
Mandatory Requirements for Therap/Healthcare Records Audit

Therap Individual Page:

Individual Data Form (IDF) – Check that it is completely filled out including contacts; Guardian (if applicable), Case Manager, Pharmacy, etc. This information transfers (auto-populates) to the Health Passport and other Therap documents such as the ECHAT.

Medication Administration Assessment Tool (MAAT) - Upon Admission, Transfer, Annually (completed no more than forty-five (45) and at least fourteen (14) days prior to the annual ISP meeting), within three (3) business days following any significant change of clinical condition, and within three (3) business days following return from hospitalization.

General Event Reports (GER) – Check for timely submission of GER's (must enter and approve High and Moderate within 2 business days unless a Moderate Level Med Error), accurate notification level and accurate Event, Event type and Subtype. Please see current GER Guide dated 10-24-14.

Aspiration Risk Screening Tool (ARST) – Upon Admission, Transfer, Annually (completed no more than forty-five (45) and at least fourteen (14) days prior to the annual ISP meeting), within three (3) business days following any significant change of clinical condition, and within three (3) business days following return from hospitalization. Check for accuracy of entries regarding whether there has been a hospitalization for aspiration pneumonia or if type of pneumonia was unknown/unspecified within the last two years and/or received outpatient treatment for aspiration pneumonia within the last 12 months. Check for accuracy by reviewing health care records for “Documented diagnosis” of dysphagia and other conditions such as chronic lung disease, immunosuppression, gastroesophageal reflux disease (GERD) not controlled with diet or medication, rumination, or vomiting.

Individual Medical Information

- **Diagnoses List**- Must be kept current. This can be checked by reviewing the last 1-2 years of appointments, hospital discharges, History and Physicals, etc. completed by medical provider that are in Therap (mandatory – see appointments) (auto-populates ECHAT).
- **Medication Profile/List** – Must be kept current. All Medication changes must be entered in Therap. Any changes to medication for the individual must be updated in this section no later than one week from the change. If the agency is using the MAR within Therap please see the DDSD Therap MAR instruction letter for associated timeframes (auto-populates MAAT and ECHAT).

Therap Health page:

Medication Administration Record (MAR)

- Data – If the agency uses the Therap MAR, review current month's MAR for completeness and accuracy. If the agency uses paper MAR or another electronic system, the agency must provide the current month of MARs to the RO Nurse for review.

Health Tracking

Required by agencies (primary and secondary) when tracking is part of a Health Care Plan (HCP) or Medical Emergency Response Plan (MERP) during the time of service delivery. If tracking of any of these items are regularly occurring for an individual but is not part of a HCP or MERP, it is strongly encouraged by DDS that the provider utilizes Health Tracker for this purpose.

- Blood Glucose
 - Immunization
 - Infection Tracking
 - Intake/Elimination
 - Menses
 - Respiratory Treatment
 - Seizures
 - Skin/Wound
 - Vital Signs
- Lab Test - Mandatory for all except Family Living without ongoing nursing service. This section of Health Tracker is required to be completed by the primary provider if the individual has routine or standing lab orders and the provider assists the individual to arrange or obtain such lab work.
 - Height/Weight – At least annually (needed for ECHAT) or per a specific frequency in the individual's HCP. The frequency of data collection is dependent upon recommendation from the physician, nutritionist, team, individual themselves, or other specialist. Data collected must be entered into this section of Health Tracker within one week.
 - Appointments - Mandatory for all except Family Living without ongoing nursing service. On the appointment module, providers are required to enter in appointment results. Appointment results can be entered by either typing in the complete results/orders/physician notes or by scanning the document and entering it as an attachment.

Comprehensive Health Assessment

- Electronic Comprehensive Health Assessment Tool (ECHAT) - Upon Admission, Transfer (an ECHAT must be completed, entered into Therap, and approved within 3 business days of transfer to the new provider agency, or two weeks following the transition meeting, whichever comes first); Annually (completed no more than forty-five (45) and at least fourteen (14) days prior to the annual ISP meeting), within three (3) business days following any significant change of clinical condition, and within three (3) business days following return from hospitalization. Pay particular attention to make sure the top section is completed and filled out correctly regarding hospital discharge date or Annual with ISP dates and date of assessment, etc. The nurse will indicate the date the HCP, MERPs, and/or CARMP are developed on the ECHAT summary sheet and may link electronic care plans or scanned plans. The nurse must fully complete all ECHAT assessment questions and is required to document additional pertinent information in all comment sections that are clinically appropriate. No section may be skipped. The final comment section must contain additional narrative notes regarding any health-related issues that were not captured in the ECHAT and reflect the nurse's complete clinical assessment of the individual's current health status, needs and a synopsis of progress toward care planned goals for individuals with established plans. Information about the nurse's actions and decisions regarding Health Care Plans (HCPs) or Medical Emergency Response Plans (MERPs) are to be noted in the narrative section at the bottom of the ECHAT Summary Sheet. (ECHAT generates Health Passport)
- Health Passport - Located in Home File, Office File and Travel/Appointment Folder. Must be taken to every appointment, Urgent Care, Emergency Room Visit, and Hospital Admission. The Health Passport for each individual shall be reprinted each time the ECHAT is updated for any reason and whenever there is a change in contact information. Make sure the Health Passport in the Home File, Office File and Travel/Appointment Folder is the most current reprinted version.

Health Care Plans (HCP)— Per ECHAT summary check that all required plans have been created. Some providers use the Therap module to create HCPs although this module is not mandated for providers. For those providers who are not using the Therap module; Regional Office staff will request a copy of all HCPs for the individual if not in Therap. HCPs do not have to be printed and kept in the home file if the Provider has Therap in the home, the HCPs are uploaded in Therap, are current, and can be accessed by Direct Support Personnel. It is required that Nurses enter the date HCPs and MERPs were created in the ECHAT summary.

Medical Emergency Response Plans (MERP) - Per ECHAT summary check that all required plans have been created. Some providers use the Therap HCP module to create MERPs. Providers need to be careful that they meet all the requirements for what needs to be in a MERP if they choose or are using the Therap module. All MERPs must still be printed out and placed in the home file. Using Therap to create MERPs is not mandated for providers. Regional Office staff will request a copy of all MERPs for the individual if not in Therap.

Comprehensive Aspiration Risk Management Plan (CARMP)- These are not required to be in Therap. There are a few providers that are attaching them in Therap but they still must have a hard copy in home file. Regional Office staff will request a copy of the CARMP.

References:

- DDSD Policy “Use of Health Tracker Components in Therap” June 17, 2011
- Director’s Release “Consumer Records Requirements” October 29, 2012
 - H.) Readily accessible electronic records are acceptable, including those stored through the Therap web-based system.
- Director’s Release “Revision to June 13, 2016 Director’s Release on Jackson Remedial Plan related to Health and Healthcare” August 11, 2016
- “Electronic Comprehensive Health Assessment Tool Requirements” February 20, 2014