planning are individual specific, this module allows agencies to create care plans for each individual. Furthermore, users are able to upload Care Plans to the Global Template Library.

Health Passport: A report which can be generated using the individual's information, primarily from the Individual Data Form, the Consultation Form and the Electronic Comprehensive Health Assessment Tool (eCHAT) modules. Agencies can create Health Passports that provide a summary of individual specific emergency details which include Personal Profile, Contact Information, Active Diagnoses, Major Safety Issues & Risk Factors, and Consent Information, among others.

The Comprehensive Health Assessment Tool (CHAT or eCHAT): may be completed on an annual or as needed basis and is designed to encompass all areas of a person's healthcare needs and guide necessary health interventions. Sections within the CHAT may be updated as changes to participant health occur to ensure accurate information is available to team members. Also, the eCHAT calculates the overall acuity level and publishes a summary with recommendations for where care plans may be required. eCHAT addresses the following:

Diagnoses and Conditions	Participant's active diagnoses
Allergies	Known allergies to food, drugs and environment and known history of anaphylaxis
Medications	Links to Medication History and addresses support to administer medications, the effectiveness of medications, treatments, and monitoring as well as any refusals of medications
Labs/Radiology	Documentation of abnormal lab work or radiology exams, management of regularly scheduled lab tests or radiology exams and general monitoring or maintenance of health status
Utilization of Medical Services	Scheduled visits to primary care physician as well as urgent care or emergency room visits and unplanned medical and psychiatric hospitalizations
Vital Signs	Record vitals if taken at the time of assessment. Addresses orders for pulse oximeter readings
Height and Weight	Assessment of current height and weight as well as any unplanned weight gain or loss in the last 12 months
Nutrition	Review of specialized diet, if ordered, and details regarding physician's order for calorie intake and texture. Fluid consistency, fluid restriction, and any supports are necessary to assure hydration or reduce risk of dehydration, and physician's orders to monitor input/output, if any
Tube Feeding/Enteral Nutrition	Assessment of tube type, details, original placement date as well as condition of tube site at time of assessment, ongoing concerns and risk for tube displacement

Aspiration Risk	Overall risk as determined by completion of Aspiration Risk Screening Tool (linked screening tool)
Oral/Dental	Level of assistance needed with oral hygiene, status of oral care/hygiene based on dental report or observation
Neurological Signs & Symptoms	Documentation related to shunts, pumps or other devices in addition to assessment of neurological changes, seizure history & frequency, diagnosis of Alzheimer's or dementia and other neurological disorders or events that may require planning
Cardiac/Circulatory/Blood Disorders	Known cardiac and circulatory disorders, detail regarding placement of pacemaker or defibrillator, and blood disorders that may require medications, monitoring, or planning
Endocrine	Summarize diagnosis of diabetes and monitoring of glucose, A1C, and insulin administration and protocol for symptoms of hypoglycemia or hyperglycemia. Assess status of any other endocrine disorder
Renal	Management of kidney/renal disorders, related diagnoses, and management of dialysis treatments
Gastrointestinal	Assessment of gastrointestinal conditions and medication management for these conditions
Bowel & Bladder	Assessment of continence, skin breakdown and infection risk factors, and management of colostomy or ileostomy monitoring and staff training required.
Reproductive Health	Document education and information provided to the individual related to gender-specific reproductive health, including but not limited to monitoring of pap smear, mammogram, PSA, and cancer history. Documentation regarding whether the participant is sexually active and has knowledge of or uses contraceptives to prevent or reduce the risk of STDs or pregnancy
Behavior Symptoms and Management	Assessment of recent change in behaviors which may be caused by medical issues. Also documents the number of psychoactive medications, any PRN psychoactive medications, reported extrapyramidal symptoms (EPS) or history of neuroleptic malignant syndrome
Infection Control	Assessment of risk for participants with compromised immune systems, including infection or colonization with multidrug-resistant organism, chronic viral infections, any other infectious processes or diseases which require planning
Respiratory	Documentation of acute or chronic respiratory issues requiring treatment and planning, including details related to use of nebulizers, inhalers, oxygen or other equipment to treat symptoms
Communication/Vision/Hearing	Documents the individual's primary method of receptive and expressive language, any use of adaptive devices for communication. Additionally, this section addresses vision, hearing and any plans related to communicative needs
Musculoskeletal/Neuromuscular	Captures information related to musculoskeletal or neuromuscular disorders which require care such as diagnosis of arthritis, osteoporosis or degenerative joint disease. An assessment of necessary monitoring for respiratory infections and skin breakdown, recent fractures, change or decline in functional ability, spasticity or contractures that require intervention
Falls	Number of falls in the last year, any falls that resulted in injury, or which required medical treatment.

