Standards Feedback and DDSD Response Report

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
1	Provider Agency	Introduction	I.5.4 Comprehensive ANE Training requirements for DOH, providers and participants – Is this implying that the current ANE training will now be required for participants? If so, the training portion of these standards need to reflect this new requirement.	Thank you for your comments. DDSD will edit to clarify ANE training is available but not required for waiver participants.
2	Provider Agency	Introduction	Thank you for offering electronic feedback.	Thank you for your positive comment.
3	Provider Agency	Introduction	Concerns with logistics, driving, time, etc...of monthly visits...the monthly visits to all my clients would require this agency to hir and train more coordinators to cover the additional visits. It would create mor of caseload for everyone.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative.
4	Provider Agency	Introduction	Recommend language to include that the the person sent by the State of NM is adequately trained to complete the wellness checks.	Thank you for your feedback. DDSD will edit to clarify DDSD staff are trained to perform home visits.
5	Provider Agency	Introduction	•1.5 #2 what is meant by the statement? Does this mean that all providers are responsible for visiting individuals in all settings regardless of which agency is providing it? Need clarification. •1.5 #4: Comprehensive ANE training: Is a new training being developed? Will participants now be required to take ANE trainings? Will the Case Managers be responsible for getting this completed and will there be a timeline? •1.5 #5: ANE identification and reporting requirements. Are these changing? If so, we need to know what the new process is for reporting this.	Thank you for your feedback. Section I.5 #2 This is an introductory chapter. Specific service requirements for each service can be found in chapters Section I.5 #4- DDSD will edit to clarify ANE training is available but not required for waiver participants. Section I.5 #5- ANE identification and reporting requirements have not changed.
6	Provider Agency	Introduction	Disagree with all providers carrying out wellness visits and request for more guidance on interpreting standards	Thank you for your feedback. Please note wellness visits referenced here are carried out by State of NM . Providers are to help facilitate as needed. Due to the focus of ANE prevention, DDSD will maintain the new initiative. DDSD will continue to provide clarification on standards to the field. Should there be questions regarding interpretation of Service Standards please feel free to reach out to Marie Velasco marie.velasco@doh.nm.gov , DDSD Program Manager.
7	Provider Agency	Introduction	I feel it would be burdensome for service coordinators to meet with CCS providers and clients in the community monthly especially for clients who we see monthly for other services as well. The new requirement to meet with CCS client in the community monthly would essentially double our monthly visits. I am suggesting that the standards allow for quarterly CCS visits in the community at least for clients who are receiving other services that require monthly visits. I would suggest that it would be appropriate to meet with CCS client monthly only if that is the only service they are receiving from our agency.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative.
8	Provider Agency	Introduction	The addition on Abuse, Neglect, and Exploitation is good.	Thank you for your positive comments.
9	Provider Agency	Introduction	The addition of the ANE language in this section and calling out of specific strategies is excellent.	Thank you for your positive comments and feedback regarding this addition.
10	Other	Chapter 1	1.5.3 The appropriate term should be everyone "served" not "serviced".	Thank you for your feedback. DDSD will correct.
11	Provider Agency	Chapter 2	Due to DHI accepting or anticipated to accept/ investigate allegations of self neglect, I do think having the section of Dignity of Risk and Duty of Care is important to detail a little more including individual self guardianship status vs freedom of choice vs self neglect and when providers need to file or initiate duty of care approaches.	Thank you for your feedback. ANE trainings are being reviewed and this issue may be considered there as well. "Duty of care approaches" does not negate having to file ANE reports for grave self- neglect i.e. the act of reporting is a Duty of Care. As self-guardians and those with guardians they have human rights that must be upheld and HRC restrictions require least restrictive means, regular review and fade plans.
12	Other	Chapter 3	The "safeguards" should include a discussion about what happens in all living supports, particularly family living and in home living supports, when the caregiver is no longer able to provide care or passes away. Teams should be prepared to continue care of the recipient. ... If it is a family provider or guardian, the team should have that discussion with the participant and family in advance.	Thank you for your feedback. Under Chapter 10.3.8.2.2.1 #1b Self-Assessment and Application: The following was added for Family Living: Succession of care plan in the event of illness or death of the direct care family provider. DDSD will emphasize in Chapter 6.1 ISP development.
13	Provider Agency	Chapter 3	3.1.1 Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. --- This is not clear wording 3.1.1.1.d MERP is referenced but is no longer valid 3.4.6.4 The use of cameras in the home is not clearly stated. The statement seems to contradict itself. The first statement indicates that cameras aren't allowed but the following statement indicates that cameras are not allowed in places of privacy (bedroom/bathroom/other places of privacy). The requirement needs to be clearly stated. This is further confused by 3.4.6.5.l (i.e., baby monitors)	Thank you for your feedback. 3.1.1-DDSD will maintain current language. This describes the ability of guardians, individuals or healthcare decision makers to make decisions based on an individuals personal and cultural values. 3.1.1.1.d - Thank you. MERP will be removed 3.4.6.4-Cameras used for remote monitoring are prohibited.

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14	Provider Agency	Chapter 3	3.4.4 #7 talks about various providers including BSC and uses the terminology evaluation or treatment plan. BSC do not do treatment plans. This language could be clarified and made consistent with DDW terminology.	Thank you for your feedback. DDSD will include DDW terminology such as PBSA, PBSP and RMP
15	Provider Agency	Chapter 3	Ch3 DCF Proccess 3.1.1 a & b Clarify: Can opt-out unless issues or problems reported? How can this be addressed as if guardian opts-out but healthcare needs addressing, it becomes required once health is impacted and evidence of failing health? We cannot report what we nurses do not see after opt-out. HRC 5. (l) Restrictions 3.4.5.12 Interventions Requiring HRC Review & Approval Use of a device and/or monitoring system through RPST may impact the person's privacy or other rights-Please clarify 3.4.6.5. HRC Prohibition from Approval Privacy violations ….or items such as baby monitors in any room of the home Clarify: Baby monitored listed as not allowable, please specify which type. Are audio baby monitors allowed as use for monitoring system allowed with HRC approval for safety.	Thank you for your feedback. 3.1.1.a: If the person or guardian opts out of a healthcare recommendation but it later becomes critical due to failing health, the team should re-evaluate the recommendation or seek a new health evaluation. HRC.5 (l) What this indicates is that if a Remote Personal Support Technology item is being used via a device or monitoring device could impinge on a person's privacy. 3.4.6.5: All baby monitors video and/or audio monitors are prohibited from approval.
16	Provider Agency	Chapter 3	Receiving DDW services should not take away a clients rights and dignity. If visits are required by DOH then they need to be done by qualified personal that have knowledge of the client.	Thank you for your feedback. DDSD will add: All Service Providers must comply to facilitate these visits by trained State staff.
17	Provider Agency	Chapter 3	•MERP is present on this page. •3.1.1 C: recommendations for non-medical activities such as working, etc. Do we now need a DCF for those who are not seeking employment? •3.1: Regarding DCF being honored in all settings: This may cause an issue as there are IL individuals that do not follow a CARMP when at home but the IL Staff follow it when they are with them. This states that it has be in every setting. They need to think about the verbiage as they live with natural supports and they choose to not follow it when at home. • 3.4.2: HRC members are now required to take ANE training and be in the CDD Waiver Training Hub. HRC is a volunteer position. How are we expected to make volunteers and clients take an annual ANE course? This could cause members to abandon their roles on the HRC which is already difficult to fill.	Thank you for your feedback. 3.1.1 -MERP will be removed. 3.1.1The Decision Consultation Form and Team Justification form is combined into one document which now includes non-medical activities as well. DDSD will continue to provide TA on use of DCF as it relates to CARMP. 3.1 CARMP and DCF: DDSD will continue to provide outreach to the system for clarifications. 3.4.2 All HRC members are only required to complete ANE training once. Committee members will not be required to recertify annually.
18	Provider Agency	Chapter 3	recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP). Recommend that this be expanded to additional clinical recommendations made by the clinical team, SLP, OT and PT. Some recommendations may not be included in the specified plans Recommend language to include procedure that the case manage coordinate and that there is a team meeting Also needs clarification about setting. For instance a guardian does not want a CARMP in the home but the CCSI provider has to implement etc	Thank you for your feedback. The question of clarified with the therapist. It was specific to therapy equipment such as devices, etc. The team should continue to document through the IDT process. The CARMP is included in the standards draft and is considered a healthcare plan.
19	Family Member/Guardian	Chapter 3	Concerns about prohibition of baby monitors especially with participant/guardian consent	Thank you for your feedback.
20	Provider Agency	Chapter 3	-IQR is cited as a possible source to use the DCP for, but it is crossed out the rest of the draft standards. -Clarity is needed on if the HRC chairperson is a voting member or not -Clarity on motion sensors would help. This has come up since the addition of audio monitors being prohibited and the language in the remote monitoring section is unclear of if they can be used and how -The use of "routine law enforcement" language has come for debate, can there be clarity added of what that means in the standards	Thank you for your feedback. IQR will be deleted. DDSD continues to refresh HRC training and clarify questions posed here. All committee members will receive training on Abuse, Neglect and Exploitation (ANE) Awareness, Human Rights, HRC requirements, and other pertinent DD Waiver Service Standards prior to their voting participation on the HRC. This HRC chairperson is a voting member.
21	Provider Agency	Chapter 3	Concerns that not all providers underdstand Gait Belts need HRC review	Thank you for your feedback. Gait belts do not require HRC approval. DDSD will continue to provide TA and training to the field.
22	Provider Agency	Chapter 4	Request for clarity on when services must start and concerns about use of old SFOC forms.	Thank you for your feedback. Providers must have SFOC and approved budget to start services. Please find the most current SFOCs' here http://sfoc.health.state.nm.us/ . The form should include date signed. Please contact PEU if you have concerns about old forms being used.
23	Family Member/Guardian	Chapter 4	Remove "ensure" from provider requirements	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage".

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24	Provider Agency	Chapter 5	Does this mean that the frequency to check weight on the CARMP is not written in by the nurse as frequency written on the CARMP is usually followed. Does the CARMP template need to reflect this and written into the template? 5.5.7.5 Additional Primary Provider Agency Responsibilities 4. The Provider Agency notifies the CARMP “Lead Contacts,” immediately, when a new DSP starts working with the person. Provider Agency needs method of notification when new services added	Thank you for your feedback. DDSD will continue to work on training and clarification of CARMP process for the field. Per number 9 in the standards the nurse is expected to observe and document any issues related to the person's weight.
25	Provider Agency	Chapter 5	Concerns working with MCO Care Coordinators if not a guardian	Thank you for your feedback. If your agency is having difficulty collaborating with MCO Care Coordinators please work with DDW Case Manager who typically communicates routinely with care coordinators and file a RORA for technical assistance from DDSD.
26	Provider Agency	Chapter 5	In Chapter 5 regarding the CARMP process Case Managers are asking secondary nurses to sign off/contribute to the CARMP. In Therap the only way this can be done is for the Primary Agency to make a Therap log in for the secondary nurse. This is not addressed at all in the standards and the process is not very well known. This needs clarification either in the standards or other means.	Thank you for you feedback, DDSD will continue to refresh Therap training and Technical Assistance to the field. In Ch 13.2.2 #5 it indicates that all nurses despite service setting need to collaborate in CARMP development. We do not indicate how, only that it needs to occur. Further TA can be provided as necessary. In Ch 20.5.6 IDT members are to utilize the CARMP Questionnaire process.
27	Provider Agency	Chapter 5	Concerns with the current Therap language in the standards that an RFP process could be stopped to explore a new system Recommend language specific to what clinicians need to complete the initial CARMP	Thank you for your feedback. DDSD currently requires the use of Therap for documentation and client records. If there is a change regarding Therap, DDSD will make adjustments. Please refer to specific clinicians included in the creation of a CARMP listed in section 5.5.2.
28	Provider Agency	Chapter 5	5.1.1 Designation of a HCC #2 Clarify: Need to specify if the client is competent to make their own healthcare decisions if HCC is consulting with them and/or work with guardian or appointed healthcare decision maker if no guardian appointed. 5.5 ARM Clarify: CCS-I does not qualify for ARM supports? If all other services are optional and it is discussed with person/guardian, this being clear that you would only discuss if they were at risk. If they make an informed decision as to opt-out (being that it’s optional) is the entire process still required, budget, complete assessments, CARMP creation, presentation etc. even though it’s optional? Would it not be optional if they are at risk and need the supports regardless? What if they cannot make informed decision on their own and do not have appointed guardian and/or healthcare decision maker? Would this mean it is required until one is appointed and has authority to opt-out? 5.5.1 b. Screening for Aspiration Risk Using ARST Clarify: Is 1 business day 24 hours from time of discharge (eg. 12:00pm day of discharge to 12:00pm next day of discharge Request: Make timelines uniform to either business days or calendar days throughout. 5.5.1#3e. Clarify: What if client or guardian decline? DCF? What if client not competent to make decisions and own guardian, does this become mandatory if no guardian in place or no healthcare decision maker? IDT becomes decisionmaker f. develop within 3 calendar days, nurse develops and trains ARM within 3 calendar days. 5.5.2 Collaborative Aspiration Risk Assessment 6. Clinicians may add recommendations to the interim ARM plan and provide training. Clarify: If family does not want ARM supports and no specialists are on the team for new allocations, can interim Aspiration plans be presented to client/guardian and a DCF be signed if wanted? Standards state clinicians may add recommendation to the interim ARM plan. Can this be presented in place of CARMP document? What if client not competent to make decisions and own guardian, does this become mandatory if no guardian in place or no healthcare decision maker? 5.5.3 Ongoing ARM Supports Request: Change “adults and young adults” to adults. 5.5.4 CARMP Development Process (Table) Request: Make timelines uniform to either business days or calendar days throughout. Feedback: Client’s and guardians can be informed on the information included in the CARMP without completing the entire CARMP process. The CARMP process is lengthy and oftentimes therapists are difficult to find, add to budget, and complete the CARMP process in a timely manner. This lengthy process oftentimes leads to missed deadlines and non-compliance as the CARMP Development Process has very specific deadlines. When this process is implemented when not desired by clients/guardians, it puts unnecessary workload on a team when oftentimes is not wanted when efforts can be used elsewhere. Simplifying this process to allowing interim Aspiration Plans to be reviewed by client/guardian allows for efficient work.	Thank you for your feedback. DDSD will continue to clarify these questions through training to the system and future standards edits. These questions about 5.1.1 and 5.5 are situational based on the person's guardianship status and should be evaluated based on their right to make healthcare decisions.5.5.3 can be changed to adults. It is indicated in table B in 5.5.4 that all days refer to calendar days unless stated. Young adult and adults need to continue to be separated in the standards.

