ISP version 3.3 update presentations April 2022 Questions and Answers

SUPPORTED DECISION-MAKING

Q1. Is the expectation now to get a Supported Decision-Making Agreement for those who do not have a guardian?

A1. The expectation is that a conversation regarding supported decision-making options is had with all individuals at least annually, regardless of whether or not they have a guardian. If interested, then a Supported Decision-Making Agreement should be developed with the individual (and his Legally Authorized Representative if he has one).

Q2. Is having a supported decision-making agreement different from having an authorized representative?

A2. Yes, Supported Decision-Making Agreements are the formal process of documenting who an individual wants to support them, in what areas of life, and how they want to be supported. The individual makes decisions based on the information they receive from their supporters. Authorized Representatives (AR) are recognized under the DBHDS Human Rights Regulations. They fulfill a designated role in supporting people with making decisions in the context of DBHDS services. An individual would develop a SDMA with the participation of their DBDHS AR. If the individual does not want to include the AR, the appointment of the AR should be reevaluated to ensure the relationship continues to be beneficial.

Q3. With the Supported Decision-Making, will SCs need to put in "Other" if they have a guardian?

A3. Supported Decision-Making and Guardianship are separate questions on the ISP. If someone has a Supported Decision-Making Agreement then the answer would be "yes" and the life areas would be selected based on the areas listed on the Supported Decision-Making Agreement. "Other" under the Supported Decision-Making question refers to other life areas indicated on the Supported Decision-Making Agreement (i.e. educational, housing, employment, etc.).

Q4. Some guardianship paperwork does not clearly/specifically identify areas in which the guardian can make decisions for the individual such as the one just reviewed in the ISP v3.3. How are SCs to determine which areas the guardian can make decisions?

A4. It is important to understand what type of guardian an individual has. If someone has full guardianship, they make decisions about all aspects of an individual's life. If they have limited guardianship the court documents will specifically state which life areas they are responsible for and which rights/life areas the individual retains.

Q5. Can you have a legal guardian and a supported decision-maker or is that choice only available for those without guardians?

A5. All individuals can have supported decision-makers and a Supported Decision-Making Agreement. There will be 2 templates for the Supported Decision-Making Agreement: 1 for individuals without legal guardians and 1 for individuals with legal guardians.

Q6. For the Supported Decision-Making Agreement does this include if they have a guardian or an appointed AR or is this a new document that we need to have on file? If it is a new document, is there a template or is this something that each agency will have?

A6. Supported Decision-Making Agreements are a separate/different document from guardianship and AR documents. DBHDS is working to create 2 templates for Supported Decision-Making Agreements.

Q7. Does the concept of Supported Decision-Making Agreement take the place of the concept of an Authorized Representative?

A7. No, please see the answer to Question 2 above.

Q8. Supported Decision-Making Agreement: Will this be the responsibility of the Support Coordinator to complete or do providers also have to have a separate agreement? If providers do not have to have an agreement, will it be provider's responsibility to obtain the agreement from the Support Coordinator for the individual's file?

A8. A Supported Decision-Making Agreement is a single document utilized by all providers/entities once it is completed. Anyone can assist the individual with completing a Supported Decision-Making Agreement, but it is important to ensure that all providers/entities have copies of the Supported Decision-Making Agreement, as well as updated copies as amendments or changes are made. The individual decides who can have copies of the Supported Decision-Making Agreement.

Q9. Why is the Supportive Decision-Maker's name not included under Representation? Should the Supportive Decision-Maker's name and contact information be included in the ISP?

A9. There can be multiple Supporters for an individual. The life areas they support the individual with and how they provide support will vary. The Supporters' names and contact information is located on the Supported Decision-Making Agreement. All CSBs and providers should have a copy of the Supported Decision-Making Agreement (or relevant sections of the Agreement) on file to utilize during decision making processes.

Q10. For the Supported Decision-Making Agreement- Who creates this agreement? How is it documented? Is it a form?

A10. Please see the answer to Question 8 above.

Q11. Is a Supported Decision-Making Agreement just a different term for having a Substitute Decision-Maker?

A11. Supported Decision-Making is different from Substitute Decision-Making. In Supported Decision-Making, an individual with a disability identifies trusted individuals to help them make a decision, however the ultimate decision is up to the individual with the disability. In Substitute Decision-Making, an individual is tasked with making the ultimate decision for the individual with the disability.