Activities of Daily Living	Outlines the level of assistance necessary to assist the individual with grooming, dressing, hygiene, bathing, transfers, and mobility
Pain	An assessment of whether the participant is currently experiencing pain and how pain levels are communicated if the participant is non-verbal, including assessment of medication to manage pain.
Skin and Wound	Review of skin integrity, skin conditions, treatment of current open skin areas and overall skin integrity as well as level of assistance needed for mobility, transfers, and repositioning
Health Practices	Assessment of the participant's engagement in improving health outcomes, information regarding tobacco/nicotine use, use of street drugs or abuse of prescription medication, alcohol use with diagnosis of alcoholism, tolerance of routine healthcare screening, information related to any sedation or medical stabilization for medical appointments, impact of health conditions on participation in work or community activities, whether the person is receiving home health care or hospice services or palliative care.

General Event Records (GER): ***Required effective January 1, 2019***

General Event Records are designed to track reportable incidents for an individual. Using the incident reporting tool, users can report and follow-up on a wide range of incidents including injuries, behavioral concerns, restraints and accidents. Each incident is categorized as either a Low, Medium, or High notification level.

Effective January 1, 2019, all incidents meeting the criteria of a Critical Incident Report as outlined in ARSD 46:11:03:02 shall be submitted in the Therap system with a High Notification Level and will be reviewed by DDD Program Specialists. As outlined in ARSD 46:11:03:02, "the report must contain a description of the incident, specifying what happened, when it happened, and where it happened. The report shall also include any action taken by the provider necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the provider to reduce the likelihood of similar incidents occurring in the future." In addition, preliminary investigation findings are required to be submitted to the division within seven calendar days as specified ARSD 46:11:03:01.

All levels of incidents are required to be submitted via Therap – doing so not only promotes open communication among all team members but also provides a central source of data aggregation and reporting to Community Support Providers via Therap Business Intelligence.

Providers are responsible for establishing standards for internal incident reporting at Low and Medium Notification levels.

General Event Report Resolution: ***Required effective January 1, 2019***

The GER Resolution is designed to "close the loop" on a GER, particularly those submitted due to allegations of abuse, neglect, or exploitation against a participant. Information related to the actions taken and preventative measures noted above may be included in the GER Resolution. The GER Resolution must also provide information as outlined in ARSD 46:11:03:01, including:

- Issuance of the final investigation findings to the division within 30 calendars days of initiation of the investigation;

- General information related to whether disciplinary action occurred if investigation findings confirm staff engagement in abusive, neglectful, or exploitative activities. The name of the staff is not required to be included, nor specific disciplinary actions;
- If the allegation was substantiated, how the participant, the participant's parent if the participant is under 18 years of age, or to the participant's guardian or advocate, if any, was notified of the results of the investigation and actions taken to prevent future incidents.

The CSP investigation is to determine whether the event occurred as reported, i.e. substantiation. The CSP does not decide the guilt or innocence for a criminal act but is responsible for following approved policies regarding disciplinary action and contacting law enforcement for any suspected criminal activity, or the Department of Human Services as required by SDCL 27B-2-26 and/or Child Protective Services, as outlined in SDCL 26-8A-3 through 26-8A-10, inclusive.

DDD Reportable Incidents:

Reportable Event	THERAP Event	Notes:
Deaths	Death	All deaths need to be reported as separate CIRs, even if the CSP has previously reported a CIR regarding the circumstances that led to the death. If the incident that led to the death (ex: Heart attack) occurred the same day that the actual death took place, then only one CIR is needed.
Life-threatening illnesses or injuries	Injury, Hospitalization, Change of Condition, Communicable Disease	
Alleged instances of abuse, neglect, or exploitation against or by any participant	OTHER: Choose YES for Abuse, Neglect, or Exploitation and choose type	Per ARSD 46:11:03:01, all reports or ANE must have an internal investigation done by the Provider and the findings must be submitted to the DDD via a GER Resolution. All alleged instances of ANE must be reported, whether the CSP has internally determined the incident to be substantiated or not.
Changes in health or behavior that may jeopardize continued services	OTHER: Jeopardizing Services, Change in Condition, Missing Person/AWOL, Behavioral Issue, Sensitive Situation	Severe Altercation, Sexual Contact: there should be a report for the Aggressor and a separate report for the Victim if both are supported by the CSP. Severe self-inflicted injury: if it occurred in a suicide attempt, suicide section should be filled out, as well as injury.