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29	Provider Agency	Chapter 5	CARMP Ch 5 Regarding CARMP development for all aspiration pneumonia events. In CARMP training I learned even if an individual develops aspiration pneumonia from a drug over dose a CARMP should be developed even if just temporarily. However, there is nothing detailing this. With Fentanyl on the rise I think it is a good idea to include this as most of the time people associate aspiration risk with medical conditions and physical impairments. Since there is many more references throughout the New proposed Standards, I do think this would help clarify "all aspiration pneumonia related events regardless of inital cause" or something to that effect to indicate that there could be various factors contributing to aspiration pneumonia. *Additionally, I personally don't agree that "prudent nursing opinion" should apply when it comes to anyone receiving DDW service regardless of situation causing aspiration / aspiration pneumonia to be used as a blanket statement to not complete a new ARST and ECHAT.	Thank you for your feedback. DDSD will take your feedback into consideration for future training to system and standards edits. When someone has an aspiration pneumonia event the person will become a risk and will require a CARMP. This is indicated on the ARST that covers the past two years.
30	Provider Agency	Chapter 6	6.5.1 Should address the required 21 days written notice from NMAC 7.26.5.12.D this is a often overlooked requirement which effects compliance on numerous annual requirements.	Thank you for your feedback. The 21 day requirement is present.
31	Provider Agency	Chapter 6	Do these Addendum A's stand for the entire ISP year or the date signed?	Thank you for your feedback. Addendum A must be reviewed at least annually and is for the entire ISP year.
32	Provider Agency	Chapter 6	This chapter states that ISPs are to be sent 14 days prior to the ISP effective date unless there are issues with approval. All other chapters don't have the part about issues with approval and this statement has caused us to receive ISPs well after they are in effect in some cases. Can that statement be clarified (perhaps stating that the ISP should still be provided with the understanding that it could be updated if an RFI is received?). It should be made clear that this applies to revisions as well so that we may receive those before we are expected to implement them in time to train our DSP.	Thank you for your feedback. Please refer to the rest of ISP chapter for common understanding of Budget and ISP being submitted
33	Provider Agency	Chapter 6	ISP Meeting Participation and Attendance There is no clear information detailing that IDT members (BSC, Therapists, RD, RN) budgeted for CARMP ONLY services for children and adults must attend the Annual ISP Meeting. While I feel memos and standards are clear and that all budgeted IDT members should attend Annual ISP meeting in person, it appears many of these providers (noted above) still believe their attendance is optional or not required at all.	Thank you for your feedback. DSDD will continue outreach to provider network.
34	Family Member/Guardian	Chapter 6	DDSD needs to provide guidance and expectations clearly on 6.4.1.G. there are other parts in the standards that mention this. Prior to approval, DDSD needs to outline and provide teams how to do this in the ISP specifically. 6.8 is redundant	Thank you for your dedication to the people we serve and for your feedback. DDSD will continue to work with CM system to develop expectations of this new requirement.
35	Family Member/Guardian	Chapter 6	I am requesting that when the completion of ISP's, prior to distributing the final ISP, the person or guardian is included in receiving a draft for review prior to submitting the final ISP.	Thank you for your feedback. Please contact your case manager and request a final draft of the ISP. DDSD included the person/guardian in the final ISP review process, in Chapter 6.9.
36	Provider Agency	Chapter 7	-Clarity on the PCA timelines would help. This states that it should be available to the CM 14 days after the meeting, but other sections say all assessments should be 14 days prior, but then the Outside reviewer kicks them back if they are not dated the date of the ISP meeting. Can their due date be stated clearly here? -This states providers should have 48 hours to review the budget, but doesn't include the ISP. However, we are expected to review the ISP to ensure we don't receive RFIs and that we don't have corrections that must be made after approval, creating revisions before it even begins. Can it just add budgets and ISPs to this chapter as part of the 48 hour review to clarify. -Can it be clarified that the 48 hour review is in relation to the timelines in the OR process rather than the 48 hour timeline being applied well before the OR submissions are coming due. Also, Case Managers seem to be under the impression that the OR is due at the 60 days still. It says 45 days in this chapter, can that be clarified more as well or stated more clearly?	Thank you for your feedback. DDSD has clarified the language in 11.4 #3. Time line clarifications can be found in Chapter 6 ISP Pg. 67 6.3 #2 2.

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37	Provider Agency	Chapter 7	7.3 Adult Category Services pg 80 Adult Category services are available to individuals 18 and older. Young adults aged 18-20 may have some services limitations in this category…. 2. a. Customized Community Supports (CCS Group includes nursing supports) Clarify: CCSI does not qualify? EPSDT? So 18 and over qualify for nursing for CIHS, FL, SL 4. a. Adult Nursing Services (ANS) (not available to young adults, age 18 through 20 unless ARM supports are needed. Not available to children under 18). Clarify: Does this mean if ARM is needed full nursing is implemented or just ARM (CARMP and monitoring)?	Thank you for your feedback. 1) CCSI is available to individuals under 18 years of age. Other CCS services such as CCS-G is not available to individuals under 18 years of age. If an individual under 18 years of age needs nursing supports this would be provided through their state plan. 2) Adult Nursing Services (ANS) is not available to children under 18 and young adults (18 years through 20 years) unless they need ARM support.
38	Family Member/Guardian	Chapter 7	7.2.1.3. There are children on DDW that are under 14 that are receiving CCSI. There is no where in this section that shows that a limit or expected age in which defines at what age. 14 and up is clear but not prior to 14. Clarification is needed. 7.3.1 Need to remove the OR	Thank you for your feedback. 7.2.1.3: Children over 14 years of age require a PCA (Person Centered Assessment). However, children under 14 years of age do not require a PCA, but are able to access CCSI 7.3.14:DDSD will adjust language to the Budget Review process as transition begins. Please look for roll out plan information coming soon.
39	Provider Agency	Chapter 8	This chapter should address the required 21 day written notification for ISP meeting date.	Thank you for your feedback. Chapter 8.2.5 #7 indicates the 21 calendar days notification of ISP meetings.
40	Family Member/Guardian	Chapter 8	I am requesting a more precise definition of what is considered a major health event. I have found when asking this question it has been left up to interpretation	Thank you for your feedback. DDSD will review for master list of definitions
41	Provider Agency	Chapter 8	•Page 93- 8.2.8- Please add DDSD Assessment Tracking Sheet to this itemized list as a reminder for CM's to distribute annually.	Thank you for your feedback. DDSD will consider the addition of the Assessment Tracking Sheet to this list.
42	Provider Agency	Chapter 8	8:1 & 2- Go over ANE at every visit and with team members. 8:2- ANE is on the face to face visit form that is addressed at each visit with the client and Direct support provider from the CM. Case Managers can not predict if an ANE will happen, but can help the client and Direct Support staff have a clear understanding on how to report. 8:2,3 E- Meet for an IDT and review the Individual being gone for 90 days and make changes to the individuals ISP and budget as needed Per situation. 8:2,5- Ensuring a person is living in a an environment free of abuse, neglect and exploitation- All DD waiver staff need to be ANE certified and Posters posted in the home. Case managers can only remind agencies to report and not harm the clients. 8:2-7 If the CM's reported concerns are not acknowledged by the Provider Agency or through the RORA process within 5 business days , the CM shall contact Statewide Case Management Coordinator. agree 8:3- financial reporting- Case managers are not Rep Payee agencies and can only seek bank statements only if agreed by the guardians.	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage".
43	Family Member/Guardian	Chapter 8	8.1 intro. Remove ensure as CM is not a 24 hour in person with each individual. Liability Insurance will not cover the CM nor DDSD if "ensure or prevent" is in this chapter. neither entity is an emergency response provider. Police and firefighters cannot ensure the safety of others, how does DDSD expect providers to. Same Response for 8.2.5.5	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage".
44	Provider Agency	Chapter 8	8.2.7 #5a States that CM face to face visits need to occur once per quarter in the home. #5b states that 1 face to face visit per quarter should occur at the CCS program. With the push to greater ANE awareness and the fact that case managers being paid, is directly tied to their once-a-month visit, and they are responsible for assessing the overall health and safety of the individual and that the required services are meeting the client needs. It would seem that at min 2 visits per quarter should be face to face in the home. I would go as far as to say every month there needs to be an in-home visit and once a quarter an additional visit at CCS. It is also worth considering that there be a stipulation that those monthly visits not be more than 45 days apart. Currently a case manager could make a visit on the first of one month and the last day of the next month leaving close to 8 weeks between visits. ANE could easily go undetected in that length of time. Bones can heal and bruises disappear. I would also suggest a stipulation that CM and living service agency service coordinator visits be done separately. Often times, especially in family living CM and SC do joint visits to minimize disruptions to the households and to be more efficient in gathering some of the same information. That practice eliminates a second set of eyes at a different point in time. If those two visits are done at different times, then there are twice the likelihood concerns can be noted and addressed.	Thank you for your feedback. DDSD will maintain the language and consider feedback as ANE prevention strategies develop.

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45	Provider Agency	Chapter 8	8.1 It is unable to ensure a client is ANE free 24/7 and wording should be specific to case management and the actual time of the visit. We are not actionable at the time of an ANE. 8.2 Case managers cannot predict the future to "prevent" ANE but case manager do review ANE reporting's requirement. 8.10 Very broad, information is covered under script. Not ALL IDT members attend meetings and provider agencies should be responsible for Direct staff. 8.2.3 e - This cannot be unpaid work, what is the funding source Assessment hours are needed. LOC should be auto started to begin process. 8.2.7 5 There are instances that clients are homeless or do not allow CM's in to the home if they do not receive paid supports. There needs to be acceptations to these circumstances. 8.2.7 - 11 RORA smart sheet should go to the CM agency and the provider agency. RORA process is a state process and needs to be improved.	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage". DDSD continues to work on improving the RORA system and will consider your feedback in future RORA system development.
46	Family Member/Guardian	Chapter 9	# 9 states that DHI has to approve a transition prior to transition. This prevents H+S when an ANE involves dramatic issues around the ANE where moving to a safer environment is needed... ANE prevention should also include DDSD vetting provider owners from starting a new agency just to obsolve themself from the open ANE or infraction.	Thank you for your feedback. DDSD is developing a simple, fast form and process to address collaboration with DHI. DDSD works with new provider agencies on ensuring they are eligible to become a new Provider Agency. All new provider agencies are required to fill out an application which is reviewed by DDSD.
47	Family Member/Guardian	Chapter 9	page 106 Transfer of documentation to be transferred to a new agency. #9 reads Social Security Card, Medicaid and or Medicare card, Birth Certificate, Certificate of Indian Blood, and ID Card. I am requesting it be added that the person or guardian be responsible for the distribution of this information unless agreed upon other wise. As a guardian I need to know who has this information and what it is being used for. If the information is being transferred I have no idea what information is being provided and for what reason. page 107 Letter of Transfer and Receipt I am requesting that the person or guardian also be provided a receipt of what has been transferred and to whom for our own personal records.	Thank you for your feedback. DDSD will add guardians to the Letter of Transfer and Receipt
48	Provider Agency	Chapter 9	•Page 99 9.3.1 A GER is already done for out of home placement. Doesn't the GER notify the needed individuals at DDSD? Why is a RORA now needed in addition? Standards are filled with redundancy, we need to simplify this. •Page 107 9.11 #18: How is an agency responsible for obtaining a clearance from DHI for no active ANE's in progress when an individual is pulled from an agency and the agency doesn't know where they went? What happens if an agency reports something, and the individual and their guardian want to switch agencies due to the ANE report being filed? Is the transfer on hold pending the resolution of the investigation?	Thank you for your feedback. DDSD is developing a form and an easy process to collaborate with DHI which will be shared with Case Managment system. The reporting of Out of Home Placement will only require GER reporting and not a RORA. Service standards have been edited.
49	Provider Agency	Chapter 9	9.3 Addition of provider agency being required to file a RORA for an Out of Home Placement when a GER is already required is redundant and this is unfair extra burden on agencies when a notification system is already in place. If the system is not working the burden of double reporting should not be placed on the agency.	Thank you for your feedback.The reporting of Out of Home Placement will only require GER reporting and not a RORA. Service standards have been edited.
50	Provider Agency	Chapter 10	Chapter 10.3.6 #3 3. When room and board costs are paid from the person's SSI payment to a Living Supports Provider Agency, the amount charged for room and board must allow the person to retain 20% of their SSI payment each month for personal use. •Does this include SSA payment also? •What if we don't provide board?	Thank you for your feedback. Edit request for addition of SSA will be taken into consideration. If a provider agency is not providing room and board, there should be any cost to the individual.
51	Other	Chapter 10	10.3.7 pg 113 water temp increased n a memo sent in 2021 to 120 degrees from 110 degrees F. Should reflect the same on page 119 3c. I have the email that was sent in December 28, 2018. Changing the temperature to reflect a change due to feedback on anti-scalding plumbing codes. It was never updated on the standards from what I saw.	Thank you for your feedback. The 6/13/22 Health Alert indicates 110 degrees F. The updated standards will continue to indicate 110 degrees F