Q12. Can "Supported Decision Maker" be changed to "Assisted Decision Maker" so it does not confuse with "Substitute Decision Maker" which is already abbreviated "SDM" throughout existing records? Also, is there a state standard for a Supported Decision Maker agreement form or agreement?

A12. The term Supported Decision-Making is internationally recognized and identified in Virginia Code § 37.2-314.3. Acronyms should not be used without explanation/clarification as they can be confusing and not understood by the individuals who receive supports. While there is not a required template, Virginia will have 2 Supported Decision-Making Agreement templates available for use in the next few months.

Additional information about the required elements to meet the definition of a Supported Decision-Making Agreement will be provided later in 2022.

Q13. I know you said that supported decision-making will be explained more later on, but is it a legal category or is it just an idea? I just wonder how it actually works. Is this something that is coming down the pike or is it already a thing?

A13. Supported Decision-Making has always been recognized in Virginia, however Supported Decision-Making Agreements were formally recognized in Virginia Code in 2021. More information can be found at: https://law.lis.virginia.gov/vacode/37.2-314.3/

PHYSICAL CONDITIONS

Q14. How far back should we refer to for past information under 2.6 Physical Conditions?

A14. There is no set timeframe. We recommend including information that is significant to the individual and their health history that is important for the ISP team to be aware of.

Q15. Under the new medical questions, what happens if you have an individual that has transferred to your CSB and you don't have all previous hospitalizations and/or surgeries information?

A15. We encourage you to gather information as best you can and include what you are able to gather.

Q16. For the additional medical questions, if yes, does the system require text to be included to explain before moving on, etc.? If not, then I am concerned we will only get the "yes" and with no explanation, which is essential to have to explain as to why the answer was "yes."

A16. Yes, a text box is required after answering "Yes" to describe each of the physical conditions question responses.

Q17. If an individual has a history of seizures but has not had seizures in 10 plus years and only takes daily meds to prevent them would that be considered resolved for the medical needs outcome section?

A17. While controlled, it is still noteworthy to list the history of seizures in the ISP. In this example, the supports would be related to routinely taking medication. Any seizure protocol should be available in the record for those supporting the individual.

EMPLOYMENT

Q18. How do we address the employment topic when someone is unable to work due to health such as bed bound, paralyzed, etc.? Or if someone has no desire to work ever? What would these discussions be expected to look like?

A18. This is a two part answer: Address this by finding activities that the person is interested in and customize them toward an employment goal, for example if someone must be in bed or is paralyzed, they may need a goal for skill development in their natural environment that can lead to employment.

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If someone has no desire to work, through meaningful conversations address the reason why, concerns, and/or fears about employment and discuss how employment can lead to a more meaningful life by being integrated with society.

Q19. What alternative sources of funding are available for employment other than DARS?

A19. The Developmental Disability Waivers are a source of support for those that qualify. Please reach out to Stephanie Subedi, State Employment Specialist, at (804) 821-4153 for additional assistance.

Q20. Are specific topics required topics for conversations related to employment? i.e. will it show that we missed a topic when we have a DBHDS audit/SCQR audit if we check "no" on these questions? If so, why do the topics appear as optional if they aren't?

A20. Employment topics are required to ensure a thorough and meaningful conversation was held and is documented. If a topic is answered with a "No" consistently, it could lead to technical assistance.

Q21. I would love to see an example of a discussion with someone that's nonverbal or is unable to communicate with any electronic or picture devices? Also, how about someone that's physically unable to have a job? What if DARS denies the referral due to the "high needs"? Lastly, how is the legal guardian considered in this conversation?

A21. Anybody that wants to work can. You may have to look into customizing the job for that individual based on need and what skills are needed to communicate in an employment setting. The Region V Regional Quality Council is currently working to develop resources to assist with these issues, which will be made available more broadly once completed. In the meantime, please reach out to Stephanie Subedi, State Employment Specialist, at (804) 821-4153 for assistance.

Q22. In regards to employment, is a statement regarding the guardian does not want the individual to work, possibly with more detail as to why, be acceptable?

Q22. The topics are designed to gather detail about the reasons and potential barriers that could be addressed with a Legal Guardian, including a timeline for reviewing options in the future. With the 3.3 version updates, we are expecting more detail about the "Why" to be explored.

