Office of Developmental Programs
Quality Assessment & Improvement (QA&I)
Changes for Cycle 2, Year 2 (C2Y2)

KEY - **Bold** = Changed
Strikethrough = Removed

QA&I Process Document

Section	Update(s)	Reason for Update(s)
Quality Assessment and Improvement Process: Full Review	**The Discovery phase in QA&I is the phase through which reviewers request and collect quality materials and other indicators from SCOs, AEs, and providers that demonstrate performance on the provision of quality person-centered services and supports to individuals as part of QA&I monitoring.** **The Discovery process includes documentation submitted by the entity to respond to data/policy and record review questions, the onsite review, and any documentation submitted up to 24-business hours following the end of the QA&I conference. It does not include self-assessment, which is a stand-alone process that occurs prior to the full review, nor is it remediation, which occurs following completion of Discovery.** **The Discovery period is defined as the time beginning when an entity is notified that they are participating in a review (including record review only) and continuing through 24-business hours after the QA&I conference is completed.** • **Entities can submit additional information up to 24-business hours following the day of the QA&I conference. Documents submitted up to this time will still be considered part of discovery. Documentation submitted after the discovery period is considered remediation and can be used to support remediation activities.** • **The only documents that will be accepted during the 24-business hour period after the QA&I conference are already existing documents the entity has on file. Any documents the entity newly creates and submits during the 24-business hours following the day of the QA&I conference will not be accepted as part of Discovery, however, it can be used to support remediation activities.** • **Note that the Discovery period ends 24-business hours following close of business (5pm ET) the day of the QA&I conference; if the QA&I conference ends on a Monday, documents must be submitted by Tuesday at 5pm. If the onsite ends on Friday, documents must be submitted by Monday at 5pm, not Saturday.** • **This time period is part of Discovery and not considered a 'grace period or an extension' which are not permissible.**	Information about the discovery phase, discovery process, and discovery period was added in an effort to support ODP's continued efforts to improve reviewer fidelity.

Administrative Entity (AE) Tool

Question	Update(s)	Reason for Update(s)
Tool Completion Instructions	Guidelines: **9. For full reviews, the entity must retain and provide all requested documentation, including policy & procedure documentation, training curriculum, records, and other training documentation as well as documentation associated with service/supports delivery. If this documentation is received more than 24-business hours after the conference, the documentation is considered remediation, not discovery.**	A new guideline was added to clarify the expectations for AEs receiving full reviews.

Q4. The AE maintains written documentation of any delegated or purchased function related to incident management (IM).	Guidance:
	• The reviewer will determine if the AE delegates or purchases any incident management (IM) functions.
	• IM functions include:
	  ○ IM Training
	  ○ Investigations conducted by a Department CI
	  ○ Administrative Review of Investigations
	  ○ Certified Investigator Peer Review (CIPR) Process
	  ○ Quality Management and Trend Analysis
	  ○ Data Entry
	  ○ IM Representative Functions
	  ○ Management Review of Incidents
	    ▪ **Initial Management Reviews**
	    ▪ **Final Management Reviews**
	    ▪ **Weekend/Holiday Incident Reviews**
	• The reviewer will verify the existence of contracts or agreements (and any amendments to contracts or agreements) related to delegated or purchased IM functions.
		The guidance was updated to reflect Management Review of Incidents can have multiple agencies delegated/purchased for specified sub-bullets listed.

Q5. The AE completes monitoring of delegated or purchased IM function(s).	Response Option: (Yes) The AE completes monitoring of **all** delegated or purchased IM function(s) and has written documentation of all the listed requirements. Source Documents: ~~55 Pa Code Chapter 6100.305~~ **Bulletin 00-21-02, *Incident Management***	The source documents were updated to clarify the correct source document that should be referenced.