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52	Provider Agency	Chapter 10	We request that Sections 10.3.7.6 and 10.3.9.2.1.1.3 be removed to eliminate the provision that requires water temperature to not exceed “a safe temperature (110 F). Add “e. Water temperature” to the checklist included in sections 10.3.9.2.1.1.2. •Our research found that the EPA and NIH recommend 120 F to minimize risk of infection from bacteria while lowering energy consumption. Per NIH, a serious burn takes approximately 10 minutes at that temperature. OSHA recommends 140 F. We didn’t find any guidelines supporting the 110 F specified in the Standards. •No specific standards for air temperature are specified although there is a possibility that physical harm may result from that measurement being too hot or cold. Water temperature should be addressed in a similar manner. •CDE, Inc. was cited in the results of the audit conducted by DDSD in 2/2023 for non-compliance with the above reference provision. No scalding incidents have ever occurred since the inception of this agency in 2008. Thermometers have been purchased and Service Coordinators are testing water temperature during their visits. However, they report that the thermometers are inconsistent and that families don’t always want to lower water temperature. Some have expressed concern regarding bacteria and others simply enjoy hotter water. •If a specific temperature cap continues to be included in the Standards, a standard deviation should be allowed when measuring. During the audit we were cited for water temperature measured at 111 F. As stated earlier, our staff observes that there can be a variance of a few degrees using multiple thermometers at the same time.	Thank you for your feedback. The 6/13/22 Health Alert indicates 110 degrees F. The updated standards will continue to indicate 110 degrees F
53	Provider Agency	Chapter 10	What is meant by “Service Provider must ensure staff complies to facilitate home visits by State of NM”? That is a very broad statement with no guidance on how this is to be accomplished. 10.3.2.7 Although the use of electronic devices is helpful for a myriad of reasons, the provider agencies cannot be held responsible providing costly IT support for DSPs that do not work in a facility setting. It is nearly impossible for IT to “maintain and operate” devices.	Thank you for your feedback. This statement is to ensure Service Providers informing their Direct Support Staff (All DSP's to include FLPs) are aware of the DDSD Home Visits and allow DDSD to conduct home visits. DDSD will maintain language in 10.3.2.7 and encourages providers to attend monthly Tech First Community of Practice Series.
54	Provider Agency	Chapter 10	10.3.3 Regarding notification for not eating or drinking in 24 hours rather than CM notification and RORA why not make this a GER? Have dueling reporting situations makes the system cumbersome and leaves too many opportunities for failure. Having one system in place is far easier to enforce and manage. 10.5.3.1- CIHS Provider Agencies must: d "Creating a safe environment free of abuse, neglect, and exploitation". When the person is living independently it may not be within the provider agency's ability to "create" that environment. This wording doesn't really work for this service. Promote may be a better word choice	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage". DDSD is modifying the not eating or drinking in 48 hours as a GER rather than a RORA. Modifications in standards are made.
55	Provider Agency	Chapter 10	State of NM employee should be defined and limited to DOH employees or quilified employees.	Thank you for your feedback. Home Visits process moving forward includes DOH employees and training
56	Provider Agency	Chapter 10	•Page 112: What is the purpose of the RORA for when an individual is not eating or drinking for 48 hours? What will DDSD do with these RORA’s? Will the process be changed to a 24 to 48 hour follow up? Shouldn’t this just be a GER since more eyes see the GER than the RORA?	Thank you for your feedback. DDSD is modifying the not eating or drinking in 48 hours as a GER rather than a RORA. Modifications in standards are made.
57	Provider Agency	Chapter 10	Family Living Comment: The State needs to put into place a review/tracking system for when an agency terminates a Family Living Agreement/Contract, or makes a decision not enter into a new Agreement/Contract with an applicant.	Thank you for your feedback. DDSD will not be implementing a tracking system at this time.
58	Family Member/Guardian	Chapter 10	Similar issues with the word "ensure" 10.3.9.1.4 as well as other sections refer to State of NM. DDSD should be clear that those doing these visits are fully trained on the same trainings all providers must go through prior to coming in contact with the individual served and have a working competent knowledge of the standards. 10.3.9.2.1.4c = Medicaid does not pay for Annual check ups. Q 2 years. Section should consult medicaid as to when they will approve certain medical followups for Annual, hearing, dental, vision. Same section #F. Clarification needs to come out from DDSD as to how it is to be documented without increasing DSP documentation already for the DDW participant. 10.3.9.2.2. FORMER JCMs should have equal amount of Subcare or increase the None JCM to 1000 hours. Being that JCM is now over; all should be have the same access as anyone else.	Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage". 10.3.9.1.4: DDSD will edit to clarify DDSD staff are trained to perform home visits. 10.3.9.2.1.4c: Please contact CSB or the persons Medicaid State Plan for assistance 10.3.9.2.1.4F: This is to ensure the health and safety of an individual and that the agency is promoting and encouraging an environment free from ANE. 10.3.9.2.2: Family Living Substitute Care of 1000 hours for Former JCM's is still in the DD Waiver Application, at this time this remain as a service for FJCMs

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59	Provider Agency	Chapter 10	10.3.3 Nursing and Nutritional Supports pg 111 Clarify: Can client or guardian opt-out of RD services? Pg 112 10.4.1.1 SL General Requirements pg 122 Clarify: Nurses attending an annual ISP meeting by phone is optional? 10.4.1.3 Additional Requirement for SL Cat 4 Nursing oversight at minimum monthly nursing assessments documented: a.Monthly notes summary of all visits r/t physical or medical condition b.Monthly notes must include description of person's current physical/medical status. c.Monthly nursing notes must include stats of physician's orders – new, discontinued, etc.), status of lab or diagnostic tests, specialist evals, medical appts, meds, treatment, and/or equipment d.Monthly nursing notes must include the skilled services provided and the person's response to the interventions. 10.5.2. CIHS Service Requirement Clarify: If client cannot be home by self, clarify who is responsible for the client outside of CIHS hours? If not independent, does the service require reconsideration. Pg 134 10.5 CIHS ANS must be budgeted if the person cannot self-administer their medication or requires or receives health related support from DSP who are not related yb affinity or consanguinity. Pg 135 10.5.1. 12 a.Healthcare coordination b.Setting up medications and/or reminders Clarify with CIHS, CCS & Respite ANS for unrelated providers.	Thank you for your feedback. There do not appear to be any questions related to ANS in this comment other than nurses being required to attend IDT's in person: 6.2 #33.IDT member participation can occur in person/face-to-face or remotely. Remote/video participation must align with Federal Guidelines for HIPAA Privacy. All confidential protected health information (HIPAA Sensitive PHI) must be sent through SComm in Therap by Provider Agencies required to have SComm accounts.
60	Provider Agency	Chapter 10	p. 116 10.3.9.2.1 #3 - Unclear – DDW therapy providers selected through the SFOC process are not consultants. Suggested revision: Monitor and document monthly that the devices listed on the AT Inventory are available, functioning properly, and are in use per WDSIs. Communicate issues related to AT or RPST devices to the appropriate therapy provider or IDT member listed on the AT Inventory. p. 127 10.4.1.5.1 #3 - Unclear – DDW therapy providers selected through the SFOC process are not consultants. Suggested revision: Monitor and document monthly that the devices listed on the AT Inventory are available, functioning properly, and are in use per WDSIs. Communicate issues related to AT or RPST devices to the appropriate therapy provider or IDT member listed on the AT Inventory. p. 132 10.4.2.4.2 #6 - Unclear – inconsistent with similar references to therapy documents elsewhere in Standards. Suggested revision: Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, HCPs, PBSP, BCIP, PPMP, RMP, CARMPs, and therapy WDSIs. p. 133 10.4.2.4.2 #7 - Unclear – DDW therapy providers selected through the SFOC process are not consultants. Suggested revision: Monitor and document monthly that the devices listed on the AT Inventory are available, functioning properly, and are in use per WDSIs. Communicate issues related to AT or RPST devices to the appropriate therapy provider or IDT member listed on the AT Inventory. p. 137 10.5.3.1 #2 - Unclear - inconsistent with similar references to therapy documents elsewhere in Standards. Suggested revision: Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, HCPs, PBSP, BCIP, PPMP, RMP, and CARMPs, and therapy WDSIs.	Thank you for your feedback. 10.3.9.2.11: Change from WDSI to AT inventory made. 10.4.1.5.1#3 Change from Therapy Consultant to Therapy Provider For #6 and #2 there is no identification of other areas of the standards where this is inconsistent.

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61	Provider Agency	Chapter 10	Sub Care Ch. 10 Pg. 115 Due to staffing shortages subcare is often not available additionally I have found some FLPs weren't educated on the ability to have subcare. I think it would help to have more clarity surrounding what the process is if sub care is not identified. Perhaps FLPs are given a reimbursement of unused subcare funds if the FLP is not given Sub Care staffing? I've had FLPs who haven't gotten sub care due to the travel required, pay, or just not having staff. Additionally, addressing if sub care can be provided to multiple individuals at once or if it must be on an individual basis? Can it be in the community, at home, can sub care staff provide overnight supports and can they provide assistance with scheduled medical appointments? Can sub care be opted out of or not? * Family Living Providers The standards indicate the FLP must be available to the individual 24hrs a day/ 7 days a week. I've been asked what are the minimal and max. required hours of FLP support must be provided on a day-to-day basis. This info may help, though I am aware this can be an individual specific needs factor. *Within the new standards revision I saw there needs to be an emergency plan for the person if FLP isn't available. I've begun having this dialog with FL SCs and FLPs and have been told they have an Emergency Placement Plan AKA an Emergency Disaster Plan. Upon review this plan looks no different than what is in in other LCAs, CCS, etc. May list sub care or a family member or emergency contact for the FLP, then lists going to a hotel followed by Law Enforcement, Poison Control Gas, Electric and Water Authorities. If I'm reading the standards revisions correctly- I think it'd help to indicate that this should be different from an Emergency or Evacuation Plan as many I have talked to believes that doesn't apply to them. *Additionally, I saw on DDSDs website that for another waiver service it's required to note this similar plan within the ISP like document. I do think that for the sake of health and safety as well as preparedness it would be helpful to have a similar requirement for DDW CMs to have to note or summarize this plan in the ISP and review this plan at least annually, so the whole IDT is aware and changes can be made if needed.	Thank you for your feedback. DDSD will maintain current language and continue to review these questions and comments for future edits
62	Family Member/Guardian	Chapter 11	Family members allowed to be paid fro CCS	Thank you for your feedback. DDSD is waiting for final approval from Centers for Medicaid and Medicare Services (CMS) on this permanent addition to the DD waiver
63	Family Member/Guardian	Chapter 11	11.5. DDSD should also have "ensure" if they are part of any team, they too should be held liable. 11.6.5.3. Former JCM should have the same services as non jcm 11.7.2.1.8 = Cant ensure if the individual works in community setting with only 1 hour of CIE Job Maintenance 1 x weekly check in. Especially when individuals work at places that are in community especially with the world's crime rate rising. No one can predict when the crime happens and no service is 24 hour rapid response.	Thank you for your feedback. 11.5: Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage". CCS-Group FJCM is still available to former JCM's. 11.7.2.1.8: Thank you for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage".

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64	Provider Agency	Chapter 11	•Page 146- 11.6.5: Since the Jackson class lawsuit is settled, why is this still in the standards as a ratio? How can conditions be placed upon agencies for former class members? •Page 149 11.6.8 #3: What if the SC is stationed at the delivery site. Does a formal meeting need to be documented, or can progress notes be kept on a regular basis? What type of formal documentation needs to be provided? How often does this need to be provided? Who do we provide this to?	Thank you for your feedback. Page 146- 11.6.5: CCS-Group FJCM is still available to former JCM's. DDSD will maintain. Page 149 11.6.8 #3-The monthly face-to-face consultation described in this section can be done at the service delivery site or in the community. The documentation needs to include the items listed. This document is to be completed monthly, after the face-to-face visit and should be made available upon request.
65	Provider Agency	Chapter 11	I would like to comment on the new CCS agency requirement regarding monthly visits. Our agency supports clients using a variety of services. Presently, we visit clients who have Family Living and Customized In-Home Supports each month. We visit clients with Customized Community Supports each quarter, but we are in touch with them on a constant basis. I do not believe increasing the frequency of our visits to CCS clients will help our agency or the individuals we serve, primarily because we do not have the staffing to support the sheer volume of monthly visits this new requirement would create, as we already need to make time for current monthly visits, and we have a large number of clients using CCS services.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative.
66	Provider Agency	Chapter 11	"It would be helpful to have more clarification on the “three-hour period break”. For example, when a CCS day is 6 or more hours long, the break can’t exceed 3 hours. If CCS day is from 1 to 2 hours, no break is allowed. If CCS day is 2 to 3 hours, break can’t exceed an hour. If CCS day is 4 to 5 hours, break can’t exceed 2 hours. **It would also be helpful for the Standards to say that this “break at home” needs to be taken in the middle of CCS shift/day. Because they try to take it at the start of their shift and help with getting the participant ready or cooking and eating breakfast. Or, they go home early and CCS Provider is still billing CCS because the participant chose rest at home then the Provider clocks out 3 hours later from when they got home."	Fg edit-CCS:11.6.2 Brief or intermittent time at an individual’s home or in an agency operated building, per individual need, not to exceed a three-hour period for lunch, break, behavioral stabilization, ADLs, and/or change of clothes, no more than 15 hours per week. This time is not to be used in an agency operated building to attend activities such as birthday parties or seasonal gatherings. This allowance is used to supplement not supplant CCS services and should be based on individual need..
67	Provider Agency	Chapter 11	Like all changes in this chapter. Very helpful.	Thank you for your positive comments and feedback regarding this addition.
68	Provider Agency	Chapter 11	I understand that the Service standards are crucial in guaranteeing the quality of services and ensuring the health and safety of participants in the DDW. I assure that our dedication to enhancing the quality and safety our services is out top priority. Furthermore, our CCS quarterly consultations have been giving us great results. On the other hand, we are afraid to be overwhelmed with implementing CCS monthly visits due to have a short staff. Not to mention, the volume of monthly visits are already significantly enough for us to attentively manage. I would appreciate if the new DDW Service Standards get revised and re-consider keeping the quarterly consultations for CCS. Thank you so much for your time!	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative
69	Provider Agency	Chapter 11	Section 11.6.8 3a states MERPs; however, everywhere else it has been crossed out. Is this a clerical error?	Thank you for your feedback. DDSD will remove the MERP.
70	Provider Agency	Chapter 11	p. 14211.6 Please clarify somewhere in this section if CCS services may be used to support individuals during therapy sessions. Previous guidance is that CCS services may be concurrent with therapy sessions. This is consistent with the Collaborative-Consultative model.	Thank you for your feedback. DDSD will continue to provide training on Collaborative Consultative Model . Yes, CCS and therapy services can absolutely be billed at the same time. It is critical that therapists work with individuals during CCS to supports needs in the community setting. CCS staff must also be trained by therapists according the IST page of the ISP.

