Kansas
Department for Aging and Disability Services

KDADS LTSS PUBLIC COMMENT MATRIX

Comment Period: 1/24/2024 – 2/23/2024 Program: AIRS

BRIEF DESCRIPTION OF DOCUMENT SUBMITTED FOR PUBLIC COMMENT AND COMMENT SUMMARY

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KDADS LTSS PUBLIC COMMENT MATRIX

#	SENDER	PUBLIC COMMENT	KDADS RESPONSE
1.	Nunya	You are running providers INTO THE DAMN GROUND with the AIRS reporting requirements. A PRN for mental health is not a restraint and the definition of Chemical Restraint is totally off base. A PRN does not CHANGE a person's behavior, it RETURNS them back to baseline. It is absolutely asinine to have to report for unplanned medical services at a walk in clinic as well. If it is a WALK IN then it does not necessarily mean it is an emergency. You have made it IMPOSSIBLE for providers to do their jobs of actually caring for people in services because all we do now is paperwork and reports. IT IS LITERALLY IMPOSSIBLE for ANY agencies to accurately keep up on this anymore. It is also IMPOSSIBLE to always report within 24 hours. All that does is result in a rushed and incomplete report. You are going to run providers out of business. In fact, you already have and others are already making plans to downsize or close. The state needs to get a grip with the unreasonable expectations and focus on things that matter such as the Clearinghouse's inability to process applications.	Thank you for your feedback. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify the expectations regarding the use of PRNs as a form of chemical restraint. We will be reviewing the current definition of emergency medical care in order to assure that the definition captures the intent of the requirement. We understand this concern. The 24-hour policy ensures that all reports are followed-up adequately and in a timely manner. Please refer to the current HCBS Adverse Incident Reporting and Management policy #2017-110 on the KDADS policy page.
2.	N/A	According to the Code of Federal Regulations, the definition of chemical restraint is as follows: A chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition. The definition in this policy is inaccurate and in fact, contradictory. You CAN NOT lump all PRNs for mental health support into a category of "Chemical Restraint" because the effects of most of those drugs do not meet the federal definition. If you require an AIRS report when people go to urgent care, the result will be detrimental to individuals in service. People will end up waiting for weeks or months for treatment due to the difficulty in getting	Thank you for your feedback. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify the expectations regarding the use of PRNs as a form of chemical restraint. Thank you for your comment. We will be reviewing the current definition of emergency medical care in order to assure that the definition captures the intent of the requirement.

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		ANYONE in to see a physician that is part of a regular practice rather than going to urgent care, filing a report and then dealing with intrusive and unnecessary follow up from the state, CDDO and MCO. The system for follow up is impractical. There needs to be a single follow up for reports that is shared with the CDDO, state and MCO rather than each following up individually.	
3.	Anonymous	I believe this should be further clarified. A Tylenol could change a person's behavior... they feel better, their behavior improves. Additionally, staff are going to be far less inclined to pass PRN's due to the excessive reporting they will have to do. This will prevent individuals from receiving medication that will offer them relief they need.	Thank you for your feedback. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify the expectations regarding the use of PRNs as a form of chemical restraint.
4.	Kris Macy Starkey, Inc.	I.C.2. Regarding restraints, previous guidance from KDADS indicated restraints do not have to be reported via AIR if the restraint was approved in a person's plan. If this practice is still acceptable in the new policy, recommend that this be clearly stated in the policy. I.A.3. "Creates the potential for harm" is very vague language, and calls for employees to make the call whether harm was a possibility. For example, a person was spinning in circles on the front porch and staff was worried the person might fall off and suffer a broken leg. According to the definition that could be an adverse incident, even though the person was compliant and followed directions to go spin in their bedroom instead.	Thank you for your comment. Any restrictive intervention used must be reported into AIRS so we can assess appropriate use of restraints according to the individual's behavior support plan. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify instances such as the example you used. Please refer to the current HCBS Adverse Incident Reporting and Management policy #2017-110 on the KDADS policy page.
5.	Deone Wilson, RCIL	Page 3, item 4. – Walk-In Clinic and ER visits require an AIR report? If a consumer reports they went to urgent care for a sore throat, providers are required to submit an AIR report? Walgreens is a walk-in clinic. If a consumer reports they went there for a flu shot, an AIR report is required? Perhaps this requirement should be qualified to require AIR reports for life-threating or serious illnesses or injuries.	Thank you for your comment. We will be reviewing the current definition of emergency medical care in order to assure that the definition captures the intent of the requirement.