Question	Update(s)	Reason for Update(s)
Q14. The AE has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	Guidance: • The reviewer will determine if the AE has a written policy related to the review of EIM restraint and medication error incident reports. The policy at a minimum should contain processes that outline: ○ The review of all restraint and medication error EIM incident reports on a periodic basis. ○ This process is **also** to include the review of reports that have been initiated but not submitted. ○ Evaluation of the circumstances and frequency of restraints and medication errors ~~(both those that generate alerts and those that did not)~~ on a ~~monthly~~ **periodic** basis, including the use of restraint dashboard. ○ Methods to recognize unreported critical incidents and ensure reporting, investigation and implementation of corrective actions. ○ Collaboration and communication with the individual's team to ensure health and safety. ○ Collaboration and communication with the individual's team to revise ISP, behavior support plan, and risk mitigation plan.	The guidance was updated to provide clarification in response to questions received during C2Y1.
Q33-Q36.	To answer the next four questions, the reviewer selects four different Providers most recently qualified by that AE by choosing Providers with MPI numbers ending in **6-9** ~~3-5~~ in the following categories: • An Agency with Choice (AWC) Financial Management Services (FMS) Provider, • A large Provider (50 or more individuals, exclude CPS only Provider), • A small Provider (less than 50 individuals, exclude CPS only Provider) and • A Community Participation Support (CPS) Provider	Updated MPI numbers to correspond with current year.
Q40. The AE attends and participates in all trainings that includes AEs as the target audience and/or is relative to the AE's staff role functions.	Response Option: (Yes) The AE attended and participated in **all** ODP offered training intended for AEs and/or the AE's staff role functions.	The "Yes" response was updated to provide clarification in response to questions received during C2Y1.
Q41. The AE provides the SCOs and Providers with assistance to support individuals with complex physical and behavioral needs.	Source Documents: • **ODP Announcement 22-116, Health Risk Screening Tool (HRST)** ~~Protocol Update Pennsylvania Health Risk Screening Tool Protocol Update, revised 1/14/21~~	The sources documents were updated to reflect the most current version.
Q42. The AE worked with the individual and their team to develop mitigation strategies when there are medical,	Guidance: • The reviewer will determine if the individual had a crisis situation by reviewing service notes, Individual Monitoring Tools, PUNs, SIS and the ISP.	The guidance was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)

behavioral, or socio-economic crisis situations.	• The reviewer will determine if the documentation demonstrates that the AE worked with the individual and their team during a crisis situation using mitigation strategies.
	• **The reviewer should request documentation during the review if it is not in the record.**
	• Mitigation strategies shall include but are not limited to:
	  ○ Locate resources and opportunities through family and/or community to mitigate the crisis
	  ○ Active engagement in identifying qualified service Providers
	  ○ Work to divert institutional placement
	  ○ Facilitate competency and guardianship appointments for individuals only as a last option for resolution and if deemed appropriate by ODP.	