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71	Provider Agency	Chapter 11	A lot of the clients I work with require a monthly visit and some require the quarterly visits at this time. I generally drive over 500 miles plus every month making sure I visit all my families and clients that I am required to visit every month. I can honestly tell you if I were to visit all my CCS clients every month in addition to the family living visits, would be exhausting, especially if I already see them for the family living visit. This would double our workload, and I would honestly request a smaller caseload. I visit all my clients and stay I contact with all of my families. I also review and approve their notes frequently, calling them as needed. I also see our visits as an intrusion to the clients lives and, yes we are ensuring client services and safety but clients need a chance to live a normal life and spend time in the community without us visiting them both in the community and at home. They need a chance to be themselves and not be asked so many questions about their lives or have their day disrupted while out in the community. Yes, we are ensuring client safety in the community but this is also the clients lives. I would hate to think of the wear and tear on me and my vehicle, in addition to the reports and meetings we have to attend. I am aware these issues are part of my job and that is my responsibility, but the monthly visits to all my CCS clients would require this agency to hire and train more coordinators to cover the additional visits., and a lot of those clients we see for family living visits already. It would create more of caseload for everyone. and doing double work for the clients we already see for family visits every month. In addition, constantly driving the highways is not safe for us. We are constantly increasing the chances of us getting into an accident just by always being on the road. The more we are on the roads the more our chances of being in a life ending or changing accident increase. Semi trucks and Albuquerque drivers are not always the friendliest or courteous on the roads. It is frankly, sometimes nerve wracking to visit these families, especially if the weather is bad. When these changes are made to the standards I do not think people that make these changes think about the reality of what it takes to adhere to the new standards Someone has to carry out those visits. People that decide this for other people do not think of logistics and what we as coordinators have to do to carry out these additional CCS visits.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative.
72	Provider Agency	Chapter 11	Chapter 11-CCS Monthly Visits Our agency conducts quarterly visits and would like to continue doing it quarterly. We don't have the manpower to do monthly visits for FL, CIHS and CCS. Please consider quarterly visits instead.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative

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73	Provider Agency	Chapter 11	Chapter 11: Community Inclusion 28. Brief or intermittent time at an individual's home or in an agency operated building, per individual need, not to exceed a three-hour period for lunch, break, behavioral. stabilization, ADLs, and/or change of clothes, and may be used in an agency operated building to attend specific planned activities such as birthday parties or seasonal gatherings. In total this time should not exceed more than 15 hours per week. no more than 15 hours per week. This time is not to be used in an agency operated building to attend activities such as birthday parties or seasonal gatherings. a. JCMs may receive CCS in the home up to 30 hours a week to maintain the same level of service received under 2007 DD Waiver Standards. •What is DDSD Regional offices take on serving "former JCM" who currently now are receiving services in the home, based on medical diagnosis, changing health status, aging population issues or environmental obstacles that each IDT Team has identified over the years that continue to impact their community involvement? •Currently we know there is an exception to Standard process to address these circumstances. Will there be flexibility to each individual's concerns? •If Regional offices deny requests, QMB reviews ISP Implementation citing deficiencies. What are the expectations for each IDT Team? •Most former JCM here in LLCP use In-Home intermittently along with Community inclusion, however there is rising concern over the complete shutdown of this practice. 11.6.2 General Service Requirements for CCS Individual, Small Group and Group 3. Staff ratios at a day facility or in the community depend on the approved CCS- Group category: a. CCS-Group Category 1 is not to exceed one-to-six (1:6). b. CCS-Group Category 2 Extensive Support is not to exceed one-to-four (1:4). c. CCS-Group Former Jackson Only is not to exceed one-to-four (1:4). i. Former JCMs may receive the CCS-Group Former Jackson Only service to maintain the same level of Adult Habilitation Medical/Behavioral Outlier services received under the 2007 DD Waiver Standards. •Can there be a more substantial definition of what this looks like for scope of services. We are assuming that that this is Adult Habilitation Outlier funding based on the MAD 046. Currently now Cat 4 to include enhanced staffing. As a community only Agency providing CCS in the greater community. What is the Regional offices recommendation to IDT Teams for agencies who do not operate "facilities" and now do not benefit from "In-Home" CCS. •Is T2021 HB U5 going to remain on the fee schedule?	Thank you for your feedback. Chapter 11.6.2: There are no changes in FJCM CCS JCM Only services. The T2021 HB U5 will remain the same. Error in removal FJCM 11.6.2 #28a, added back to the service standards.
74	Provider Agency	Chapter 11	CCS: 11.6.2 - #28 (page 138) It would be helpful to have more clarification on the "three-hour period break". For example, when a CCS day is 6 or more hours long, the break can't exceed 3 hours. If CCS day is from 1 to 2 hours, no break is allowed. If CCS day is 2 to 3 hours, break can't exceed an hour. If CCS day is 4 to 5 hours, break can't exceed 2 hours. **It would also be helpful for the Standards to say that this "break at home" needs to be taken in the middle of CCS shift/day. Because they try to take it at the start of their shift and help with getting the participant ready or cooking and eating breakfast. Or, they go home early and CCS Provider is still billing CCS because the participant chose rest at home then the Provider clocks out 3 hours later from when they got home.	Thank you for your feedback. 11.6.2 Brief or intermittent time at an individual's home or in an agency operated building, per individual need, not to exceed a three-hour period for lunch, break, behavioral stabilization, ADLs, and/or change of clothes, no more than 15 hours per week. This time is not to be used in an agency operated building to attend activities such as birthday parties or seasonal gatherings. This allowance is used to supplement not supplant CCS services and should be based on individual need.
75	Provider Agency	Chapter 11	-Again, clarity on the PCA timelines for the annual -11.6.2.28 seems contradictory to the specific sections for CCS I, CCS G, and CCS Small Group. It discusses the agency operated building options, but this varies based on the service type. Can this be clarified?	Thank you for your feedback. DDSD has clarified the language in 11.4 #3. Time line clarifications can be found in Chapter 6 ISP Pg. 67 6.3 #2 2.

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76	Provider Agency	Chapter 11	Thank you for amending the Service Standards. Many of the new provisions seem to assist in the care of individuals without placing too much stress on the resources available to provider agencies. The one provision that concerns me and my agency is the requirement to visit every single CCS individual in the community monthly (11.6.8 (3)). While I understand the desirability of having monthly checks on people in the community, visiting every individual monthly adds a huge new burden on the coordinators at the agency which I run. In addition to the time to do the additional community visits (this likely doubles the number of visits coordinators need to make each month), there is the travel costs (gasoline, wear and tear on company vehicles) and the documentation expense. This represents a new significant unfunded mandate since the agency has set up the coordinator oversight, processes for providing services, and pay to direct support providers for CCS services based on the requirements that are currently in existence. I would propose instead that the community visits be made quarterly instead of monthly. I believe this would meet the needs of seeing people in the community regularly and protecting against ANE while not overtaxing the provider agencies. Alternatively, for individuals who are already being seen monthly in their homes (because they receive either family living, supported living or CCS services) and are already being checked monthly to assure that their safety and well-being are good, the community visits should be reduced to quarterly or twice-annually.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative
77	Provider Agency	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
78	Provider Agency	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
79	Provider Agency	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
80	Other	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
81	Other	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
82	Provider Agency	Chapter 12	I really appreciate the revisions related to allowing Telehealth on a limited basis and as a support to in person therapy consult. There are times when it really is needed as an option and can actually be a benefit to the person. Thank you.	Thank you for your positive comment.
83	Provider Agency	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
84	Family Member/Guardian	Chapter 12	Remove Red section 12.2 and 1 thru as all providers prviding services should do in person supports. If telehealth is an option for Professional Services, then CIE, CCS, CM etc should also have that option for overseeing service or plan implimentation. BSC professional services if the others services are to "ensure" environments, should have that included in their responsibilities.	Thank you for your dedication to the people we serve and for your feedback. DDSD has modified the use of the term "ensure" and changed to either "promote" or "encourage". DDSD will continue to review Telehealth provisions.

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85	Provider Agency	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
86	Provider Agency	Chapter 12	In section 12.3.3 it says to have documents completed in a timely manner but, I think a time frame would be more helpful. The other service areas have a specific time frame where they need to turn in the reports, WDSIs and TFD and I think it would help the BSC and the core members of the IDT to know when those documents need to be completed and distributed.	Thank you for your feedback. In 12.3.3 there is reference timely complete of assessments and plans. 5.Timeline and Distribution: a.New WDSIs are due, following strategy development and before expected DSP/IDT member implementation. b.Ongoing, continued or maintenance WDSIs should be reviewed and revised as needed and redistributed at least annually after development of a new TDF and at least 2 -weeks prior to the ISP effective date for a new ISP cycle. All WDSIs shall be distributed to the CM, to all IDT members and to all agencies where the instructions will be implemented. c.Annual retraining of ongoing (continued or maintenance) WDSIs should be completed within 30 calendar days following the ISP effective date. d.WDSIs may be revised as needed within the ISP annual cycle. When the WDSI is revised, re-distribution and re-training of DSP/IDT members are necessary.
87	Provider Agency	Chapter 12	I have concerns about meeting with clients at home once a month. Typically, as a BSC, this occurs anyway but sometimes there are circumstances that are out of my control. For example, this month I had 2 appointments scheduled with an individual and her mother (FLP). The first was cancelled due to a dentist appointment and we were not able to find another opportunity to reschedule before the next scheduled appointment. The second was cancelled last minute today when the FLP locked her keys in the car in the community. The best I can offer them at this point is a phone consult next week which is the end of the month. They reside 30 minutes away from me and others on my caseload, so rescheduling is quite the task. There is a BSC in my agency who works with an individual whose behavioral challenges revolve around impulsivity making it difficult to connect with her as appointments often get cancelled or the individual is a no call/no show. This occurs with all team members making home visits a struggle even for the Case Manager. What will the ramifications be for us and/or the individual if we cannot meet this quota? Will there be a justification form or other way to document that we have tried but been unsuccessful? Thank you for this opportunity to provide feedback.	Thank you for your feedback. Should a provider need an exception to visit an individual the provider must submit a request for an exception to the Regional Office.
88	Provider Agency	Chapter 12	Chapter 12/ Appendix A Client File Matrix – a.An OT PT SLP BSC PLAN is dated 04.01.2023 but the ISP YEAR on the plan is 06.01.2023 TO 05.31.2023. •Does the term “Annual” refer to the report date of 04.01.2023 date or the expiration of the ISP YEAR 05.31.2023? Chapter 12/ Appendix A Client File Matrix . 1. a. Service Coordinator TSS’s due 14 days prior to the start date of the ISP and OT PR SLP and BSC documents due Annually. •Is it possible to simplify by aligning these due dates-with all OT PT SLP AND BSC docs due 14 days prior to the ISP?	Thank you for your feedback. Annual refers to the ISP Expiration. The Annual budget years cannot be changed.