Q23. What about individual's over the age of 17 that may be in school until age 22? Why end at 17?

A23. Continued services through the school system is an option up until age 22. The two questions that are required for 14 – 17 year olds will appear if you check "Yes" to having the conversation with someone of that age group. If the individual chooses to stay in school through 22, this detail is appropriate throughout the other questions / answers.

Q24. The training gave an example of stating "no" for the conversation to pursuing employment because the person wants to stay at their day support (which is a very common occurrence with our individuals). However later on in the training it was eluding that the conversation is expected, so if we say "no" to the employment discussion question, we will be out of compliance then, correct?

A24. If you answer "No" to the question, "Was there a conversation with the individual/substitute decision-maker about employment", this is confirming there was no conversation about employment. There must be documentation as to why the conversation didn't occur. If there was discussion about current satisfaction or dissatisfaction (the person wants to stay in their Day Support service), the answer

to the above question is “Yes” as this was discovered in the conversation. You are correct. An employment discussion is expected and in the example above, follow-up questions about interest in volunteer work or barriers to employment, etc. are appropriate.

Q25. Just looking for clarification on the question that asks was a conversation held about employment. I believe you showed an example that said "no", but the explanation was that the person didn't want to work. Would you not check "yes" to show that you asked the person? It appears if you check "no", that no discussion was held.

A25: You are correct. Please see A24.

Q26. For employment, we always write a support activity about maintaining employment and then choose this as a skill building activity. Depending on each job, the individual can have several job duties. Should we choose just one specific duty or skill to measure?

A26. Yes, choose a more specific skill (more than just maintaining employment). It should be something specific to the individual that they would like to work on in order to maintain their employment. The above is too broad for a skill building activity and not person centered if you have the same thing for everyone.

Q27. Do the discussions on Employment and Community Integration have to happen during the shared planning meeting or can the discussions happen before the shared planning meeting and noted?

A27. Best practices would have these discussions occurring throughout the entire plan year with the individual/substitute decision-maker. At the planning meeting, a summary or narrative about where they stand in each topic area would be added in.

Q28. Will there be additional trainings to assist us in presenting these questions through a person-centered lens for individuals who require total care? For example, an individual who is paraplegic, non-verbal, uses a G-tube for nutrition, and has a legal guardian who provides round the clock care for them (repositioning, etc). Conversations for those folks look quite different in terms of employment/volunteering.

A28. Guidance regarding these conversations will be part of upcoming Employment Resource updates. DBHDS recognizes those conversations can be sensitive for all involved.

Q29. Is there any assistance that could be offered to individuals and their families whom are interested in employment, but frustrated with how long it takes to obtain services with DARS? It is taking the majority of the calendar year following referrals just to obtain services with DARS. Families are reporting several months without communication with DARS regarding where they are in the process.

A29. Please reach out to Stephanie Subedi, State Employment Specialist, at (804) 821-4153 for assistance.

Q30. All of this as we were told by Service Authorization staff can ONLY be covered if individuals have Supported Employment Services! So is there a change?

A30. The employment and community involvement conversations are genuine conversations that may lead to the creation of outcomes related to employment or community involvement. Depending on the

nature of the outcomes, they can be related to Employment under Supported Employment Services, but they do not have to be. Activities around employment that are not specifically related to completing job tasks can be addressed in other services. Per Medicaid Waiver policy, Community Engagement can include: the "development of skills that enhance career planning goals in the community, where "career planning" includes gaining information to make an informed decision about whether a person wants to work, as well as exploring types of work opportunities and gaining information regarding the person's employment interests and preferences."

Q31. How do we pose the employment questions for people with severe physical disabilities who need total care? And for folks with severe aggression/ behavioral support needs? What is the expectation for the answers?

A31: Guidance regarding these conversations will be part of upcoming Employment Resource updates. Conversations about employment with individuals and their substitute decision-makers when the individual has significant needs are more sensitive. Please see A18.

Q32. Are there any recommendations for individuals who have severe medical needs on how to address employment and volunteering questions annually? I have had parents/guardians cry in meetings as they know this was not an option for their loved one. I want to perform my job well but also want to be sensitive to those who we provide supports to.

