DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
DEVELOPMENTAL DISABILITIES SERVICES

OFFICE OF THE DIRECTOR

February 12, 2016

To All Providers and DDDS Staff;

In preparation for migrating data from Therap to Cx360 - DHSSCares, it has been identified that documents currently scanned and attached to the various components of the Therap record are not easily migrated. In order to continue having access to necessary documents, we have drafted the attached guidance in which to follow. Starting March 1, 2016, we will begin requiring that these documents be maintained in the residential and/or day program sites for each individual for access as needed by supporting team members. The documents should no longer be scanned and attached in Therap, this will be an unnecessary extra step. The documents accumulated during this transition period will later be scanned and attached as external documents in the new system.

Although we have done our best to highlight the "What" and "Who" impacted by this change, we realize that you may have questions. Please feel free to contact your Regional Program Director (RPD) and/or DDDS program Supervisors, that you work with closely, have your questions answered.

We appreciate your efforts to comply with this guidance, as it will eliminate duplicate handling of external documents by your staff and have vital information accessible to support team members of the individuals that we serve during this transition period.

Sincerely,

Terrence J. Macy, Ph.D.
Director of Community Services

Robert J. Goodhart
Quality Assurance Administrator

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Guidance ECRS 2016-02

Handling of External Documents and Hard Copy Files
Effective March 1, 2016

It has been identified that we are not able to migrate documents from Therap that have previously been attached to some record element within the system. The ability will exist to house external documents within the new system, but downloading from Therap and reattaching in the new system is not the most efficient use of resources. Future guidance will be provided as to how the information we will be keeping, as identified below, will be loaded into the new system.

During this transition period, in order to have these documents easily assessable for going live with the new system, case documentation will need to occur as follows:

Residential and Day Providers will need to establish hard copy Client Oriented Records (COR) as was done in the past via binder or file and maintained on site with access as requested.

During this transition period, **DDDS Case Managers** will continue to complete the Essential Lifestyle Plan (ELP) – although we are moving to a Life Span Plan, the ELP we know will not be migrated. Do not attach any external documents as was previously done (nursing assessments, behavior support plan with PROBIS packet, signature page, birth certificate, SSN card, etc.). These documents should be printed and placed in the Residential COR with the printed copy of the ELP. Copies should also be sent to the respective Day Program service provider to be maintained in their COR.

Guidelines for Behavioral Services - Transition from Therap to Core Solutions
Beginning March 1, 2016, Behavior Analysts will start keeping a paper copy of certain information in the Client Oriented Record (COR) for each individual. This is in anticipation of the transition from Therap to the new electronic record. If the Behavior Analyst doesn't have access to the COR, documentation in Word or Excel should be electronically sent to the **Residential Agency staff** for inclusion in the COR. If agency staff is present at the psychiatric appointment, they must obtain a copy of the PAIR/MAIR/CAIR to be taken to the home for filing. If emailed, PAIR's must be in PDF format instead of Word or Excel since once completed/signed, as they should not be changed. These should be sent via secured email as they will possibly contained Personal Health Information (PHI). The BA will maintain the originals.

The following procedures will be followed by the assigned **Behavior Analyst** until the new electronic record is operational:

- **T-logs and ISPs** will continue to be completed in Therap. The form(s) will be PRINTED when complete and added to the individual's COR.
- **Quarterly reports** will be completed/ printed and signed by the BA as currently is being done, then filed in each individual's COR.

- **Risk Benefit and Titration Reports** should continue to be completed as currently done by the BA, and signed by team members then filed in the COR for each Individual.
- **EMBIS forms** relating to behavior or PRN medication should continue to be completed in Therap and printed, then submitted to PROBIS. PROBIS maintains completed reviews in a scanned PDF file, and provides access or copies to the BA after their review. Additionally, the BA will need to file the document in the COR for each individual.
- **Psych appointments** will need to be tracked in Therap or as is currently done, but also maintained on either a paper calendar or some other electronic means.
- **All MAIRs, CAIRs, PAIRs, diagnostic testing, lab reports, etc.**, will be filed in the CORs.
- A **Medication/Behavior History** is used to track medication changes and frequency of symptoms identified in the BSP as completed currently by the BA. The Medication/Behavior History will be kept separately by the BA written in Microsoft Word.
- The current **Behavior Support Plan and reviewed/approved PROBIS Packets** should be printed and added to the COR. PROBIS maintains completed reviews in a scanned PDF file and provides access or copies to the BA after reviews. Working copies of Behavior Support Plans should be written using Microsoft Word.