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
89	Provider Agency	Chapter 12	I am a Speech-Language Pathologist, and I have a single member LLC, Icon Innovations LLC. I believe the following in section 12 is best practices and I appreciate that you have put this into the Standards: Section 12.5.7.1 - collaboration with multiple DSP; co-treatment for a functional and/or clinical need; therapy support of visions and outcomes; collaboration with family; Section 12.5.7.2 - I believe it is important to be able to participate in annual ISP, ARM, IDT meetings bot in-person and hybrid. It is critical that virtual attendance be approved because of ongoing health and safety (e.g., resurgence of COVID and flu season, etc.) and because this is a state with unmet rural needs and not enough therapists!! Thank you for the common sense approach of providing traings, monitoring, and therapy services either in person or virtually! Services in person are not magic! Services in person can be poorly done or well done. The same can be said for virutal provision of services. The quality of therapy, training, etc. depends upon the content, methods, and collaborative model, among other things. I live in Albuquerque and provide services in Gallup. In order to provide the best services with frequent follow-up depends on being able to implement the hybrid model of providing ALL therapy services both in-person and virtually. I appreciate the focus on the Collaborative/Consultative Model which provides for the best outcomes for the individual. I have found some unfortunate situations in which therapists have been "reported" for providing periodic co-therapy. In other situations, some therapists refuse to collaborate. More education of Providers and Provivder Agencies is needed! All other sections and details in /chapter 12 appear appropriate. One other issue that is affecting therapy provision is that there are many new Case Managers now that are not aware of DOH DDSD DDW timelines and due dates for documents and also don't seem to understand basic roles of therapy disciplines. I'm sure this will change, but it can be a challenging situation. Thank you for your work on the STandards!	Thank you for your dedication to the people we serve and for your feedback. BSC is a consultative model therefore their scope does not allow for the providing of direct therapy services only consultation services. DDSD will provide continue to provide outreach.
90	Participant	Chapter 12	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
91	Provider Agency	Chapter 12	All individuals must have a minimum of one monthly face to face visit by the OT, PT, SLP, or BSC provider in the residence of the person, unless the person is on fading/monitoring status. This seems like an unachievable ask in my opinion. Our Agency provides OT and PT services to individuals specific to their individual needs and therapy goals, but it does not always include monthly home visits. We serve nearly 100 individuals in the NW region which includes very remote areas. Most of our individuals attend day programs and are not home until after 3pm. This would mean that therapists would have 1-2 home visits every day after 3 pm requiring extensive drive times in order to get to all of our clients residences each month. The hours that we all work as DD Waiver therapists already seem to lack boundaries completely blurring into family time. This requirement would create a significant hardship to our therapists. Thank you for your reconsideration of this recommendation.	Thank you for your dedication to the people we serve and for your feedback. Due to the focus of ANE prevention, DDSD will maintain the new initiative.
92	Provider Agency	Chapter 12	p. 161 12.2 – telehealth allowed #6. Is what a 'fade out plan' is defined or described somewhere? p. 161 12.2 – telehealth allowed #7Could this be added at the end "or documented on the TDF" to include OT, PT, SLP services? p. 161 12.2 – in person required #1 What if there are no paid providers in the home - and no visions or outcomes are being addressed in the residential setting? Please clarify if, in this situation, therapists are required to do monthly face to face visits in the home and also in CCS or other setting where visions/outcomes are being worked on? p. 161 12.2 – in person required #3 Unclear. Does this mean all services in the first 45 days must be in person? Or at least one time in the first 45 days? p. 161 12.2 – in person required #6 Suggest this state the full document name: “Comprehensive Aspiration Risk Management Plan” p. 19112.6.1 #10Unclear if “IDD Program” is the same as “DDW Program”? This phrase is not used in current Standards.	Thank you for your feedback. Concerns around not seeing individual in the home to verify that living conditions are safe and no neglect is occurring. 12.2 Definition of fading can be found in the Master List of Definitions https://www.nmhealth.org/about/ddsd/pgsv/ddw/publications/

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
93	Provider Agency	Chapter 12	Language regarding frequency of Telehealth is confusing. One area states we see the person once a quarter as listed in Item 1, then here it lists that it cannot exceed 50% of visits Telehealth is intended to supplement, not supplant, in person delivery of services. Telehealth allows for an individual to choose a combination of in-person and remote service delivery options. Therapists must follow the agreements made regarding the modality in which the service is delivered. It may not exceed 50% of total visits..	Thank you for your feedback. For clarification Telehealth cannot be more than 50% of visits.
94	Provider Agency	Chapter 12	*BSC services Ch 12 pg 160 There is no information on the timelines BSCs have for developing inital plans. I've seen BSCs report they need more time than 30 days when developing initial plans as it is different from Annual plans. *Pg 171 IDT Participation There is no clear details if therapists are budgeted for CARMP only/ AT or E Mods only, that they must attend the Annual ISP meeting. Those budgeted for those purposes have shared they aren't required to because they're not providing full therapy services. Additionally, After the memos sent out in March 2023 discontinuing telehealth and resumption of services and attendance in person, Various providers (BSC, Therapists, RNs and RDs), believe they aren't required to attend meetings or they can attend virtually. Clarifying these would certainly help!	Thank You for your feedback. Timeline for documentation can be found in Chapter12.3.5.1 DDSD will consider your feedback. and continue to provide TA and training to provider network.1.1.1.1IDT Participation Therapists support the individual in achieving their ISP visions, Desired Outcomes and Action Plans through the following requirements: Therapists are required to participate in additional IDT meetings when the agenda contains issues relevant to their specific therapy disciplines.
95	Provider Agency	Chapter 12	12.2 Telehealth for Professional and Clinical Services Telehealth is allowed and billable for the following: 9. Initial trainings for Direct Support Staff to a “knowledge” level of competency until an in-person training to skill level of competency can occur. Feedback: BSC's oftentimes are unable to train to a "skill" level as we are not always present when the individual is exhibiting challenging behavior. We are therefore unable to model and/or observe how strategies are utilized by direct support staff. Since this is the case, can BSC's train via telehealth to a "KNOWLEDGE" level without then completing an additional training in person which would be redundant. In person, face-to-face visits are required for the following: 1. All individuals must have a minimum of one monthly face to face visit by the OT, PT, SLP, or BSC provider in the residence of the person, unless the person is on fading/monitoring status. For those on fade out plans or monitoring status, at least one visit a quarter must be face to face in the residence of the person. Feedback: Is this stating that each ancillary provider, OT, PT, SLP, and BSC need to conduct a face-to-face monthly visit? Or is it stating that one of the providers on the IDT needs to conduct the visit? Should the "or" (highlighted above) be replaced with "and"? I think we will need some clarification on this just so that we are sure ancillary know what the expectation is.	Thank you for your feedback Most BSC plans are and should be set at skill level- not knowledge or awareness level. It is the BSCs responsibility to train all staff and have them demonstrate the necessary skill, this doesn't have to be done with the individual demonstrating the need, it can be done through roll playing and practicing and then shadowing while the BSC observes. Very few BSC plans are awareness or knowledge level on the IST. Face to face visits must be completed monthly by each Therapy provider and BSC provider on the individuals budget.
96	Provider Agency	Chapter 12	I agree with the addition of telehealth under the proposed guidelines. Specifically, that one face to face visit per month is required and "telehealth is intended to supplement, not supplant, in person delivery of services".	Thank you for your feedback.

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97	Provider Agency	Chapter 12	12.2 this section needs some work to clarify what is and isn't allowed for each discipline for telehealth. #8 says telehealth is allowed for DSP that have been previously trained to skill. #9 says initial training to knowledge. This makes sense for therapists and perhaps some situations for BSC but in general, this doesn't make sense for BSC. I think this should be clarified for circumstances in which getting to skilled level requires in person training (PT teaching how to transfer, SLP needing hands on training on CARMP, etc.). If training to skill can be done remotely that should be allowed, particularly for BSC. In the section related to in person face to face visits please clarify the first point that states 1 monthly visit in home by OT, PT, SLP OR BSC. Does this mean only one discipline needs to do a face to face in person visit in the home every month? Or that every discipline needs to do one face to face visit in the home? I am not sure how practical it would be to stipulate that every discipline needs to do a face-to-face visit in the home. Some clients only require one visit per month and those visits may not be needed in the home or not every month. Once a quarter would be more reasonable if that is the intent of the standard. For BSC specifically, it is possible that an individual has little to no concerns at home but has challenging behaviors at CCS or other community settings. Or that is the location where they encounter the most challenges and the efforts need to be focused. Insisting that a visit be made in the home monthly isn't in line with our roles. While it is all of our responsibilities to be aware of and assessing for ANE it seems the focus of our work should be on providing the services our clients need/want based on the clinical discipline. There are IDT members whose responsibilities do directly related to the health and safety thru assessment of ANE and other factors for the individuals (case managers and living services service coordinators). Perhaps adding somewhere that one face to face visit be made to the client monthly for various disciplines. The location at the discretion of the provider.	Thank you for your feedback. Due to the focus of ANE prevention, DDSD will maintain the language in standards and continue to develop as needed.
98	Provider Agency	Chapter 12	I agree with the addition of telehealth under the proposed guidelines. Specifically, that one face to face visit per month is required and "telehealth is intended to supplement, not supplant, in person delivery of services".	Thank you for your feedback.
99	Provider Agency	Chapter 12	First, thank you for the inclusion of specific guidelines and clarification for telehealth services. The proposed rationale for utilizing telehealth. The allowance for using telehealth in cases where individuals have demonstrated progress and have expressed a personal to continue telehealth services will be of great benefit to several of the individuals I support. Further, providing for the ability for the individual/guardian to receive in-person services at their request is crucial. The proposed revisions and clarifications strike an appropriate balance between flexibility for telehealth services while recognizing the critical role that in-person services play in our support of individuals.	Thank you for your feedback

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100	Provider Agency	Chapter 12	12.2 this section needs some work to clarify what is and isn't allowed for each discipline for telehealth. #8 & #9 This makes sense for therapists and perhaps some situations for BSC but in general, this doesn't make sense for BSC. I think this should be clarified for circumstances in which getting to skilled level requires in person training (PT teaching how to transfer, SLP needing hands on training on CARMP, etc.). If training to skill can be done remotely that should be allowed, particularly for BSC. In the section related to in person face to face visits please clarify the first point that states 1 monthly visit in home by OT, PT, SLP OR BSC. Does this mean only one discipline needs to do a face to face in person visit in the home every month? Or that every discipline needs to do one face to face visit in the home? I am not sure how practical it would be to stipulate that every discipline needs to do a face-to-face visit in the home. Some clients only require one visit per month and those visits may not be needed in the home or not every month. Once a quarter would be more reasonable if that is the intent of the standard. For BSC specifically, it is possible that an individual has little to no concerns at home but has challenging behaviors at CCS or other community settings. Or that is the location where they encounter the most challenges and the efforts need to be focused. Insisting that a visit be made in the home monthly isn't in line with our roles. While it is all of our responsibilities to be aware of and assessing for ANE it seems the focus of our work should be on providing the services our clients need/want based on the clinical discipline. There are IDT members whose responsibilities do directly related to the health and safety thru assessment of ANE and other factors for the individuals (case managers and living services service coordinators). Perhaps adding somewhere that one face to face visit be made to the client monthly for various disciplines. The location at the discretion of the provider.	Thank you for your feedback. Due to the focus of ANE prevention, DDSD will maintain the language in standards and continue to develop as needed.
101	Provider Agency	Chapter 12	I would like to address the section relating to doing home visits once per month. As this is usually the goal, sometimes we find it difficult to get in front of our individuals due to cancellation, no call/no shows, individuals who have trouble keeping/scheduling appointments due to mental health, family inconsistency and recently in my experience homelessness. As discussed with other Behavior Support Consultants creating a form or some way to document attempts to meet at home. Would Telehealth count if we cannot get in touch with them at their home? In thinking of the benefits of telehealth, would we be able to train staff or job developers, guardians, through Telehealth. It has been more difficult to get all staff or team members together at the same time especially when there is a time limit to train.	Thank you for your feedback. Providers should always document their attempts to make contact. Anytime a provider is unable to resolve and make contact, they should contact BBS for assistance.
102	Provider Agency	Chapter 12	-For discharged therapies/BSC can it be clarified how to integrate strategies into the ISP. Some believe we keep the original plan and just recycle it for however long we want it, but nobody can edit. Some believe it should be integrated into the actual ISP so that we can use the parts that apply and possibly modify/update as needed. -Can it be made more clear the BSCs role in regards to actually giving therapy. The standards read that BSCs are consultants for the IDT, but a lot of CMs and BSCs are accessing this service for counseling and companionship and more of a therapist role. Some clarity would help us all identify a bit better what the role should be. -Clarity on the PBSP due date language. It states "no later than 30 calendar days of the start of the annual ISP term" this can read as before or after. If it is after, can something be stated about IST having time after this due date to be completed (as its mentioned for WDSIs having 30 days after the budget start)	Thank you for your feedback. BBS continues to review BSC scope with the provider network. BSC is a consultative model therefore their scope does not allow for the providing of direct therapy services only consultation services. Assessments are due 14 days before the ISP meeting this is so the CM can submit the budget on time. It is assumed that there will be discussions during the ISP meeting that will impact the BSC plans and having the plans due no more than 30 calendar days from the start of the ISP year gives the BSCs time to make those necessary revisions.

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
103	Provider Agency	Chapter 13	On the whole, I agree with the proposed revisions, with two exceptions: 1. I have significant concerns about the wording of 13.2.4b, which would mandate that during routine visits, "must document the safety of the environment and any concerns about possible abuse, neglect, or exploitation must be reported following Chapter 19." This would place a significant burden on DD waiver nurses' licenses and is so vaguely worded that nurses would be held responsible for conditions they may not be qualified to evaluate. Implementation of this wording would make DD waiver nursing even more burdensome and undesirable that it already is. 2. Section 13.2.9.2c reads in part: "If the emergency response involves delivery of a PRN medication, non-related DSP (not related by affinity or consanguinity) must contact the agency nurse and receive approval before the medication is given. 1) The only exceptions to contacting the agency nurse before delivery of a PRN is if the person has a severe condition that requires prompt delivery of medication in an emergency. This may only include the specific approved emergency medications as listed on the DOH-DDSD-Clinical service Website." I have two reservations about this language. First, it contradicts itself because if the situation is emegent then waiting for nursing approval of a PRN medication could work against the resident's best interest and could delay life-saving health care. HCPs and MERPS already outline the administration of emergency medications for conditions such as seizures, something this passage doesn't recognize. Second, there is no mention here of StationMD, so what is the nurse's responsibility if the emergency takes place after hours on the weekend? ARCA no longer employs an evening or weekend on-call nurse because StationMD is our on-call service, but the language of this passage makes the Waiver nurse both responsible and liable. I also suggest that this revision of the Standards needs to include specific language about PRN medication ordered by StationMD physicians. StationMD is not designed to follow the current practice of calling the on-call service for each use of a PRN medication, as those calls prevent the triage and assessment of medically severe cases that actually require a physician's time. Language needs to be added to the Standards specifically allowing staff to give a PRN medication X number of times in Y days per the StationMD practitioner's order. Otherwise, StationMD will waste time triaging low-priority calls and staff will simply stop calling for PRN medications after hours and on the weekends.	Thank you for your feedback Language has been modified from ensure to promote encourage. StationMD is not a required service, it is an optional service for a Provider to use. Should a Provider choose to use StationMD, the Provider is required to have policies specific to the use and implementation of StationMD to include PRN approvals.