	Report may also include Abuse, Neglect, and Exploitation	Behavioral Issue: The Division does not need a report for each incident but would prefer one report for a compilation of incidents that may be jeopardizing services for the person.
Serious medication errors	Medication Error, Other Events-Hospitalization, Neglect	To be reported as a CIR, the even must have resulted in emergency medical treatment, hospitalization, or death.
Illnesses or injuries that resulted from unsafe or unsanitary conditions	Injury, Neglect, Abuse, OTHER-select appropriate category from dropdown	Unexplained injuries should be reported to DDD by the CSP when the injury is identified as unexplained and is suspicious in nature and/or part of an identified trend.
Any illegal activity that involves a participant in which there is law enforcement involvement	OTHER: Law Enforcement Involvement	This category does not include infractions of the law that do not involve law enforcement or are minor infractions. If charges have been pressed against a person, a CIR is warranted.
Any use of physical, mechanical, or chemical intervention not part of an approved plan	Restraint, Restraint Related to Behavior	Restraints need only reported if they are not part of an approved plan or were not implemented as written. The individual's Guardian must be contacted. If the restraint resulted in an injury, the injury section of the form should also be filled out, indicating the primary cause as a restraint.
Any bruise or injury resulting from the use of a physical, mechanical, or chemical intervention	Restraint, Restraint Related to Behavior, Injury	Any time a restraint results in injury or bruising, even when there is an approved plan for the restraint.
Any reportable communicable disease involving a participant	OTHER-Communicable Disease, Hospitalization, Change of Condition	All communicable diseases must be reported regardless of severity.
Instances of corporal punishment, seclusion, denial of food or other practices prohibited in SDCL 27B-8-42	Abuse, Neglect, or Exploitation OTHER-then choose applicable event under "Event Type-Other"	

Other Critical Incidents as required by DDD	OTHER- then choose applicable even under "Event Type-Other"	Altercation/Assault: unless the injury is severe, altercations are not reportable AWOL/Missing Person Suicide Attempt/Threat

Person Centered Planning – Progress Towards Goals

ISP Programs: ***Required as of April 1, 2019 for Community Support Providers***

ISP Programs provide a platform to facilitate discussions and help in the decision-making process when creating a person-centered service plan. Providers can use this tool to plan, organize and implement the individualized service plans for each individual in a HIPAA compliant manner. The ISP module includes program definition, data collection, and report generation which offers a flexible way of tracking the goals and progress of an individual. *Community Support Providers* shall create ISP Programs in accordance with the Individual Support Plan and as agreed upon by the team. ISP Programs shall outline Desired Outcomes and related Action Steps, Rights Restrictions, Highly Restrictive Procedures and Behavior Support Plans included in the ISP Risk Section. DDD requires the use of ISP Programs to document:

- Goal progress documentation (Action Steps in ISP associated with Desired Outcomes);
- Restoration Plans for restrictions of rights – progress toward restoration;
- Behavior Support Plans - tracking behaviors included in a BSP and behavior intervention strategies;
- Routine supports - *the ISP Team must determine the need for and frequency of documentation for routine supports* such as toothbrushing, shaving, and similar supports. Documentation needs identified by the ISP Team may be based on various factors, including but not limited to:
    - The participant is developing skills related to activities of daily living – documentation is warranted to demonstrate progress
    - The participant's skills are declining/additional assistance is necessary and documentation is needed to demonstrate provision of the support (prompting, hand over hand guidance, etc.)