A32. Guidance regarding these conversations will be part of upcoming Employment Resource updates. Conversations about employment with individuals and their substitute decision-makers when the individual has significant needs are more sensitive. Please see A18.

INTEGRATED COMMUNITY INVOLVEMENT

Q33. I'm not sure about that "no more than 3 people with DD present". If a provider takes 3 people to a baseball game and there happens to be 20 other people there with DD what then? Seems arbitrary. Maybe specify what you're looking for there.

A33. The Integrated Community Involvement Life Area is appropriate if at any point by any provider has a ratio of no more than 1:3. The Community Living Life Area is appropriate if involvement never occurs at a ratio of 1:3 and is always 1:4 or higher. The frequency is based on the needs and interests of the person. When the outcome is supported by a DD waiver provider, there must be one or more associated support activities in at least one service of no more than 1:3 to be considered integrated. Services and supports, regardless of the service or setting, that involve people in their community at a ratio of no more than 1:3 would be considered more integrated. If a person is being supported to achieve their outcome by an unpaid person, friend or family, and it is an outcome that is about being part of their community then it would still fall under the Integrated Community Involvement Life Area.

Q34. How do we have a meaningful discussion of services like Community Engagement and Community Coaching when these services are not available or are extremely limited in the individual's area? This has been a really difficulty discussion as COVID has closed these once-held services to many.

A34. The pandemic has created additional challenges at a time when providers are limited. Limited service availability can be listed as a barrier and part of the discussion with the individual/substitute

decision-maker. Support Coordinators and providers can contact their Provider Team CRC to discuss options and possible service development needs. The CRC contact chart is available online at: Provider Development CRC Contact Chart effective 1/1/22

Q35. For the "current barriers question", previously, checking "none" meant they received the service. Is this still the case?

A35. Yes. If you check “None”, this means there are not barriers to community involvement.

Q36. In the community involvement area, what if they live in a rural area without many options or transportation (even modivcare/logisticare is not reliable)? Do we list there are no options available due to area in which they live and lack of transportation or no funds to do activity?

A36. Yes, narrative boxes are provided for the details of your discussion about options, lack of transportation, and other topics. Conversations may lead to creative options. Support Coordinators and providers can contact their Provider Team CRC to discuss options and possible service development needs. The CRC contact chart is available online at: Provider Development CRC Contact Chart effective 1/1/22.

Q37. It seems the COVID-19 pandemic and health vulnerability can be a barrier to community involvement, but the hope is that this barrier is not forever. Should we include reference to this as an actual barrier?

A37. Yes, you may include this as a barrier under “Other”.

Q38. I have found that providers will often submit CE/CC SAs and the plans very clearly appear to be for more of a "Community Presence" vs "Community Involvement". Will Pre-Authorization pend service authorizations that do not reflect community involvement in these plans?

A38. Yes. Service Authorization will pend a Community Engagement or Community Coaching request when involvement/engagement in the community is not included in the Part V. This activity is a core component of these services. In some instances an individual could be working towards engagement, but is should be clear in the instructions how efforts are leading to this result.

Q39. Who will train the COMMUNITY BUSINESSES, CLUBS, ORGANIZATIONS to accommodate and accept individuals with disabilities?

A39. We all connect to others through one-on-one connections, similar personal interests, mutual friends, employment, volunteer work, etc. Exposure to and genuine connections with others in business, clubs and various organizations will create opportunities for understanding and acceptance on both sides.

Q40. Why is it important that there are no more than 3 individuals present with disabilities? What if the individual wants to spend time with other individuals with disabilities? Should we be pressuring them to spend time with non-disabled people? This just seems arbitrary and not very person-centered.

A40. People have the right to choose where they spend their time and with whom they spend their time with. We are encouraging increased opportunities for individuals to belong to their community. They may certainly choose to spend a good amount of time with others with disabilities but options for more

individualized involvement may be just as meaningful. Additional information about integrated community involvement will be available through upcoming Provider Roundtable meetings.

Q41. Will this presentation be offered in a pdf form for printing?

A41. Yes. The PowerPoint, video and this Q & A will be available through the ListServ.