Q46. The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.	Guidance: • The reviewer ensures that the current, approved Annual Review Update ISP was approved and authorized prior to the Annual Review Update Date (ARUD). • **The Annual Review Update approval must occur prior to the ARUD (Question 43).** • PATH: HCSIS > Plan > History > Summary > Annual Review Update ○ Access Annual Review Update ISP and review the ARUD included on the ISP. • If the Annual ISP is marked "ODP Approved" it means it was auto-authorized. COMMENT NEEDED – If "No," document how many calendar days past ~~365 calendar days~~ **the ARUD** the plan was approved. Response Options: (Yes) The AE approved the ISP ~~within 365 days~~ **prior to the ARUD**. (No) The AE did not approve the ISP ~~within 365 days~~ **prior to the ARUD**. Source Documents: ODP Announcement ~~22 050, Fiscal Year (FY) 2022-2023~~ **23-040 FY 23-24 Renewal Guidance** Individual Support Plan (ISP) Renewal Guidance	The guidance and response options were updated to provide clarification in response to questions received during C2Y1. The sources documents were updated to reflect the most current version.
Q47. The AE ensures that the individual's ISP includes all assessed needs and includes	Guidance: • The reviewer determines if the **most recent Critical Revision or Annual Review ISP within the timeframe of review** ~~AE~~ approved and authorized **by the AE was** ~~an ISP that is~~ based on all formal and informal assessments	The guidance and response options were updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
services that adequately address the assessed needs.	based on a review of the service notes, Individual Monitoring Tools, PUNS (ID/A), the SIS assessment (ID/A), HRST (if applicable), communication assessments and any applicable assessments. o The ISP reflects the full range of a waiver individual's needs and therefore must include all Medicaid and non-Medicaid services, including informal, family and community supports and supports paid by other service systems to address those needs. • The reviewer determines if the AE reviewed the content of the ISP prior to approval and authorization of ODP paid supports identified to ensure the individual's assessed needs are met. • The AE has authorized services funding through an ID/A Waiver as necessary to address documented and current Assessed Needs. Response Options: (Yes) The **ISP** ~~plan~~ contains evidence that all assessed needs have been reviewed and/or addressed. (No) There are identified assessed needs that have not been reviewed and/or addressed **within the ISP**. (N/A) The **Annual Review** ISP was auto-authorized (ODP Approved) **and there were no Critical Revisions within timeframe**.	
Q49. The AE authorizes services consistent with the service definitions.	Response Option: (N/A) The individual ~~receives Base or SC Services Only~~ **is not enrolled in a waiver**.	The "N/A" response was updated to provide clarification in response to questions received during C2Y1.
Q50. The individual has an identified change in need.	Response Option: (N/A) There was no change(s) in need identified, ~~or if~~ the change in need was requested by the individual**, or the individual is not enrolled in a waiver**.	The "N/A" response was updated to provide clarification in response to questions received during C2Y1.
Q51. Due process rights information was provided to the individuals with a change(s) in need.	Guidance: • A change in need is one that would result in an ODP funded service being reduced, suspended, terminated or denied. • The reviewer determines if written notification of Due process rights was provided. • Acceptable documentation MUST include an indication that a copy of the DP 458 was distributed to the individual/family/surrogate. • **The individual's name, date, and specific change in service should be identified within the DP 458.**	The guidance and response options were updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
	Response Options: (Yes) There is written notification accompanied by the DP 458 **for all change(s) in need**. (No) There is no written notification or DP 458 **for at least one change in need**. (N/A) There was no service change resulting in reduction, suspension, termination and/or denial of services, **all the plans which captured the change(s) in need was auto-authorized, all** ~~or if~~ the change**(s)** in need was requested by the individual**, or the individual is not enrolled in a waiver**.	

Q54. The DP 251 form is complete.	Guidance:
	• The reviewer determines if the DP 251 was signed and dated within the past year at the time of the QA&I review.
	• The annual reevaluation must be signed and dated by the Qualified Developmental Disabilities Professional (QDDP) and AE designee for compliance.
	    ○ Electronic signature and date are acceptable.
	    ○ AE signature and date must be after **(can be on same day)** the QDDP signed and dated to be in compliance.
	
	Response Option:
	(N/A) Individual is not enrolled in waiver.
		The guidance and response options were updated to provide clarification in response to questions received during C2Y1.

Q55. The DP 251 is timely.	Guidance: • The reviewer determines if the DP 251 (AE signature and date) is timely. • "Timely" is defined as the first reevaluation of need for an ICF/ID or ICF/ORC level of care is to be made within 365 days of the individual's initial determination (date on the current DP 250) and subsequent reevaluations are made within 365 days of the individual's previous reevaluation. • Remediation ~~will~~ **is** only ~~be~~ **<u>required</u>** for ~~those~~ DP 251s <u>NOT</u> completed at the time of the QA&I review. **If the DP 251 is completed but not timely, remediation is not needed.** COMMENT NEEDED – If ~~"No,"~~ **not timely,** document how late the DP 251 was in comments. Response Option: **(N/A) Individual is not enrolled in a waiver.**	The guidance and response options were updated to provide clarification in response to questions received during C2Y1.
Q56. The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.	Response Option: (N/A) The reevaluation was completed using the SIS™ **or the individual is not enrolled in a waiver**.	The "N/A" response was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
Q57. The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251.	Response Option: (N/A) The reevaluation was completed using the SIS™ **or the individual is not enrolled in a waiver**.	The "N/A" response was updated to provide clarification in response to questions received during C2Y1.
Q58. The AE used the Waiver reevaluation tool to complete the reevaluation process.	Response Option: (N/A) The QDDP had to complete the initial LOC process for reevaluation **or the individual is not enrolled in a waiver**.	The "N/A" response was updated to provide clarification in response to questions received during C2Y1.
Q59. The annual reevaluation date is entered into HCSIS.	Guidance: • The reviewer determines if AE or delegated entity entered the **most current** annual reevaluation date (DP 251) into HCSIS. • PATH: HCSIS > Individual > Eligibility > Eligibility Documentation Response Options: (Yes) The most current **annual reevaluation** date is entered into HCSIS in the correct location. (No) The annual reevaluation date **in HCSIS** is incorrect (old). (N/A) ~~The~~ Individual is ~~receiving Base-funded services~~ **not enrolled in a waiver**.	The guidance and response options were updated to provide clarification in response to questions received during C2Y1.
Q60. The AE offers choice of Supports Coordination Organizations (SCOs) to the individual/family upon initial enrollment to TSM that includes documenting the offering of choice.	**Moved from Newly Enrolled question to a Record Review question.** Response Options: (N/A) ~~Enrolled in waiver, not MA eligible, or choice prior to date determined, not newly enrolled.~~ **The individual was not newly enrolled.**	The question was moved and response was updated to provide clarification in response to questions received during C2Y1.