* The transition from Therap to Core Solutions is going to involve a several month process. Undoubtedly there are going to be occasions during this time period where consumers will transfer from one behavioral support provider to another. When this happens, the transferring BA is expected to provide the receiving BA with electronic copies of the current Behavior Support Plan with PROBIS Packet, a working BSP in Microsoft Word format, any PROBIS reviews in addition to the BSP PROBIS Packet, an up-to-date Medication/Behavior history, a copy of the last Risk Benefit and Titration (completed and in Microsoft Word format), a copy of the last PAIR signed by the psychiatrist, the date/time/location of the next psychiatric appointment, any working BA Microsoft Word Documents, and BA quarterly reports for the past year.

Guidelines for Nursing Services - Transition from Therap to Core Solutions
Beginning March 1, 2016, Nursing consultation service providers will start keeping a paper copy of certain information in the Client Oriented Record (COR), maintained at the **Residential provider** for each individual. This is in anticipation of the transition from Therap to the new electronic record.

The following procedures will be followed by the assigned **Nurse Consultant** until the new electronic record is operational:

- **Monthly Health Audits and E-CHATs** will be completed in Therap, but the form(s) will be PRINTED when completed and added to the individual's COR.
- **Significant Medical Conditions** will be printed and put in the COR for each individual.

- **Medical appointments** will need to be tracked in Therap as is currently done, but also maintained on either a paper calendar or some other electronic means.
- **All MAIRs, DAIRs, PAIRs, diagnostic testing, lab reports, etc.**, will be filed in the CORs. No documents from medical appointments are to be filed in Therap.
- **Shared Living Provider Quarterly reports** will be completed on the paper form previously used (Shared Living Community Services Nursing ELP Quarterly Report) and placed in the COR.
- **Responses to Monthly Medication and Health Audits** will be documented on the previously used response form (Response to Medication and Health Audit) and placed in the COR.
- A **miscellaneous data record and/or the individual's MAR** will be used to track vitals (weight, height, blood pressure, bowel movements, menses, etc.). The Miscellaneous Data Record will be kept in the COR.
- **Seizure Reports** will continue to be completed on Therap, but must be printed and kept in the COR.

  * The transition from Therap to Core Solutions is going to involve a several month process. Undoubtedly there are going to be occasions during this time period where consumers will transfer from one nursing support provider to another. If proper documentation is maintained in the COR, then there should be access to the information by the new nurse consultation provider.

* Staff from OPD will work with the standard **Clinical Service forms** (nursing and behavioral) to convert them to on-line fillable forms so they will be accessible and can be utilized during this transition period. It is our plan to have these forms available on the DDDS website.

Residential Provider staff will continue to complete the monthly Clinician Report and save in Therap as is currently being done. A copy will then need to be printed and maintained in the Residential COR.

Day Provider staff will continue to complete the quarterly Clinician Report and save in Therap as is currently being done. A copy will then need to be printed and maintained in the Residential COR.

Nurse Consultants will continue to complete the monthly health audit in Therap. When complete it should be printed and maintained in the Residential COR.

Behavioral Consultants will continue to complete the quarterly progress report. When complete it should be printed and maintained in the Residential COR.

The **Residential COR** will also store copies of the

a) **HRC packets**
b) **HRPC packets**

c) **Probis Packets**
d) **Medications Orders**

DDDS Case Managers (only)

1. Each regional office will create an electronic folder for every person in residential placement on the F drive.
2. The Folder will have Name and MCI in the following format - Last name, first name (space) and MCI #
   (for example) **Doe, Jane 1234**

3. In each of the folders DDDS will place all DDDS external documentation.
4. Please save each document using this guidance in each individual file
   a) ELP mmddyy Jane D (Where mm is the month, dd is the day, and yy is the last two digits of the year)
   b) ELP mmddyy sig Jane D (for the signature page)
   c) Echat mmddyy Jane D
   d) BSP mmddyy Jane D
   e) BSP prog Jane D
   f) Rights mmddyy Jane D
   g) Fall Risk mmddyy Jane D
   h) Aspiration mmddyy Jane D
   i) Significant Health Jane D
   j) Nursing assessment mmddyy Jane D
   k) HRPC mmddyy Jane D (for the packet)
   l) HRC mmddyy Jane D (for the packet)
   m) Birth Cert Jane D
   n) SS Card Jane D
   o) Primary Insurance Jane D (for copy of insurance card)
   p) Guardianship Orders Jane D
   q) POA Jane D
   r) Burial Plan Jane D
   s) Level of Care mmddyy Jane D

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