ISP Program Titles: *DDD Recommendations*

Program name: Brief description to describe what the program is related to
Specific name of program: frequency of documentation

- Limited to 50 characters

Example:

- Goal-Maintain Employment: weekly
- Support-brushing teeth: twice daily

Types of programs:

- Goal – activities related to the Desired Outcomes in the ISP and related Action Plan
- Support – activities of daily living which the participant requires staff assistance or prompting to complete
- BSP – any program part of a behavior support plan
- RRO – Rights restriction that fall under the ARSD for other rights restrictions
- RRC – Rights restrictions that fall under the category of chemical restraint
- RRP – Rights restrictions that fall under the category of physical restraint
- RRM – Rights restrictions that fall under the category of mechanical restraint

Providers may choose to include key terms in the ISP Program title in order to collect additional data on the type of restriction or ISP Program. In these instances, specific criteria would be included after the DDD program type. Frequency of documentation – providers *may* include detail regarding how often the program should be implemented and documented. Frequency of documentation is customizable and should meet documentation and data collection needs for the specific goal or restrictive procedure to which it pertains.

ISP Programs shall be developed in accordance with the following criterion:

- Goals: a separate ISP Program for each Outcome/Goal in the ISP – the description of the measurable step should be listed as tasks. Below is a table reflective of the Action Steps in the Individual Support Plan.

	Measurable Steps that will be taken to reach the Desired Outcome				
	Description of Measurable Step	Who is Responsible?	How Often or Due Date	Where to Record	Notes
ISP Program location	**Task**	**For Home/For Work:** *CSP Therap Program the Participant is Enrolled in* **For Other:** *Party other than CSP who will carry out the step/task*	**Schedule/Frequency**	**ISP Program**	**Suggestions related to steps – participant interests and other pertinent information**

Example: Sally has a goal to get a job at the local grocery store. The ISP Program would outline the associated action steps such as working functional math skills, counting money and making change, and completing job applications as tasks. Data can be collected for each task within the ISP Program as well as data regarding overall progress towards goal attainment.

<u>Documentation of Rights Restrictions & Behavior Support Plans:</u>

Rights Restrictions:

- Restrictive measures not related to generalized purpose shall be captured in a separate ISP Program(s)
- All restoration plans must be **individualized, measurable, attainable, time limited and outcome based**. ISP programs allow for documentation of progress towards regaining a right, in full or in part, which has been restricted
- DDD requires **all** restoration plans to be documented in ISP programs, in accordance with ARSD.
- One ISP Program which encompasses several restrictive measures related to one generalized purpose (Ex. risk of harm to self-results in restrictions to unsupervised time, community access, and locked cabinets)
  - Within the generalized purpose, the design of ISP Programs is flexible. ISP Programs may be grouped by type of documentation required (yes/no), frequency of documentation (Ex. daily or weekly) or as otherwise defined by the team
  - One ISP Program may be used in instances of restrictions which share common criteria, as follows:
    - Long Term Objective
    - Goal/Service
    - Reason for Program

Behavior Support Plans – one ISP Program with "tasks" for each component of the BSP

- This includes tracking of actual behavior and results of a behavior intervention techniques.
- Behavior not part of a behavior support plan or which occur intermittently may be documented in GERs.
- Behaviors part of BSP shall also be documented in an ISP program, in addition to GER reporting as specified in the BSP or ISP.

The use of an ISP Programs is **not** required for:

- Psychoactive medications (including PRN medications) for a diagnosed mental health condition;
- Medications for Procedures;
- Emergency Rights Restrictions.

Documentation of due process shall be attached to the ISP Risk section after each Human Rights Committee review, in addition to documentation of side effects, team review, etc. as outlined in ARSD 46:11:05. (See page 12 for additional detail regarding the ISP Risk Section)

Rights Restriction Example:

- *RRO: Locked Cabinets: Personal Finances*

Long term objective: Outcome based statement related to how the restriction will improve skills and help to achieve goals and help the person to be an active member of the community.

- Example: *Joe will learn basic money management skills in order to be more self-reliant when he leaves his home and makes purchases*

Goal/Service: Summary of the restrictive measure that have been put in place. The specific measures should be in the task section so that the agency can gather data on each specific task.

- Example:
    - *Joe carries no more than $5 in cash per day*
    - *Joe's checkbook is stored in a lock box in his apartment when he is not using it & the key is kept in the staff office*
    - *Joe does not use a debit card, credit card, or mobile app to pay for purchases*

Reason for Program: Summary of the Functional Analysis.