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
104	Provider Agency	Chapter 13	Chapter 13: Nursing Services, specifically 13.2.8.1.3 Assistance with Medication Delivery by Staff (AWMD) - For people who do not meet the criteria to self-administer medications independently or with physical assistance, trained staff may assist with medication delivery if: 1. Criteria in the MAAT are met. 2. Current written consent has been obtained from the person/guardian/surrogate healthcare decision maker. and 3. There is a current Primary Care Practitioner order to receive AWMD by staff. 4. Only AWMD trained staff, in good standing, may support the person with this service. 5. All AWMD trained staff must contact the on-call nurse prior to assisting with a PRN medication of any type - Additional clarification is needed; are all DSPs to contact the nurse prior to giving a PRN, or only non-related staff? Per this wording, even a related FLP would have to contact the on-call nurse prior to giving PRN. a. Exceptions to this process must comply with the DDSD Emergency Medication list as part of a documented MERP with evidence of DSP training to skill level - I understand MERP is going away and being merged with HCPs. DDSD Emergency Medication list also discusses MERP. Chapter 13: Nursing Services, specifically 13.3.2.4 Nurse Delegation - Nurse delegation must be budgeted if delegation relationships exist or the nurse determines that delegation may be utilized to support the delivery of specific tasks in Family Living with surrogate/host families or when DSP support the individual in CIE, CCS-I or small group, substitute care, respite, or other settings where Adult Nursing is delivered – Additional clarification is needed; is this budgeted into the nursing services already, or is there a separate service within nursing for nurse delegation? The only reason is because there is additional time and training required in these instances, and to use the word budget is not helpful here.	Thank you for your feedback. DDSD will continue training and provide development and updates in Community of Practice for clarification
105	Provider Agency	Chapter 13	13.2.3 section A and C say the same thing. Can these be combined to avoid confusion? 13.2.3 section 3C: If DDSD is requiring agencies to accept verbal medication orders, DDSD will need to work with the Pharmacy Consultants as they do not accept verbal orders for medications.	Sections 13.2.3 - Thank you for your feedback. Letter A provides instructions for when a person or guardian make a refusal, while letter C gives instruction for when a nurse determines an order should be held. 13.2.3 section 3C- Thank you for your feedback. The agency nurse will need to work with the pharmacy develop a way to accept verbal orders..
106	Provider Agency	Chapter 13	Good changes here.	Thank you for your positive comments and feedback regarding this addition.
107	Family Member/Guardian	Chapter 13	13.2.8.3.17. If this is used, and they dont receive nursing, then no medical is then required if nursing isnt responsible for assisting family with things, who does this then fall upon for annual required medical in previous sections to ensure they are dont. #17 contradicts this section Why is MERP discontinued. HCPs are for specific items identified by the echat, if no merps, staff are not clinicians for HCP implimentation.	Thank you for your feedback. MERPS are not discontinued. The MERP is incorporated into the HCP. There is now one document HCP that includes the HCP and MERP
108	Provider Agency	Chapter 13	On 13.2.2 number 4 on page 196, a MERP was left in.	Thank you the MERP will be removed.

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109	Provider Agency	Chapter 13	Ch. 13 Medication Delivery There is no indication regarding Medication Delivery by staff regarding injections (insulin, birth control, etc.) However, on Ch 13 pg. 200 It does indicate that a CMA Level 2 can administer subcutaneous insulin. CMA level 1 cannot. There are many individuals who are insulin dependent and I have heard two different things: Staff cannot administer subcutaneous medications unless trained and delegated by nursing. I've also heard that individuals must be able to administer their own subcutaneous medications, because staff cannot. I think it would help greatly to clarify this.	Thank you for your feedback. In regards to insulin- Chapter 13.2.2.1.4 states " A Certified Medication Aide (CMA) Level I or II may administer medications through all routes included in the Certified Medication Aide chapter of the New Mexico Nursing Practice Act. a. CMAs must have a current certificate in good standing and must be supervised or directed by an RN. b. CMAs may only work for and perform medication administration for a DD Waiver agency that is currently approved by the Board of Nursing as a CMA Provider and functions in accordance with all New Mexico Board of Nursing Rules. c. A Certified Medication Aide Level II may deliver subcutaneous insulin via pen only. CMA Level I may not deliver insulin." Futher, standards state " Nurses must administer medications or treatments for routes that are not addressed under the AWMD training program, unless trained by the nurse (such as enemas) or formally delegated by the nurse (such as specific routes such as a G tube) or the DDSD Emergency Medications. Refer to Chapter 13.2.11 Medication Administration and Nursing." Subcutaneous insulin should only be given by a Level II CMA. Other types of subcutaneous injections may be given by a CMA if trained by and delegated by a nurse. All service standards referenced in chapter 13.2.8.1.3 must be met.
110	Provider Agency	Chapter 13	19.5 #3 - For nursing semiannual - Information about client is already in Therap from our visits thus semiannual is repeating information already available.	Thank you for your feedback. Semi-Annuals are intended to update the CM to guide future planning. DDSD is currently requiring Semi-Annual reports.
111	Provider Agency	Chapter 13	Chapter 13.2.3-A a.The nurse will contact the ordering or on call practitioner as soon as possible, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. or within three business days, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties. •Can you please clarify as soon as possible? Is there a timeframe there?	Thank you for your feedback. Clarification to Chapter 13.2.3A has been made. As soon as possible has been modified to upon being notified that the implementation cannot occur.
112	Provider Agency	Chapter 13	13.3.2.2 #1With the wording "after the CARMP has been developed and presented to the person and guardian" crossed out, is this saying that development of an initial CARMP is no longer required when the ARST indicates moderate or high risk? I'm very concerned many will opt-out prior to completion of an informed decision making process or even engage in any discussion about the risk factors and consider possible ways to minimize the risk.	Thank you for your feedback. No this is not the intent. In 5.5 #2 it indicates, 2."After the ARST is completed, the CARMP is developed. After the CARMP is developed the CM presents it to the person and guardian". The same expectation needs to be included in 13.3.2.2 as in 5.5 #2. The deleted section needs to be reinserted.

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
113	Provider Agency	Chapter 13	13.19.5 #3 - For nursing semiannual - Information about client is already in Therap from our visits thus semiannual is repeating information already available. 13.2.8.1.3 Assistance with Medication Delivery by Staff (AWMD) - For people who do not meet the criteria to self-administer medications independently or with physical assistance, trained staff may assist with medication delivery if: 1. Criteria in the MAAT are met. 2. Current written consent has been obtained from the person/guardian/surrogate healthcare decision maker. AND 3. There is a current Primary Care Practitioner order to receive AWMD by staff. 4. Only AWMD trained staff, in good standing, may support the person with this service. 5. All AWMD trained staff must contact the on-call nurse prior to assisting with a PRN medication of any type - Additional clarification is needed; are all DSPs to contact the nurse prior to giving a PRN, or only non-related staff? Per this wording, even a related FLP would have to contact the on-call nurse prior to giving PRN. a. Exceptions to this process must comply with the DDSD Emergency Medication list as part of a documented MERP with evidence of DSP training to skill level - I understand MERP is going away and being merged with HCPs. DDSD Emergency Medication list also discusses MERP. Chapter 13: Nursing Services, specifically 13.3.2.4 Nurse Delegation - Nurse delegation must be budgeted if delegation relationships exist or the nurse determines that delegation may be utilized to support the delivery of specific tasks in Family Living with surrogate/host families or when DSP support the individual in CIE, CCS-I or small group, substitute care, respite, or other settings where Adult Nursing is delivered – Additional clarification is needed; is this budgeted into the nursing services already, or is there a separate service within nursing for nurse delegation? The only reason is because there is additional time and training required in these instances.	Thank you for your feedback. Nurse Delegation is included in the rate.
114	Provider Agency	Chapter 14	Request for all docs to include AT Inv and CARMP be due 14 day prior to ISP start date!	Thank you for your feedback. AT inventory: Please refer to 12.5.7.3 regarding due dates to ISP. Due to the complexity of CARMP it is difficult to mandate 14 days prior to ISP start date.
115	Provider Agency	Chapter 14	p. 246 14.4.2 #19 el see this item is crossed out. Is this expectation captured elsewhere, possibly in the provider contract?	Thank you for our feedback. The Enviromental Modification Service Provider works with DDSD in renewal of their DDSD application.
116	Family Member/Guardian	Chapter 14	?	
117	Provider Agency	Chapter 14	Supplemental Dental Care Ch 14 There is a sentence in this description that doesn't read correctly there seems to be two separate ideas put together under Service Requirements # 3. "A Supplemental Dental Care Provider Agency is not required to attend IDT meetings must provide documentation of the visit from the dental clinician as needed or requested by the CM." Additionally, there is nothing indicating that there is a need for an SFOC nor is the service listed on the SFOC website. Even if a service is unavailable it is still able to be selected on the SFOC website and when you search you get a "No Providers Available" message in all bold. There is not an indication on how to obtain the provider ID and provider name to be able to put this on a budget either.	Thank you for your feedback. DDSD is currently working access to Supplemental Dental and will provide additional information as soon as possible.
118	Family Member/Guardian	Chapter 15	15.6.5.cd. this is incomplete.	Thank you for your feedback. DDSD will fix the error.
119	Provider Agency	Chapter 16	Qualified Provider Agencies, specifically 16.2 Accreditation - Provider Agencies of Case Management, CCS, CIE, CIHS, Living Supports (Family Living, Supported Living, and IMLS), and Respite are required to become accredited by CARF International or The Council on Quality and Leadership. Accreditation requirements include – The word “required” stood out to me.	Thank you for your feedback. It is a requirement for Provider Agencies to be CARF or CQL accredited for the services listed.
120	Family Member/Guardian	Chapter 16	Grammer checks needed	Thank you for your feedback

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
121	Other	Chapter 16	Suggestion - 16.3 with the current workforce situation, can there be consideration about eliminating the high school diploma or GED requirement? It would still be an agency decision about whether to hire someone without the diploma or GED, but it might allow some relief from the current situation. 16.6 - this seems to be in conflict with the Appendix K flexibility on hiring relatives to provide CCSI services. 16.7 - I think at least the New Mexico Department of Workforce Solutions should be consulted. The United States Department of Labor has already taken action against providers in other states regarding misclassification of employees as independent contractors. Apparently, there is at least one legal action in New Mexico about people not being paid overtime. This can have a large impact on the availability of services without knowing which providers or counties could be impacted.	Thank you for your feedback. Educational Requirements are in the approved waiver and will remain at this time. When DDW amendment is approved changes to LRI will be made to service standards.
122	Other	Chapter 17	While I am thrilled with awareness level training being allowed once again using telehealth, many of us would like to see rules written that no credit will be given to attendees off camara and/or driving a vehicle.	Thank you for your feedback. This is ultimately at the trainer's discretion. The other option is the agency can put a policy in place stating participants will not be given credit if they are off camera or attempting to drive while attending a training via livestream.
123	Provider Agency	Chapter 17	Comment regarding #2 it says: Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings as identified in the NM Waiver Training Hub, job classification document, and be on shift with a DSP who has completed the relevant IST. The statement mentions that it is necessary for agencies to collaborate with another DSP who has completed the relevant IST. When there are two staff members present, the likelihood of encountering a staffing emergency decreases. Staffing emergencies typically arise when there is no trained personnel available to provide support. In these cases, it is worth exploring the options that agencies have in utilizing their existing therapy plans, WDSI's that have instructions on how to properly work with the person, and medical documents that are available. Additionally, it is worth considering whether there is a requirement for therapists to provide a designated trainer specifically for emergent situations.	Thank you for your feedback. Therapist do have the option of designating a staff member at the agency to provide relevant IST training when the therapist feels confident that the staff person is competent to train the plan/WDSI. There will not be a requirement placed into the standards that will require a therapist to designate a trainer at the agency and will continue to be left to the discretion of the therapist.
124	Provider Agency	Chapter 17	On section 17.1 number 2. It states the following, " Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings as identified in the NM Waiver Training Hub, Job Classification Documents, and be on shift with a DSP who has completed the relevant IST.". A clearer definition is required because in case of a shifting emergency, if we have a trained staff on the individuals' ISTs available to work, then it would not be an emergency. It is deemed an emergency when there is no regular trained staff available to work a shift or a specific period of time. An mergency would arrived when the scheduled staff calls out of a shift minutes before they were supposed to go in. The SC is already covering another home and they can't be two places at once and they already called their other regular staff an no one can come in. This is a crisis emergency and at this point, we would need someone to go in. It would be more helpful what the minimal requirements are at this type of crisis. I think we need to assume an emergency is when an IST trained staff is not available and then, tell us what the minimum requirements are. Withouth this assumption, is trully not an emergency and this point is not helpful nor realistic.	Thank you for your feedback. At this time DDSD will maintain requirement as this is to ensure the safety of the individuals in the home.
125	Provider Agency	Chapter 19	Deletet semi annual reports from nursing requirement	Thank you for your feedback. DDSD will maintain requirement at this time.
126	Provider Agency	Chapter 19	Repeating earlier feedback that Out of Home Placement RORA is redundant with GER and that 24 hours without nutrition/hydration should be a GER to be consistent with reporting requirements.	Thank you for your feedback. DDSD is modifying the not eating or drinking in 48 hours as a GER rather than a RORA. Modifications in standards are made.