Provider Tool

Question	Update(s)	Reason for Update(s)
Tool Completion Instructions	Guidelines: **9. For full reviews, the entity must retain and provide all requested documentation, including policy & procedure documentation, training curriculum, records, and other training documentation as well as documentation associated with service/supports delivery. If this documentation is received more than 24-business hours after the conference, the documentation is considered remediation, not discovery.**	A new guideline was added to clarify the expectations for Providers receiving full reviews.
Q13. *The Provider's staff completed annual training core courses as required in the training year.	Guidance: **Reflects the difference between entering training information into the spreadsheet if completing a self-assessment or full review.** Source Documents: ~~ODP Announcement 21-060, "Guidance for 24-Hour Annual Training Requirements in Training Years 2021 and 2022~~	The guidance was updated to provide clarification on different process of using spreadsheet if review is a self-assessment or full review. Removed outdated Source Document.
Q14. New Provider staff completed orientation training core courses as required prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual.	Guidance: **Reflects the difference between entering training information into the spreadsheet if completing a self-assessment or full review.** Source Documents: ~~ODP Announcement 21-060, "Guidance for 24-Hour Annual Training Requirements in Training Years 2021 and 2022~~	The guidance was updated to provide clarification on different process of using spreadsheet if review is a self-assessment or full review. Removed outdated Source Document.
Q15. Provider staff completed the required number of training hours in the training year.	Guidance: Reflects annual training "The safe and appropriate use of behavior supports if the person works directly with an individual" **is not applicable to staff that ONLY render transportation.** Source Documents: ~~ODP Announcement 21-060, "Guidance for 24-Hour Annual Training Requirements in Training Years 2021 and 2022~~ Remediation Option: 15a. Provider ~~ensures Provider staff complete required training~~**develops/modifies a policy**. Remediation Option Guidance: ~~• The Provider submits documentation that demonstrates the Provider staff completed all required training hours as appropriate.~~	The guidance was updated to provide determination from ODP policy that staff that only render transportation are not required to take annual training course. Removed outdated Source Document. Remediation option changed per determination that by only making up the missing training hours does not remediate the non-compliance.