- Example: *Joe is at times impulsive with his money. He understands that money is necessary to pay bills and purchase the things he likes; however, Joe has difficulty with self-control when he sees items he likes, or he knows someone he cares about would like. His generous nature has resulted in overdraft charges, credit card debt, and Joe being taken advantage of by others.*

Schedule and Frequency: Summary of when the restriction is implemented. For example, under what circumstances would a physical restraint be implemented. The specific frequency and circumstances of implementation of the rights restriction should be outlined in the tasks section so the agency can gather data on all areas surrounding the implementation of a rights restriction.

Frequency of documentation: Each CSP can determine how often the staff need to complete documentation on the restriction just like for any other ISP program.

Criteria for completion: Restoration plan. What is required for the restriction to be lifted. Must be attainable and time limited.

- Example: *Each month Joe actively participates in creating a budget, pays his bills on time and maintains a positive balance in his checking account, he will move on to the next phase of restoring his right to handle his personal finances.*

Scoring method: How the CSP wants to do documentation of the restriction and teaching plans. This section should demonstration how the restoration plan is measurable as required in ARSD.

Teaching Method: The detailed instructions to implement restrictions and help people to learn new skills to regain his or her rights. This information can also be included in the tasks so staff can see the teaching methods each time they open the ISP program and can document on teaching strategies.

- Example:
    - *Joe and staff create a monthly budget*
    - *Staff assist Joe to download the online banking app on his phone and check the balance weekly*

ISP Data: ***Required as of April 1, 2019 for Community Support Providers***

The term "ISP Data" refers to entries which are made to document the delivery of supports outlined in an ISP Program.

Users with the ***ISP Data*** role are able to enter ISP Data for the individuals they have access to through their caseloads.

ISP Reports: ***Required as of April 1, 2019 for Community Support Providers and Case Managers***

ISP Reports enable users at both the Case Management and Community Support Provider to review ISP Data entered by those supporting the participant daily. CSPs may use this data to monitor provision of supports from a supervisory standpoint. For example, review of data entered to monitor staff implementation of supports at the frequency and scope outlined in the ISP, trends in progress, quality of implementation and documentation. This enables CSPs to assure quality supports are provided and identify the need for additional training for DSPs, increasing responsiveness to participant needs.

The Case Managers' review of data is also intended as a quality assurance measure; however, the Case Manager review does not extend to quality assurance of DSP's job performance. The Case Manager review is specific to whether supports are implemented to maximize the participant's health, safety, and quality of life. ISP Reports are one set of data reviewed to increase the Case Manager's ability to advocate on the participant's behalf as necessary.

Users with the ***ISP Report*** role can create reports on ISP Programs for the individuals on their caseloads. Reports can be generated for Approved and Discontinued ISP Programs.

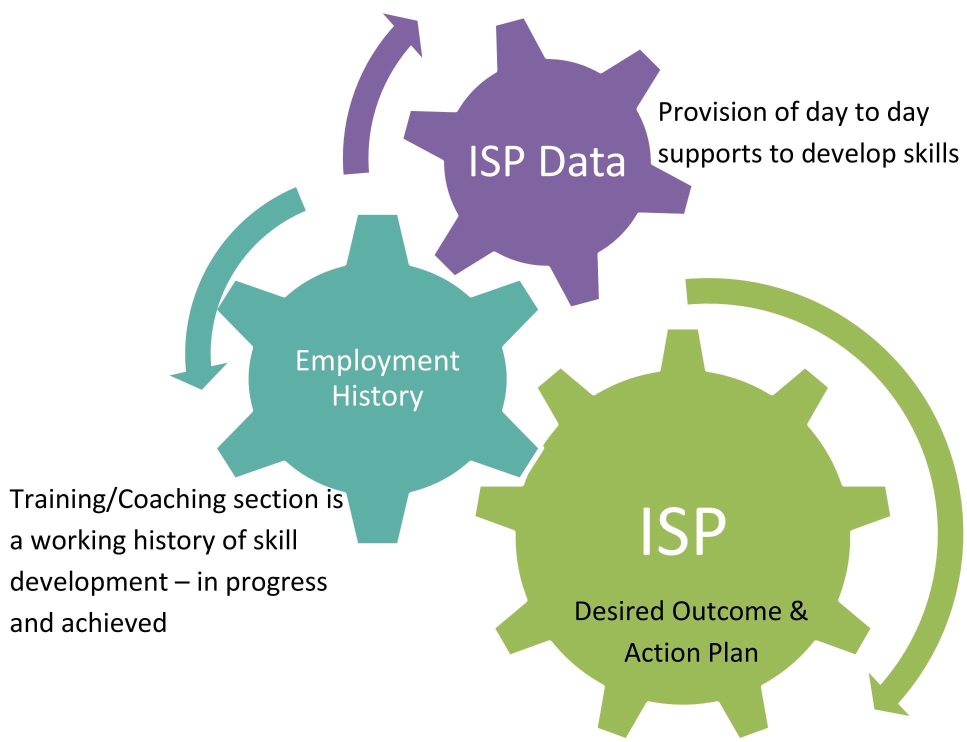
Employment History: *Not Required by DDD*