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127	Provider Agency	Chapter 19	•Page 304-305: RORA 19.6 #4 RORA must be completed for any person in the IDD program who has not eaten or drank or not receiving nutrition or hydration for more than 48 hours. ----- We need clarification. - Who do you RORA if Intervention Radiology for Gtube exchange is more than 48 hours and there are no other means to get nutrition or hydration. - Along those lines, if a specialist is referred but you can't get an individual in for 6 to 8 months what good will a RORA do?	Thank you for your feedback. DDSD is modifying the not eating or drinking in 48 hours as a GER rather than a RORA. Modifications in standards are made.
128	Provider Agency	Chapter 19	19.2 General Events Reporting (GER) no longer is stating the reporting timeline requirement of two business days. It states: "Provider agencies may use GER reporting for events that are not required at their discretion. When using the GER to report such events, the report must have a modification level that must be low, be entered and approved within two business days of the event." this is the only timeline given, the original "19.5.1.b. Each is required to enter and approve GERs within 2 business days of discovery or observation of the reportable event." was scratched out.	Thank you for your feedback. Entry timelines for GER can be found in the updated Appedix B GER Requirements. Bullet 3 points points to the requirements for each GER Type that is outlined by standards. Most GER's entered required a 2 day entry and approval from the event, with the exception of a few events.
129	Other	Chapter 19	There should seemingly be some provider reporting requirement around the HB 395 reporting for the DSP workforce. The report is due in April each year for the previous calendar year on a form approved by the Department.	Thank you for your feedback. DDSD will updated requirements in this area as developed.
130	Provider Agency	Chapter 19	DDW Respite: 19.5 - #2 (page 281) I have always understood that I need Semi-Annual Reporting for Respite when an Individual is over the age of 21, has only Case Management and Respite on the budget. (When this is the situation, a DCF should be in place as to why only these 2 services are on the budget) #2 of 19.5 Semi-Annual Reporting of the Service Standards do say: (page 281 – 19.5#2) -A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desire Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. However, Respite is NOT listed in #1 of this same section (19.5) as it lists which services are exempted from completing semi-annuals: (page 281 – 19.5#1) - DD Waiver Provider Agencies, except AT, EMSP, PRSC, SSE and Crisis Supports, must complete semi-annual. Then, I go to page 241 of the Service Standards and read again that "When respite is only service on budget for someone 21 and older, service tracks progress on Action Plans and Desire outcomes. (page 241 – 14.8.1 #6) - When respite is only service on budget for someone 21 and older, service tracks progress on Action Plans and Desire outcomes. SO, #5-b. says The Respite Provider Agency must submit semi-annual progress reports to the CM that describes progress on the Action Plan(s) and Desired Outcome(s). (**This is where I have always known that I do not need semi-annual reports for Respite when other services are on the Individual's budget): (page 242 – 148.2 #5a & b) - a.-The IDT shall complete a Decision Consultation and Team Justification Form (DC/TJF) to explain why respite alone the appropriate service delivery approach for the person is. This document must be attached to the ISP. b.-The Respite Provider Agency must submit semi-annual progress reports to the CM that describe progress on the Action Plan(s) and Desire Outcome (s). I keep on reading onto Agency Requirements for Respite and semi-annual reporting is NOT listed on page 242 – Chapter 14.8.3. Finally, my question, are we required or NOT required to submit Semi-Annual reports for Respite services for Individuals that have Case Management, Respite and other services on their budget? **Can this be clarified?	Thank you for your feedback. Chapter 19.5: Respite is not added to #1 of this section as it has some caveats of semi-annual progress reports that the other services do not have. Therefore, Respite has a separate number (32) for this delineation. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older.
131	Provider Agency	Chapter 19	Chapter 19: Provider Reporting Requirements, specifically 19.2 General Events Reporting (GER) - The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB – What about children? We have received many new allocations for children receiving CCS services. Guidance from DDSD for minors is also needed and should be added here as this section specifies GER requirements for individuals in CCS.	Thank you for your feedback. If children are receiving a service that is required to report a GER, they will be required to use it. At this time children do not usually receive adult services and thus the GER is not required. As children are now entered into Therap, GERs are available to be used but if they do not receive a support service mandated to report there will not be a requirement for entry per standards.

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132	Provider Agency	Chapter 19	Chapter 19: Provider Reporting Requirements, specifically 19.2 General Events Reporting (GER) - The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB – What about children? We have received many new allocations for children receiving CCS services. Guidance from DDSD for minors is also needed, and should be added here as this section specifies GER requirements for individuals in CCS.	Thank you for your feedback. If children are receiving a service that is required to report a GER, they will be required to use it. At this time children do not usually receive adult services and thus the GER is not required. As children are now entered into Therap, GERs are available to be used but if they do not receive a support service mandated to report there will not be a requirement for entry per standards.
133	Provider Agency	Chapter 19	19.4 Employment First Reporting Requirements Provider Agencies operate under the assumption that all working age adults with developmental disabilities can work if given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options, per New Mexico's status as an Employment First state. Provider Agencies who offer Community Integrated Employment are required to submit semi-annual data to the Regional Office Community Inclusion Coordinators by the 15th day following the reporting month. First semiannual reporting months are January through June with report due on July 15th and second semi-annual reporting months are July thru December with report being due on January 15th. Information must be submitted in Smartsheet. •When will this training take place? Who is going to lead this training? •Have there been information on the Smartsheet and what is to be required to report on passed out to each Employment Agency? •CCS information will no longer be part of this information gathering? Awesome!	Thank you for your feedback. At this time this requirement is on hold at this time.
134	Provider Agency	Chapter 19	p. 30419.6 #4Unclear if "IDD Program" is the same as "DDW Program"? This phrase is not used in current Standards.	Thank you for your feedback. DDSD will adjust the language

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135	Provider Agency	Chapter 19	GERs Ch19 pg 279 There is a list of required GERs to be entered in Therap. However, in the Therap GER there are many more options to document a Therap GER. I have seen agencies state they will only track what the standards say which does pose a barrier on an individualized bases when IDT members see a need for other information needing to be documented. I've also seen agencies state they use iTherapy docs or paper IRs which only creates barriers for IDT members and them being notified of events as well as being able to view live documentation as events occur. I think it would help clarifying that GERs can be entered beyond what is currently required in the standards or including that IDT members can agree to additional events being tracked. (I hope this makes sense.) *GER reporting requirements for Case Managers In the standards it indicates CMs are to also do GERs, however, I've been told CMs don't do GERs its the LCA, CIES, CCS responsibility. It would help to clarify GER reporting requirements for CMs. *GER reporting requirements for ALL services (BSC and therapists). I think given the situations that have gone on it may be reasonable to expect that all service providers regardless of the scope are expected to submit GERs in Therap. * Notification to IDT members I've noticed significant issues regarding GERs and CM, Guardians and other IDT members not getting notified if such an event or being told IDT members have Therap IDT members can just check it to find out. It would help to include if a GER is entered who on the IDT must be notified and within what time frame. *In the topic of ANE and GER reporting and since the standards will soon have many references regarding reducing ANE and ensuring health and safety, I do think it would uphold accountability to clearly detail in these sections that the provider with the event must report ANE and GER even if these events and these reports will be considered "late" these still must be reported and documented. *RORA Pg 282 I couldn't find it in this section, but I know it is somewhere in the standards I believe it may be within the LCA section where it indicates to file a RORA after two requests. Could we include the RORA process mentioning sending 2 requests then proceed with a RORA if no resolution/ or whatever number of requests or timeline is deemed as appropriate.	Thank you for your feedback. Chapter 19.2 bullet 3 discusses provider agencies utilizing GER outside of the GER. The IDT is what sets the individualized requirements for documentation. DDSD cannot dictate individual need, that is left to the team for consensus. As a case manager if a team discusses and agrees upon utilizing GER for more than is required, remember to document it within the ISP so that is available to the whole team for reference and to allow quality checking as well. Thank you for your feed back!
136	Other	Chapter 20	20.5 Communication and Documentation in Therap I suggest adding in that in order to keep an Individual's address current, the Case Manager, and all Provider Agencies involved, need to update address and contact information for the Individual within 10 business days of the person moving, changing phone number, and any other contact information.	Thank you for your feedback. At this time the requirement for updating address and contact information is 5 business days.

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137	Provider Agency	Chapter 20	20.5.2.3.b has Adaptive Equipment to be input in the IDF. There isn't a place in the IDF to put that.	Thank you for your feedback. Within the IDF, in the Individual Details sub page, Medical Information, there is a 3,000 character 'Adaptive Equipment' field. See Therap's Help and Support Guide for Updating the IDF: https://help.therapservices.net/app/answers/detail/a_id/359#IDF-IndividualDetails
138	Family Member/Guardian	Chapter 20	20.5 The provider Agency requirements for records in Therap #3 reads Therap is required to be used by all Provider Agencies and "available" to guardians and individuals supported upon request. As an unpaid guardian I found getting a secured email to be sent very difficult. I am requesting that Therap also be "required" for unpaid guardians to protect the person's information when being sent.	Thank you for your feedback. Please reach out the Case Manager if you are having trouble being included on secure emails through Therap. DDSD cannot dictate the requirements of guardians. DDSD can require that provider agencies make their records available, which is why the language is available which is also a Federal HIPAA requirement of any health decision documentation. Guardianship is dictated through Law and Courts outside of DDSD's oversight.
139	Family Member/Guardian	Chapter 20	no major issues. ? does Case Management have access to add appointments based on hierarchy stated for therap?	Thank you for your feedback. Yes, Case Managers can enter appointments within their own agencies account if given privileges by your provider agency administrator. The following Therap Guide for Appointments covers entry and the Super Roles required for that: https://help.therapservices.net/app/answers/detail/a_id/276
140	Provider Agency	Chapter 20	20.5.1.1 All paid IDT members must use Individual Care SComms for communication concerning the individual. Paid IDT members include Case Management, Community Inclusion, Living Support, Adult Nursing, BSC, OT, PT, SLP and Nutrition. DDSD can't dictate how team members of varying agencies choose to communicate regarding a participant. How does DDSD plan to enforce this standard? This should stay as previously stated or state that the use of SComms is highly encouraged. Even DDSD/DHI staff don't use SComm consistently for communication about a participant. If this is to be the requirement, it should be added that state employees will exclusively use SComm. Will Therap continue to be the sole system within DDSD? It is my understanding that an RFP went out and other systems could be introduced? If so, the standards may need to be written to include other state-approved systems so that they are included in the standards without the need for another revision. 20.5.1.2 This list leaves off LCAs, we also need this information	Thank you for your feedback. Therap is the current required platform. DDSD will follow state required purchasing requirements when exploring new systems.
141	Provider Agency	Chapter 20	•Page 312 - DDSD will need to advise agencies on how to print blank consultation forms as these are generated after an appointment is made. •Page 313 20.5.4 section 1F. Currently, the Health Passports are given to and left with the medical provider after the appointment so it would be impossible for agencies to scan and attach the signed consultation form with the health passport after the appointment. The signature page has a box that states "I have received a copy of the health passport".	Thank you for your feedback. Therap provides a robust help and support page. Please visit the Therap Guide: Generate Health Passport (step5): https://help.therapservices.net/app/answers/detail/a_id/1350 This allows you to produce a blank Consultation Form. As you mentioned it is preferred to produce a Consultation Form from an scheduled appointment entry as it will include information from that entry offline that will be helpful for supporting the individual at the appointment.
142	Family Member/Guardian	Chapter 21	Add index back. Some people print them. is there going to be a GER tutorial being that they dont follow it anyway as to reporting so that trends can be identified.	Thank you for your feedback. DDSD will not be reinstating the index. However, the Table of Contents will remain. Therap Unit continues to develop guides and trainings for use of Therap
143	Provider Agency	Chapter 21	Ch 21 Requirements for at Cost Services *FMAE is not listed in this area. FMAE is listed under 21.9.5 #2e *Additionally, I am unclear if these Cost values will continue to be accurate as I know we've had some changes with Non Medical, AT and EMods. There are temporary AT and Emods avaialble which are not included in the statndards as they are temoporary increases.	Thank You for your feedback The cost listed in the service standards do not include temporary increases. At this time there are no changes in cost for FMAE.