Question	Update(s)	Reason for Update(s)
	• **The Provider develops/modifies and submits a policy that ensures that staff complete required training during training year.** • **The Provider trains staff that did not meet the requirement on the developed/modified policy and submits verification of training**.	
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	Guidance: • **This question is NOT applicable to Transportation only Providers.** • The reviewer determines if the Provider has a policy that addresses sexual health, personal relationships, and sexuality consistent with the guidelines. • The policy should support the concept of Everyday Lives and be consistent with the considerations identified in ODP Bulletin 00-18-01. Response Option: **(N/A) The Provider is a Transportation only Provider.** Remediation Option: ~~Provider trains staff on the existing policy.~~ ~~• The Provider trains staff on the existing policy and submits verification of training~~.	The guidance was updated to provide determination from ODP policy that Providers that only render transportation are not required to have this policy. Added Transportation only Provider to N/A option based on policy determination. Remediation option removed as question was if policy existed, not if staff were trained on policy.
Q20. The Provider completes monitoring of delegated or purchased incident management function(s).	Response Option: (N/A) The Provider does not delegate or purchase any incident management functions **or the delegated/purchased incident management function did not need to be utilized during the review period.**	The "N/A" response option was updated to clarify that if an Incident Management function was not utilized, despite a contract /agreement being in place, the response option should be "N/A".
Q25. The Provider has an individual record sample.	Guidance: • If an individual receives multiple services from a Provider, the Provider's ~~self-assessment~~ review must encompass all services the individual receives	The guidance was updated to provide clarification that if an individual receives multiple services from a Provider, the review, self-assessment and full review, must encompass all services the individual receives.
Q27. **Staff are trained on the individual's communication profile	Guidance: • The reviewer determines if the individual has **a functional communication impairment, and a corresponding communication profile and/or formal communication** system based on a review of the individual's ISP.	The guidance was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
and/or formal communication system.	• **An individual with a functional communication impairment is someone who cannot effectively communicate basic wants and needs such as "I want that" or "I am in pain."** • **A communication profile is a term used to describe how the individual communicates and how communication partners communicate effectively with the individual through strategies and systems utilized, across environments.** • **A communication system includes all strategies and aids used to effectively communicate.** • If the individual has a communication profile and/or formal communication system identified in the ISP, the Provider will give a list of all Provider staff who worked and rendered authorized supports and services to the individual during the review period. Response option: 1. (Yes) **The individual has a functional communication impairment and** all staff reviewed completed training on the individual's communication profile and/or formal communication system. 2. (No) **The individual has a functional communication impairment and** one or more staff reviewed did not complete training on the individual's communication profile and/or formal communication system. 3. (N/A) The **individual does not have a functional communication impairment** ~~individual's ISP did not have a communication profile and/or formal communication system identified~~.	
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan.	Guidance: • **This question is applicable to all direct services from the Provider <u>EXCEPT</u> Transportation.** Response option: **(N/A) The individual only received the excluded service(s) from the Provider during the review period.**	The guidance was updated to provide determination from ODP policy that Transportation direct service is exempt from this requirement. Added Transportation direct service N/A option based on policy determination.

Supports Coordination Organization (SCO) Tool

Question	Update(s)	Reason for Update(s)
Tool Completion Instructions	Guidelines: **9. For full and record review only reviews, the entity must retain and provide all requested documentation, including policy & procedure documentation, training curriculum, records, and other training documentation as well as documentation associated with service/supports delivery. If this documentation is received more than 24-business hours after the conference, the documentation is considered remediation, not discovery.**	A new guideline was added to clarify the expectations for SCOs receiving full or record review only reviews.
Q9. The SCO completes monitoring of delegated or purchased incident management function(s).	Response Option: (N/A) The SCO does not delegate or purchase any incident management functions **or the delegated/purchased incident management function did not need to be utilized during the review period.**	The "N/A" response option was updated to clarify that if an Incident Management function was not utilized, despite a contract/agreement being in place, the response option should be "N/A".
Q11. The SCO has a policy to monitor EIM **incidents reports, including but not limited to**, restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	Guidance: • The reviewer will determine if the SCO has a written policy related to the review of **all** EIM **incident reports, including but not limited to** restraint and medication error incident reports. The policy at a minimum should contain processes that outline: ○ The review of all **EIM incident reports, including but not limited to** restraint and medication error EIM incident reports on ~~a monthly~~ **an ongoing** basis. This process is to include the review of reports that have been initiated but not submitted. ○ **The ongoing review of EIM auto generated email notifications that indicate when a restraint or medication error report is in need of follow-up. If it is determined that a critical incident is to be filed, the SCO must verify in EIM or follow up with the reporting entity to ensure the filing of a critical incident.** ~~○ Evaluation of the circumstances and frequency of restraints and medication errors (both those that generate alerts and those that did not) on a monthly basis, including the use of restraint dashboard.~~ ○ Methods to recognize unreported critical incidents and ensure reporting, investigation, and implementation of corrective actions. ○ Collaboration and communication with the individual's team to ensure health and safety. ○ Collaboration and communication with the individual's team to revise ISP, behavior support plan, and risk mitigation plan.	The guidance was updated to clarify the expectation that the policy must include all incident reports and not just restraint and medication error reports.
Q12. The SCO completes monthly individual incident data monitoring.	Guidance: • The reviewer will determine if the SCO monitored incident data to take action(s) to mitigate risk, prevent recurring incidents, and implement corrective action as appropriate. • The reviewer will review documentation of the activity from the last three months.	The guidance was updated to clarify that the SCO is responsible for conducting monthly individual incident data