The Employment History Module is a versatile and comprehensive outline of information as it pertains to the development, acquisition, and maintenance of job-related skills and progress towards obtaining and maintenance of employment. Case Managers have the ability to view data entered in the Employment History module.

The Employment History Module includes the following sections:

Individual Information	Basic demographic information about the participant
Funding Source	Due to start and end date feature, an entry for each funding source is required. For example, the participant is receiving CHOICES HCBS Adult funding for Individual Supported Employment to maintain his/her current employment and at the same time is receiving funding through the Division of Rehabilitation Services to find a new job with the assistance of a Vocational Rehabilitation Counselor.
Employment Referral	Referral Source: party recommending the participant receive support to obtain employment. Referral Type: • Select "Internal" if the referral source is within the provider organization • Select "External" is the referral source is from outside the provider organization, i.e. participant or guardian request Initial Meeting Date indicates to team members and DDD when the ISP Team met to discuss the participant's desire to pursue employment and created an Action Plan and *is documented in this section by the CSP*. Based on the ISP Team's determination regarding supports needed to assist the participant to achieve the identified goal, the ISP should be updated to reflect the Path to Employment in the Employment/ATE section *by the Case Manager.*
Assessment	Providers may attach various employment-related assessments in this section.
Career Development Plan	After the initial meeting to develop an Action Plan, a Career Development Plan can be entered, which may include: • An outline of agreed upon activities to assist the person to obtain employment • If known, the type of work the person is interested in • Any other pertinent details related to supports in place for the person and who will provide it • Document meetings with individual regarding the employment plan The Career Development Plan can be updated periodically and is one way to track activities and progress within the Career Exploration service.
Employment Milestone	Milestone Type, Start Date, and Due Date enable the team to establish specific target dates to track progress towards activities outlined in the Career Development Plan. Updates to the Employment Milestone section can be an indicator that the person is making progress towards their desired employment outcome, signal a lack of progress and trigger a team meeting to assess supports in place and make necessary changes.
Training/Coaching	Document existing work readiness skills and track progress towards additional work readiness skills outlined in the ISP. "Skills Developed" may serve to build the participant's employment portfolio. Training/Coaching outlines the functional skills the person is working to develop and/or has gained. The graphic on page 22 demonstrates how the Training/Coaching section can be used in relation to the ISP Desired Outcome, which is broken down into Action Steps then written as tasks in an ISP Program, later documented as ISP Data.

	During the initial meeting to develop an Action Plan, any training or coaching needed by the person in order to be successful should be considered. As supports are provided and the person's skills increase, updates to the Training/Coaching section reflect the participant's progress.
Application and Interview	To be used when a participant submits a job application <u>and</u> attends an interview. In order to thoroughly document, the Employer must be added to the Employment Contacts (see below) <u>prior</u> to completing this section and can then be selected from the dropdown menu.
Job Detail	Must have employer and position entered into job bank before the Employment Record can be completed DDD Recommended fields: • Job Category • Employer • Benefits • Work Schedule • Job Start Date When employment ends, the following fields are required by DDD: • Job End Date • Reason for Job Loss
Employer (Employer Contacts)	Each provider may create a "library" of known employers, similar to Professional Services. Users with the ***Employer Management*** Administrative Role will be able to save, update, and delete Employers, save and delete Contacts/Interactions with Employer, import Employers from Excel, search imported Excel, and view Update History. Users with the ***Job Development*** Administrative Role will be able to view Employer and save and delete Contacts/Interactions with Employer.