Q42. In regard to the employment and community involvement...many Support Coordinators struggle with simply locating providers due to lack of providers (especially in SWVA). Same goes for employment providers. This has become increasingly difficult, especially in the past year. Even if we have individuals interested in these services there are no choice of providers to provide the service. Along with the ongoing and increasing worsening issue of lack of staff in group homes, ALF's, etc. Even if we have individuals interested in pursuing these services, there's not enough staff to provide transportation. How are we expected to provide the necessary supports and justification when we continue to experience these ongoing issues? The ISP will be unable to fully be carried out until certain issues are resolved. Lack of providers/ongoing staffing concerns will only continue to impact the population that we serve.

A42. The pandemic has created additional challenges at a time when providers are limited. Limited service availability can be listed as a barrier and part of the discussion with the individual/substitute decision-maker. Support Coordinators and providers can contact their Provider Team CRC to discuss options and possible service development needs. The CRC contact chart is available online at: Provider Development CRC Contact Chart effective 1/1/22.

Q43. When completing the employment and CE/CC sections, is there any understanding that all services are understaffed and finding staff and being creative are almost impossible right now? GH's are understaffed, most DS and CE/CC providers aren't taking new clients, SE providers are struggling to find jobs because employers want someone who can be cross trained on multiple jobs. So we are having these discussions and then having to tell people they can go on a waiting list and hopefully things will get better or there are just no providers to address these dreams right now. SC's caseloads are, across the board, too high to be able to spend the time on the creative aspect of person centered thinking like we used to because the documentation requirements have exponentially increased for each person, thus setting us up to fail in your expectations. Reduce documentation requirements instead of adding and we can focus on some of these things like we could do in the past. Does DBHDS have any idea of reality out here?

A43. The pandemic has created additional challenges at a time when providers and support coordinators are limited. Limited service availability can be listed as a barrier and part of the discussion with the individual/substitute decision-maker. The updates to the 3.3 ISP are intended to capture this information, as it always has, but broken down into specific topics.

Part V

Q44. Can she repeat the 5 words again to be used in Part 5?

A44. Some common words used in support instructions are assist, support, remind, encourage, and monitor.

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Q45. Our description boxes in our plans can be quite lengthy, can we still say "further support instructions are attached in his plan for support"? I don't think ours will fit in the boxes in WaMS most of the time.

A45. Yes, you may still upload additional support instructions.

Q46. What is the difference between “How to support” and “support instructions”?

A46. “How to support” is the name of the area in WaMS and on the template (for modified use) where you will enter support instructions. Support Instructions indicate how to support the person, so essentially, these terms are interchangeable.

Q47. What would support instructions be for nursing services, PDN and SN? What are some examples?

A47. Support Instructions for these services would be just like any other service, and spell out how the nurse supports the person with the support activity.

Q48. When we have such details on support instructions, Medicaid wants to see staff document about EVERY support instruction. If we document about every detail it is way too cumbersome and time consuming, taking away valuable time to actually provide the service. How do we address the competing priority?

A48. DMAS QMR looks that you are documenting for every support activity through a progress note or supports checklist as defined by your service, then your documentation will focus on the “individual's responses to supports and specific circumstances that prevented provision of the scheduled service (12VAC30-122-120 12e).” The length of the support instructions is based on the needs and preferences of the individual. They should be sufficient to ensure success with an activity across supporters.

Q49. If I understood correctly, we now enter our plan for support instructions in WaMS. Are we still responsible for uploading our Plan for Support as an attachment?

A49. You continue to have the option to complete the Part V through “Modified Use” where you complete the required fields in WaMS then upload your full Plan for Supports as an attachment. If your agency is using the WaMS through the “Complete Use” method, no additional uploading is needed, unless your agency opts to use a separate schedule format.

Q50. Since the Part 5 has Support Instructions now, do providers need to upload anything additional, or is just completing the Part 5 in WaMS sufficient? Do they need to upload a signature page, or can they just say they have it on file?

A50. If you complete the Part V in WaMS through “Complete Use,” you will not need to upload anything additional to WaMS; however, you will need to have a signed copy of your plan for supports in the individual’s record.

Q51. What will the changes in the Part V look like in the Interim Plan for Supports?

A51. The changes on the Interim Plan for Supports mirror the changes in the standard Part V.

Q52. Could you provide an example of when a backup plan is needed?

A52. A back-up plan is required for both Agency-Directed and Consumer-Directed Personal Assistance, Companion, and Respite, as well as In-Home and Shared Living Services. A back-up plan provides steps that will be taken to ensure the health and safety of the individual when the provider is unable to provide supports.