Question	Update(s)	Reason for Update(s)

	• **SCOs are responsible for monitoring monthly incidents that are reported by the SCO.**
	• Documentation of this monthly activity must include at a minimum:
	  ○ Review of incident data to detect incidents that have been initiated but have not had the First Section submitted
	  ~~○ Evaluation of the circumstances and frequency of restraints~~
	  ~~○ Evaluation of the circumstances and frequency of medication errors~~
	  ○ Identification and implementation of preventative measures to reduce:
	    - The number of incidents
	    - The severity of the risks associated with the incident
	    - The likelihood of an incident recurring
	    - The monitoring of the effectiveness of any noted corrective actions in incident reports
	    - Actions taken by the SCO to address ineffective corrective actions
	  ○ Documentation of:
	    - The need to revise the ISP with the ISP team to include new and/or revised information, risk mitigation plans, or a change in services or supports
	    - The need to consult with a County ID Program/AE/BSASP Risk Manager for assistance related to monthly data monitoring
	    - The actions and outcomes of any activities that occurred related to the monthly data monitoring
	
	Response Option:
	(N/A) There were no incidents ~~to monitor~~ **entered by the SCO** for the review period.
		monitoring on incidents the SCO is responsible to report.

Q16. The SC documents the individual was provided with information about on-going opportunities and support necessary to participate in community activities of the individual's choice.	Response Option: (Yes) The individual was provided with information about **on-going opportunities** and ~~getting~~ support **necessary** for community activities of the individual's choice.	The "Yes" response was updated to provide clarification in response to questions received during C2Y1.
Q26. The SC conducted all monitorings at the required frequency.	Guidance: • The reviewer determines if the SC conducted monitorings at the required frequency based on a review of the Individual Monitoring Tools. • PATH: HCSIS > SC > Indiv Monitoring. • For the ID/A waivers, if the individual has an approved non-statutory frequency, identify them in the comments section by MCI#, name(s), or initials.	The guidance was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
	• Consolidated and Community Living is minimum of a monitoring once every two months during a six (6) calendar month timeframe. • P/FDS is a minimum of a monitoring once in every three (3) calendar months. • **TSM and Base is a minimum once a year and the monitoring cannot take place on the same day as the annual ISP meeting.** • AAW is a minimum of a monitoring once per quarter over a 12-month period based on the individual's Plan Effective Date.	
Q27. The SC conducted all monitoring at the required location.	**The question was not applicable during C2Y1. The guidance, response options, and remediation options were updated for C2Y2.**	Since the question was not applicable in C2Y1, the guidance, response options, and remediation options were updated to clarify expectations and requirements for C2Y2.
Q30. The SC provided due process rights information at the annual ISP meeting.	Guidance: • The reviewer determines if the SC provided the due process rights at the annual ISP meeting **(or initial AAW ISP meeting if newly enrolled in the AAW)** based on a review of the ISP Signature Page or service notes. • During the emergency period, consent with the ISP could be verified by electronic signatures, or electronic verification via secure email consent from the participant, his or her designee if applicable, and service providers, in accordance with HIPAA requirements. Signatures would include a date reflecting the ISP meeting date. • In addition to electronic signatures or electronic verification, verbal consent with the content of the ISP was acceptable. SCs were responsible for documenting the verbal consent of the participant and all providers responsible for implementation of the ISP and any other members who attended the ISP meeting on the ISP Signature Page or in a Service Note.	The guidance was updated to provide clarification in response to questions received during C2Y1.
Q31. *Choice of Providers was offered to the individual/family. Q32. *Choice of services was offered to the individual/family. Q33. *The SC provided the individual information on participant directed service (PDS) options annually.	Guidance: • The reviewer determines if the SC provided the due process rights at the annual ISP meeting **(or initial ISP meeting if newly enrolled)** based on a review of the ISP Signature Page or service notes. • During the emergency period, consent with the ISP could be verified by electronic signatures, or electronic verification via secure email consent from the participant, his or her designee if applicable, and service providers, in accordance with HIPAA requirements. Signatures would include a date reflecting the ISP meeting date. • In addition to electronic signatures or electronic verification, verbal consent with the content of the ISP was acceptable. SCs were responsible for documenting the verbal consent of the participant and all providers responsible for	The guidance was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