Frequently Asked Questions

1. ***Can we set up various types of funding, for those not funded by DDD, with permissions for providers to add participants****?*
   a) CSPs can add participants to Therap and not link them to the oversight before they are approved for funding by DDD for services. Once DDD eligibility and funding are established, the provider would then link the participant to the oversight account and their information will sync between the accounts.
2. ***Will only those participants funded by CHOICES waiver or CTS be linked to the oversight account?***
   a) Yes, that is correct
3. ***What access will providers have to "old" account information after January 1st?***
   a) This will be based on user permissions. Most CSP user access will be disabled but specific administrative staff may retain access for *certain* modules. "Old" account will be deactivated and will no longer be available for data entry.
   b) Case Managers will have access to historical information for participants assigned to caseloads. DDD will have access to historical information for all active and inactive participants.
4. ***The super role privileges are those controlled by the Division or the CSP's?***
   a) For DDD staff - they have a Super Role and Caseload just like your staff. They manage their own Super Roles and caseloads.
   b) For CFCM - there is what is called a shareable super role in the state oversight account. The administration of this Super Role is controlled by DDD. For access to CSP data, only this super role can be assigned. This is done by CFCM staff.
5. ***How will HIPPA compliance be ensured?***
   a) The Therap system tracks all activity in all Therap accounts in Oversight, CM, and CSP. HIPAA prohibits users from viewing data that they do not have justification to view. It is the right of the participant and/or their guardian to request a log of all users who've accessed their file/information, and it is the DDD's responsibility to provide this information. All users should consider whether they can justify review of the information before accessing the record.
6. ***We have a few people who receive their residential services at another CSP and we subcontract for day services only. How will this work in Therap? Will there be two CSP accounts? Do both duplicate ISP programs related to the goals that CFCM writes in ISP?***
   a) Providers cannot access each other's data. Day services ISP Programs would be written by one CSP and residential ISP Programs by the other CSP. You can only add one ISP Program for each action step. Read only access to the ISP Programs written by other CSP will be available via the shared ISP Plan.
7. ***How can a CSP initiate a multi-provider SComm to a Case Manager?***
   a) Multi-provider SComms are accessible through Individual Care by choosing the Oversight Account. Case Managers are associated with the Oversight Account. Click the blue arrow next to DDD-SD and you'll find case management. These SComms are participant-specific. Sending general information to Case Managers is not an option.
8. ***If a DSP accidently signs off the wrong time on the MAR, the next person coming on shift is unable to sign off the medication because it is already signed for.***
   a) The update role is required to change mistakes. We only assign that role to a few select people (not DSPs) because that will allow them the ability to change the MAR.
9. ***When a medication is discontinued, could it be a highlighted in a bold yellow color and/or dropped to the bottom of the MAR?***
   a) In only shows as pink when the MAR is being edited. Once you approve the MAR for staff to document it is no longer pink and it appears the same as all the active meds-except for the word "discontinued" that is blended in with the other parts of the entry.

10. ***Who is responsible to link the ISP Program to the Individual Support Plan?***
    a) DDD recently learned that Case Managers are NOT able to link the ISP and ISP Programs as previously thought due to the fact that the ISP and the ISP Program are housed in two separate accounts. Therap is currently working to problem-solve this issue.
11. ***Can the BSP, protocols, rights restrictions, HRC docs, etc. be linked in the ISP Risk section?***
    a) No-these documents must be attached as they are not a live document.
12. ***ISP acknowledgement process by all team members (CM, CSP, family/guardian) verify that all team members can acknowledge the ISP under Oversight structure***. Acknowledge is a Super Role based privilege that can be assigned to any user.
    a) There is only one approval of an ISP, which is done by the case management provider.
    b) CSP team members, based on roles/permissions will be able to acknowledge ISPs.
13. ***Can a report on ISP due dates be run through the CSP account? This information is helpful to kick off many of our internal systems.***
    a) From the CSP account, go to the Unified Search for ISP Plans. Don't enter a name, just hit search. That will show all the ISP plans from the CFCM accounts start and end dates for those who get services from the CSP. This can be downloaded into Excel.
14. ***Will there be a unified search for ISP quarterly monitoring so CSPs can see the documents vs. having to save them in Document Storage?***
    a) DDD and Therap are exploring alternatives to the current Quarterly Monitoring housed in a custom form. In the meantime, Therap is developing a Unified Home Page which will provide a central location for all Plans, ISP Programs, and Quarterly Monitoring.