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144	Other	Chapter 21	21.9.1 - Since the recommended daily rates for the Supported Living Categories 1, 2, and 3 don't cover the 12 or more- hours of service provided, eliminate the 12-hour requirement for billing the daily rate. The PCG rate study recommends the rate for Supported Living Category 1 at $210.35. The hourly rate for Category 1 is $31.50. That only covers 6.67 hours. The PCG rate study recommends the rate for Supported Living Category 2 at $258.69. The hourly rate for Category 2 is $31.50. That only covers 8.21 hours. The PCG rate study recommends the rate for Supported Living Category 3 at $339.09. The hourly rate for Category 3 is $31.50. That only covers 10.76 hours. The PCG rate study recommends the rate for Supported Living Category 4 at $440.25. The hourly rate for Category 4 is $31.50. That covers 13.97 hours. With the 12 or more hours of service provided, you are requiring more than the rate purchases except for Category 4, which is Extraordinary Medical/Behavioral Supports. To only be able to bill for 1/2 day at less than 12 hours of documented services, when you aren't purchasing 12 hours, is a really bad optic.	Thank you for your feedback. DDSD will not be changing rate models at this time .
145	Provider Agency	Chapter 21	We request that 21.8.16 be amended to further clarify the statement, as follows: “When two or more services allocated to an individual include similar components (i.e. personal care services and CIHS), the services cannot be provided and billed for concurrently.”	Thank you for your feedback. DDSD will maintain current language.
146	Provider Agency	Chapter 21	21.8 #16. Please clarify if this is relevant for OT, PT, and SLP services. Co-treatment between therapists is a large part of the Collaborative-Consultative model. I’m wondering if this added wording could be interpreted to mean this is now a non-billable activity. 21.9.5 #2 aWill this fund be returning to $500/year as of the effective date of Standards revisions? Or will the increase based on ARPA funds remain until March 2024? 21.9.5 #2 cWill this fund be returning to $5000 as of the effective date of Standards revisions? Or will the increase based on ARPA funds remain until March 2024?	Thank you for your feedback. 21.8#16: Each therapist provides different services and this does not apply to co-treatment. Also, therapists are providing different services than a Residential or CCS/CIE provider. 21.9.5#2 a & c: Temporary increases are not noted in service standards, The increase will remain in effect until March 2024
147	Provider Agency	Chapter 22	KP{'s have been removed as indicated.	Thank you for your feedback
148	Provider Agency	Appendices	•Appendix B (GER Guide) page 340- Injury: Does this include any assessment from the nurse or basic first aid? Or does it still mean requiring medical intervention such as urgent care, EMS, etc.?	Thank you for your feedback. .
149	Provider Agency	Appendices	Chapter 14/ Chapter 5/Appendix A Client File Matrix. a.Request for all docs to include AT Inv and CARMP to be due 14 days prior to ISP start date! Chapter 12/ Appendix A Client File Matrix – a.An OT PT SLP BSC PLAN is dated 04.01.2023 but the ISP YEAR on the plan is 06.01.2023 TO 05.31.2023. •Does the term “Annual” refer to the report date of 04.01.2023 date or the expiration of the ISP YEAR 05.31.2023? Chapter 12/ Appendix A Client File Matrix . 1. a. Service Coordinator TSS’s due 14 days prior to the start date of the ISP and OT PR SLP and BSC documents due Annually. •Is it possible to simplify by aligning these due dates-with all OT PT SLP AND BSC docs due 14 days prior to the ISP? Chapter 6/ Appendix A Client File Matrix --- a.Addendum A which are often signed 89 days prior this ISP year, but the next ISP year may be signed 30 days prior? •Do these Addendum A’s stand for the entire ISP year or the date signed?	Thank you for your feedback. The term annual refers to the clients ISP budget year. DDSD will maintain the current document submission schedule. Addendum A's are to be reviewed by the case manager with the guardian/individual prior to the annual ISP budget meeting.

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150	Provider Agency	Appendices	-The client file matrix should clarify which appointment records are required by service. All LCAs don't have the same requirements, and it is very unclear from the matrix what our records should have. -Who is responsible for completing the AT Inventory? One chapter mentions that the Case Manager distributes this document, and the matrix has a list of therapists or the nurse. The expectation from all IDTs is that the Service Coordinator for the provider agency should complete this document. Can this be clarified in the standards? -The Matrix lists RPST as a required document. It does not clarify what this document is. And it has therapies and nurses as responsible, but many with RPST don't have these services or they are not responsible for the items.	Thank you for your feedback. DDSD will continue to review the file matrix to simplify and provide clarification.
151	Provider Agency	Appendices	Appendix B: COVID is no longer a PHO – why are we tracking vaccinations and declined vaccines?	Thank you for your feedback separate from COVID, DDSD has made a decision to track all vaccinations.
152	Provider Agency	Other	1. Physical Therapist Assistant can use physical therapist units. Currently we have a separate units for PT and PTA.. Revision takes longer...We need to put PTA on board right away not waiting for 30 days revision. 2. Some of our clients just needs counseling or behavior therapist..Some clients just needs somebody to talk so they won't explode. Currently we have BSC for staff consultant.	Thank you for your feedback. 1) PT and PTA's have different licensure requirements and rates which cannot be interposed. DDSD is looking at streamlining the submission process. 2) The waiver is a supplement to the Medicaid State Plan and Counseling/psychiatric services is available through an individuals' state plan.
153	Provider Agency	Other	The overall aim of the Draft seems focused on reporting ANE after the fact and NOT preventative at all. So, without more significant ideas, not much will change except a bigger backlog of ANEs and RORAs. I think we need to do better than that and focus on prevention, education, accountability, & quality by incorporating bold ideas such as: 1.Annual Mandatory Discipline Specific STANDARDS training including a competency exam (≥75%) for ALL paid providers a.This can coincide with the mandatory ANE training & exam b.Civil Monetary Penalties should be implemented if any provider is out of compliance with STANDARDS training c.The STANDARDS training content should be similar to the QA Survey questionnaire sent out annually (or semi-annually for inadequate providers) See below 2.Eliminate QA/QI self-assessment (AKA Annual Reports) AND replace with Discipline Specific STANDARDS surveys (QA) for ALL paid providers sent out annually to random samplings of all IDT members a.Face sheets of all ISPs can be sent out by Case Managers to all IDT members for reviews and corrections with a 48-hour turnaround deadline b.Emails and cell phone numbers of all IDT members including guardians and individual direct staff can be uploaded for surveys •It is crucial that these surveys are sent out to providers that are regularly in the field for an accurate measurement of service delivery. It is not helpful to send surveys only to directors, owners, administrators, supervisors etc. •These surveys must be anonymous with zero tolerance for retribution/retaliation, include user-friendly language, & take only a few minutes to complete (e.g., Monkey Survey) •Civil Monetary Penalties should be implemented for poor participation (e.g., must complete at least 3/5 surveys) 3.Implement 2-tiered rate schedule including current rate for providers with inadequate (<75%) survey results AND recommended higher rate (PCG) for providers with adequate (≥75%) survey results a.Inadequate providers can submit a Quality Improvement (QI) plan and request semi-annual survey distribution to a new random sampling of IDT members to qualify for the higher rate b.For larger companies, they must have at least 75% of their employees/contractors score at least 75% on their surveys to get the higher rate (discipline specific) c.Money saved with the 2-tiered system and money generated with Civil Monetary Penalties can be utilized to remedy the most inadequate providers AND give bonuses to the most outstanding providers d.Provider Contracts can be terminated for failure to meet QI requirements after X number of failed attempts.	Thank you for your feedback. DDSD will consider your suggestions and to develop ANE prevention strategies and incorporate as applicable.
154	Provider Agency	Other	Thank you for your efforts to clarify and incorporate the use of telehealth in a meaningful way!	Thank you for your positive feedback.

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155	Family Member/Guardian	Other	It would be very helpful to unpaid guardians to have a place to reference.	Thank you for your feedback. DDSD encourages parents and guardians to work with their case manager and interdisciplinary team to answer questions and resolve problems. If more help is needed, feel free to contact a member of DDSD. Contact information can be found on NMhealth.org.
156	Other	Other	Add BCBA and ABA as a service	Thank you for your feedback. DDSD researched this in the prior year. It is not a duplication to receive both ABA and BSC services. The Positive Behavioral Support (PBS) model works with the individual, the parent/guardian and provides training to the DSP. DDSD will not be adding ABA as a new service.
157	Provider Agency	Other	How did DDSD determine that the Index is not utilized? I do not believe this to be an accurate statement. The underutilization was more than likely due to inaccurate page numbers in the 2021 standards, making manual searches impossible. There are many providers who still print a copy of the standards due to the importance of the contents. Further, we all need to have the ability to search a manual copy when the electronic version is unavailable to us. Please keep this in the standards and ensure that the page numbers are accurate on this rewrite.	Thank you for your feedback. DDSD will not be reinstating the index. However, the Table of Contents will remain.
158	Provider Agency	Other	•Regarding mandatory visits from DDSD- What is the plan when an individual is their own guardian and they refuse to meet with DDSD?	Thank you for your feedback. DDSD will address on an individual basis.
159	Provider Agency	Other	-This is unrelated to the standards themselves, but I wanted to mention that the ISP template does not match the language or requirements in the standards. It would be helpful for all IDTs if this was updated to meet requirements of the standards and of the OR -Children's waiver are not included in Therap despite DDW being required to utilize Therap. We have no way to communicate securely as this chapter is requiring. CMs and Providers cannot communicate in a general SCOMM but are not able to connect in Therap for children. Our agency still builds a profile in Therap so we can document appropriately, however, we cannot communicate with the CM via SCOMM and have no way to securely share documents. -In regards to document timeframes. We are expected to create TSS that are built from the action plans in the ISP and integrate therapy plans into the TSS, however the final ISP and the WDSIs are all due 14 days before the budget, which is when our TSS are due. We are receiving these documents either at the end of that due date or after in many cases, however we are having to send out TSS that contain information from those documents that same day. This causes our TSS to either be late or they have to be completely redone when we finally receive the documents we need.	Thank you for your feedback. The current ISP is not slated for a revision at this time There is a new requirement for Children to be entered into Therap. DDSD will maintain the current document submission schedule.
160	Provider Agency	Other	*Being that many access their copies of the DDW Standards electronically, could a resource page be added to include important DDSD forms links, such as links to the SARL, CARMP, Transition Plan, RORA, DHI Reporting, ARF, AT, EMod, etc. etc. *Perhaps also having links straight to DDSD pages for BBS, Clinical Services, CM, I&E, etc. I have found it interesting to discover that not many DD providers are aware of how much DDSDs website has to offer and there are many forms on there. For rural NM Stakeholders (individuals, staff, families and providers) *I have individuals, families and staff in who still heavily rely on paper documents, post/ mail as opposed to using internet and technology, some do not have smartphones nor like devices. These folks have made references that it would be greatly appreciated to get more Town Hall info, DDSD, State of NM and Waiver- related Memos in the mail, so they are up to speed. I know this may not be a large population, so would it be possible to set up a mailing list, so these folks can sign up to recieve post mail of memos or related documents? Perhaps the Case Managers or Service Coordinators can assist with signing up anyone interested in this? *ANE Tribal Numbers. I found this on DDSDs site, I am not sure if this is current or not everyone I have asked doesn't seem to know about this, but perhaps indicating these if this still applies.	Thank you for your feedback. DDSD will maintain one set of standards. All other information can be found on nmhealth.org. DDSD will consider the distribution of updates through the mail. DDSD will maintain its' policy on the use of telehealth.

	Submitter Type	Chapter	Public Comment Shortened Version	DDSD Response
161	Provider Agency	Other	I want to thank you for the opportunity to review the proposed revisions and to provide feedback, it's greatly appreciated. Thank you!!!	Thank You for your positive feedback.
162	Provider Agency	Other	From the Behavior Support Consultant perspective, the emphasis on ANE is very much appreciated. The increase in flexibility regarding remote methods for initial BSC trainings is also very positive. I also believe the ratio of 50%/50% for remote/in-person visits is a very good guideline. In my agency, I have always recommended a minimum of two in-person visits per month. One concern I would note with interpreting this recommendation would be this: Remote visits might realistically outnumber the number of in-person visits because they are usually a little shorter per encounter and they are more tangential and situational. For example, an individual and/or staff may call several times per week to work through a particular problematic situation. These encounters are rarely more that .25 hour. So while the billable time for remote and in-person visits might be equal or approximately so, the number of encounters might be much higher for remote rather than in-person visits, even though the time of intervention is essentially equal. Perhaps changing the standard to reflect this might be helpful as it would encourage the flexibility and topical nature of remote visits, which in my experience are highly effective in preventing the development of issues. One other thing that I, as a Behavior Support Agency, would love to see is the inclusion of Master-degreed Special Education Teachers as being qualified to provide BSC services under supervision. I have had to turn down highly qualified candidates due to the fact that this is not considered an appropriate qualification. While I do understand that they are not clinically licensed, their experience of understanding and intervening with persons with intellectual and developmental disabilities is outstanding and, in my experience, they have a commitment to the population that is unrivaled. It would be nice if they could at least be considered on a case by case basis. Overall, the standards are thorough and seem to capture most anything I can think of. I will offer one comment. With the clear emphasis on preventing ANE, I think it would be helpful if the standards outlined more specific and frequent supervisory inspection and support of living care arrangements. In my visits, I rarely see supervisory personnel at residential sites that I visit. It seems that promotion of ethical and professional care falls mainly on case managers, therapist and consultants that visit sporadically. While I acknowledge and embrace that role as a BSC, I believe the visits of professionals of the ilk I mentioned are simply too infrequent to ensure quality support and to prevent ANE development. I am a firm believer that more supervisory presence in living care arrangements would go a long way to preventing ANE incidents. As a person who worked as a DSP for a substantial time as I went through college, I can say that the comportment of all DSPs was always more professional and effective when supervisors were present. I think there is just simply a high degree of human nature at work in this statement. I believe that one can look at this in two equally important aspects: policing and supporting. DSPs are put in very challenging situations and increasing meaningful support to them that is beyond informational is a key to their success in being effective supports themselves. I would be happy to converse with anyone who is curious about my comment.	Thank you for your feedback. DDSD will maintain the ratio of in person and remote visits for BSC providers. DDSD will continue to allow provider agencies the opportunity to determine supervisory roles for their managers.