Q53. Is the Part V Plan for Supports document that the individual signs going to be changed?

A53. The Part V Plan for Supports document is going to be updated to add “How to Support” into the body of the template and not as a separate template.

Q54. Is the "How to Support" area where we put the "Support Instructions" from the Part V? Is the language for the Part V changing from "Support Instruction" to "How to Support"? Should we update our templates?

A54. You can use these terms interchangeably, so you do not need to update your template to say “How to Support” unless you wish to do so.

Q55. Many SA Reviewers in WaMS require providers to put the Back-Up plan for supports for sponsor, group day, community engagement, etc. - Are those NOT required?

A55. SA may request additional information depending on an individual’s particular circumstances, and may wish to see information that states what a person will be doing in the event they cannot attend their day program or job; however, back-up plans are only required for both Agency-Directed and Consumer-Directed Personal Assistance, Companion, and Respite, as well as In-Home and Shared Living Services.

Q56. When entering the Support Instructions, do you add all the Support Instructions for the Support Activity in the text box, or do you have to enter the Support Instructions one at a time?

A56. You will enter each separate support activity along with its respective “I no longer want/need supports when…” statement and the support instructions for that individual support activity. For support instructions and preferences that occur consistently across activities and settings, those will be entered at the beginning of the plan for supports under “Service.”

Q57. For listing the type of skill in a "skill-building goal" will there be a list of skill types to choose from or is it an open question to answer?

A57. It is an open question to answer, but you will want to keep in mind that general skills like, “cooking” should be whittled down into more specific skills such as “cutting vegetables,” “setting the oven temperature,” or something similar.

Q58. Aren't the "support instructions" in provider’s plans? So they have to be in SC ISP plan?

A58. Support Instructions are an element of the Part V Plan for Supports, so SCs should also have Support Instructions in their Part V, as well. For example, if the Outcome Statement is “Mary sees a therapist each week so that she does not feel sad all the time,” the Support Activity might be, “Mary finds a therapist that she likes,” and then your Support Instructions would detail HOW the SC will support Mary to accomplish that activity. The SC Part V is held in the CSB electronic health record instead of WaMS.

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Q59. Regarding the "Document in the daily progress note Melanie's participation..." sentence for the Part V: Is this not redundant since the expectation is that the DSP would document Support Activities that were run in the progress notes? Is the expectation that such a sentence be present for all Support Instructions?

A59. What to record should be clear to supports in the body of the support instructions or under "What to Record." This may include something to the effect of, "Was Sophie's blood sugar tested and recorded as stated in her plan (record any concerns in a note)? Yes; No," or "Indicate on supports checklist whether or not Melanie completed her morning routine as indicated (Yes or No). If not, include in her progress note why she did not as well as any concerns." For a Skill Building Activity, "Record in the Skill Building log if Tom completed 7 types of weigh exercises at the gym. If not, record how many he did complete and any pertinent details about the trip to the gym in his progress note."

Q60. For the Part V changes (specifically the back up plans), what would be anticipated in the Support Coordinator's Part V?

A60. Since the Support Coordinator's Part V is not included in WaMS, there are no changes necessary as long as the SC's Part V includes the required elements for their service.

OTHER

Q61. Does a legal guardian have the right to exclude the person they are legally responsible for on HCBS rights?

A61. Home and Community Based rights apply to everyone. Legal Guardians cannot exclude those they are responsible for from them.

Q62. Is DBHDS doing something to help address staffing shortages?

A62. DBHDS recognizes there are widespread shortages for many positions in the field of disability and in general. We continue to support providers and support coordinators with training and technical assistance and encourage competencies to promote staff retention and longevity.

Q63. We can address in the PCP that this is what is wanted/needed, but where do we address the reality that we can't find staff or services? Where do we address this is what would be done in the GH if they had more than one staff per shift?

A63. Document barriers under the Barriers question. We recognize multiple barriers can and do exist.

Q64. Will this information be summarized for providers to include important dates?

A64. Yes. The PowerPoint, video and this Q & A will be available through the ListServ.

Q65. We use data sheets to record participation. If we state that learning is documented in progress notes, does this mean that we do not need to have data sheets to record data?

A65. Data sheets continue to be an option to supplement progress notes. They assist with ensuring routine documentation when every support is not described in the note.