	implementation of the ISP and any other members who attended the ISP meeting on the ISP Signature Page or in a Service Note.	
Q34. The individual attended the Annual Review Update ISP meeting or ARP ISP meeting or if the individual did not attend the meeting, the SC reviewed the results with the individual.	Guidance: • The reviewer determines if the individual attended the **Annual Review Update** ISP meeting or **ARP ISP meeting (or initial ISP meeting if newly enrolled)** based on a review of the ISP Signature Page or service notes. • If the individual is under 18 or has a surrogate/legal representative, they are not required to attend. • During the emergency period, consent with the ISP could be verified by electronic signatures, or electronic verification via secure email consent from the participant, his or her designee if applicable, and service providers, in accordance with HIPAA requirements. Signatures would include a date reflecting the ISP meeting date. • In addition to electronic signatures or electronic verification, verbal consent with the content of the ISP was acceptable. SCs were responsible for documenting the verbal consent of the participant and all providers responsible for implementation of the ISP and any other members who attended the ISP meeting on the ISP Signature Page or in a Service Note. • The reviewer determines if the SC reviewed the results of the ISP meeting with any individuals who did not attend based on the ISP Signature Page or in a Service Note.	The guidance was updated to provide clarification in response to questions received during C2Y1.
Q39. **At the annual ISP meeting, the SC provided education and information to the individual about employment services (i.e., competitive, integrated employment, OVR services, benefits counseling or the "Guidance for Conversations about Employment").	Guidance: • The reviewer determines if the SC offered individual information about employment services **at the annual ISP meeting (or initial ISP meeting if newly enrolled)** based on a review of the ISP Signature Page or service notes. • During the emergency period, consent with the ISP could be verified by electronic signatures, or electronic verification via secure email consent from the participant, his or her designee if applicable, and service providers, in accordance with HIPAA requirements. Signatures would include a date reflecting the ISP meeting date. • In addition to electronic signatures or electronic verification, verbal consent with the content of the ISP was acceptable. SCs were responsible for documenting the verbal consent of the participant and all providers responsible for implementation of the ISP and any other members who attended the ISP meeting on the ISP Signature Page or in a Service Note.	The guidance was updated to provide clarification in response to questions received during C2Y1.
Q40. A referral is made and the eligibility determination or case closure letter from OVR is in the individual's record for those individuals who are under age 25,	Response option: (N/A) The individual is enrolled in the AAW **or the individual did not meet the criteria**.	The "N/A" response option was updated to provide clarification in response to questions received during C2Y1.

Question	Update(s)	Reason for Update(s)
authorized for the prevocational component of CPS, and are paid subminimum wage.		
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM.	Response option: **(Yes) There is evidence that the individual was offered education about the circumstances of all incidents reported in the EIM system by the SCO or was offered but refused the information.**	Added a second "Yes" response to account for individual who were offered education about the circumstances of all incidents but refused the information.
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	Guidance: • The reviewer determines if the SCO identified an issue and took action upon review of final incident reports in EIM based on a review of the record which includes service notes, Individual Monitoring Tools and SC Comments in EIM. There may be times when the SC notes something in the SC Comments that the reviewer would expect to see in the Final Section but upon review of the Final Section, information is not contained in the Final Section. • **Physical Restraint and Medication Error incidents do not have final incident reports.** Response Option: (N/A) The documentation indicates that the SCO did not identify an issue upon review of final incident report(s) in EIM, or if the final section of the incident report has not been completed yet, **or if the incident does not have a final incident report**, or there were no incidents in EIM.	The guidance and "N/A" response option were updated to provide clarification in response to questions received during C2Y1.