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		Page 5 b) & c) – Question - How do KDADS and the MCOs confirm, investigate or verify details around deaths? MCOS are required to determine if a death was preventable? Do they verify this will law enforcement?	The state is required to follow up on all cases of death individually to collect information regarding the incident. This information is collected by KDADS Program Integrity and Compliance team and disseminated to the assigned MCO, and the appropriate KDADS program manager. The MCOs and program managers then reach out to the individual's support network to clarify information leading up to the event and make determinations on whether it was a case of abuse, neglect or exploitation and report back to KDADS.
6.	Nichole Hall, CDDO of Butler County	Policy: B.14 – definition of chemical restraint needs reworded. The first part indicates "any medication, used routinely or as situation requires" would be reported. The last part indicates "except medication prescribed to the participant as part of their daily medication regimen". Is the intent to report any chemical restraint even if it's a daily/routine med or does this only apply to PRN/as needed medications? Procedure: B.3.c/d – is "affirmed" listed under c supposed to be item d? What is the difference between "affirmed" and "unsubstantiated"?	Thank you for your feedback. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify the expectations regarding the use of PRNs as a form of chemical restraint. CPS and APS use different language in their findings and determinations. "Affirmed" is specific to CPS cases similar to an unsubstantiated finding for an APS case.
7.	N/A	Emergency Care needs to EXCLUDE urgent care. The average wait time to see a primary care physician in the US is 3 weeks. Most Americans use urgent care for most sudden illnesses anymore. It is asinine to expect a provider to do AIRS reports on all urgent care visits. You need to classify the TYPE of care NOT the location care was received.	Thank you for your comment. We will be reviewing the current definition of emergency medical care in order to assure that the definition captures the intent of the requirement.
8.	N/A	It's hypocritical to say a provider has 24 hours to report an incident yet the state has 1 business day to rooute it. Fix the language so providers also have 1 business day. The double standards are detestable.	Thank you for the feedback. We understand this concern. The 24-hour policy ensures that all reports are followed-up adequately and in a timely manner. The policy currently reads that the provider shall report any adverse incident within 24 hours of becoming aware of the occurrence. Please refer to the current HCBS Adverse Incident Reporting and Management policy #2017-110 on the KDADS policy page.

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9.	Anonymous	All psychotropic medications are prescribed and monitored by a licensed physician. Chemical Restraints are not used to discipline a client or for staff's convenience. Prescribed medications are to treat a diagnosis and is a benefit for that individual to maintain stability for day-to-day living. It is a client right to receive medications as prescribed. Outlined and defined in Item #14 is Chemical Restraint: Any medication, used routinely or as the situation requires, that changes a participant's behavior or restricts a participant's freedom of movement, except medication prescribed to the participant as part of their daily medication regimen. It's my understanding that the term "Chemical Restraint" is actually defined as any drug that is used for discipline or convenience and not required to treat medical symptoms. ALL prescribed PRN medications are treating a medical diagnosis. It may be a PRN for anxiety prior to completing a routine dental cleaning, or a PRN for agitation related to autism disorder, again treating a medical condition. To add this as an additional AIR's report would further delay Critical Reports that need timely attention.	Thank you for your feedback. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify the expectations regarding the use of PRNs as a form of chemical restraint.
10.	Travis Chapman, Lakemary Center	1.A.3 - Would actively receiving HCBS waiver services at the time of the occurrence mean with provider staff only? Would it include time with family/friends in the community/vacation away from provider staff? We are having difficulty defining reasonably neccessary for Self-neglect and wanted to see if you could include examples. Would manual/physical methods approved by the person and outlined in their Person Centered Support Plan or Behavior Management Plan be included?	Thank you for your feedback. It is the responsibility of the provider to communicate with the state so they can follow up and document any additional observations within 24 hours that they became aware of the incident in an AIRS report, regardless of where the incident took place. We will review the policy to clarify this requirement. Any behavior that would put the participant or those around them at imminent risk of harm or has an impact on their ability to continue receiving services. This needs to be documented in an AIRS report within 24 hours of becoming aware of the incident.

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11.	Nick Wood, InterHAB	Several IDD providers have noted that certain terms are not well defined or defined so broadly that interpretation could vary widely depending upon the reviewer. For example, "misuse" of medications could encompass lack of informed consent before taking a new prescription. However, IDD service providers do not prescribe medications and are not able to advise every participant about all of the possible pro's and con's of taking a given medication. Regarding restraints, previous guidance from KDADS indicated restraints do not have to be reported via AIR if the restraint was approved in a person's plan. If this practice is still acceptable in the new policy, recommend that this be clearly stated in the policy. "Creates the potential for harm" is very vague language, and calls for employees to make the call whether harm was a possibility. For example, a person was spinning in circles on the front porch and staff were worried the person might fall off and suffer a broken leg. According to the definition that could be an adverse incident, even though the person was compliant and followed directions to go spin in their bedroom instead.	Thank you for your comment. This is a multi-waiver policy. This specifically addressed in the Medication Administration training required for I/DD service providers. It is also covered in the AIRS training provided by the state to clarify the requirement per waiver service. Thank you for your comment. Any restrictive intervention used must be reported into AIRS so we can assess appropriate use of restraints according to the individual's behavior support plan. We will be providing updated training on the AIRS policy for stakeholders, and we will be revising the policy that will further clarify instances such as the example you used. Please refer to the current HCBS Adverse Incident Reporting and Management policy #2017-110 on the KDADS policy page.
12.	CDDO Feedback	I. Policy: There is no mention of any involvement or responsibility of the CDDO as it relates to critical incidents. Is that KDADS' intention? II. Procedure: B.3.c/d – is "affirmed" listed under c supposed to be item d? What is the difference between "affirmed" and "unsubstantiated"?	Thank you for your feedback. It is not KDADS' intention to exclude CDDOs from the tracking of critical incidents. As a best practice, the state encourages each CDDO to design a process that is efficient for their catchment area. There was a formatting error and has since been fixed. Section B.3.c is supposed to be Section B.3.d. CPS and APS use different language in

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