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Q66. What does new Provider IDs refer to?

A66. This is a unique ID provided by DMAS that is used to identify providers.

Q67. It would be great if there could be clarity around the responsible party... i.e. Is the provider or support coordinator responsible for this task?

A67. The entire ISP team is responsible for development of and input into the ISP led by the individual and substitute decision-maker, if applicable. The Support Coordinator typically completes the Part II: Essential Information with team input and each provider is responsible for their Part V.

Q68. Will there be a template version of the WaMS 3.3 for SC's to type on in the field if internet access is down?

A68. Yes. We will provide a listing of elements with space for entering text. This will be provided as soon as it is completed.

Q69. Are we no longer using word templates for the ISP? And just putting all information for the ISP directly into WaMs?

A69. The ISP Parts I through IV need to be directly entered into WaMS or transferred into WaMS from a CSB EHR. Word copies uploaded into WaMS are no longer acceptable for Parts I through IV. Provider may continue to use Word templates with the "modified use" Part V option. WaMS entry is necessary for Part Vs under the "complete use" method with fewer elements included under the "modified use" method.

Q70. Where will we be able to find this slideshow?

A70. The PowerPoint, video and this Q & A will be available through the ListServ.

Q71. Is there a specific reason (technical issues maybe) that there is a limit on the characters for these boxes? Some of our individuals require more space as there is important information that we do not want to leave out. I have found myself in the past deleting information I thought should be listed in the ISP.

A71. All text boxes that could be were increased from 3000 character to 6000 characters. If 6000 characters is insufficient, uploading an attachment with the additional information continues to be an option.

Q72. Will we get a blank copy of the new ISP and what each area is looking for?

A72. Yes, there will be a blank copy posted on the WaMS Homepage under Training as soon as possible.

Q73. Are we required to use the Aspiration Calendar in WaMS?

A73. Yes, all individuals with DD Waivers must have the Individual Planning Calendar and the Aspirations Calendar completed in WaMS.

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Q74. During a recent training with DBHDS representatives, they mentioned to put words the individual would use in the goal. For example, if the person would not use the word "purchases" or Marshall "introduces" himself to others, then we'd have to just write it in their own words. So, we would say something like "Marshall says hi to others". Is that still ok to do?

A74. Using an individual's own words when writing outcomes is one of the ways outcomes can be written. Quotes may be used for an individual's own words with additional text for clarity when needed.

Q75. Is there a specific way for the RAT areas to be added in to the various parts of the plan?

A75. Information from the RAT must be incorporated in the PC ISP, as appropriate. One of the new elements added to the Essential Information provides space for "current Medical conditions." If a new diagnosis is identified in the last 12 months, it should be listed under the element "Are there current Medical conditions?" element under the revised Physical and Health Conditions section. The supports would be included under the "Identified Health and Behavioral Support Needs" section and then developed into outcomes in Part III with corresponding support activities and instructions in Part V's. If a potential risk is identified, the risk must be confirmed by a qualified professional in order to develop outcomes and supports in the ISP. If an individual declines consultation with a qualified professional, the team must confirm enough support and monitoring is in place to ensure health and safety with the potential risk for continued access to Waiver services.

Q76. For support coordinators writing the Part III would the support instructions remain general for the providers to then make the specific supports and preferences of the individual known?

A76. The support instructions in Part III should include some of the key supports each provider providers, however each provider's Part V will have more specific, detailed support instructions and preferences than what is included in the Part III.

Q77. Can you provide more information about Provider IDs? What does that process look like for providers and what does it look like for CSB?

A77. This is a unique ID provided by DMAS that is used to identify providers. No action is needed. The transition to this new identifier is expected to streamline the options seen in the WaMS system when selecting a specific provider agency.

Q78. What about provider ID's changes as of 4/3? Do Providers need to initiate that change or do anything to ensure the change occurs?

A78. No action is needed by providers. The Provider ID will be assigned automatically in WaMS.

Q79. As an In-Direct Therapeutic Service Provider- Who would the best contact be for questions?

A79. Please contact the Provider Team CRC for your Region. The CRC contact chart is available online at: Provider Development CRC Contact Chart effective 1/1/22.

Q80. Is it possible to have an update Service Authorization Contact Sheet sent out via the Listserv?

A80. Please see the contact sheet provided with this Q&A document.