# FAQ for On-Site Visit Tool – July 2026

## General Information Questions:

**Timeline for Statewide Implementation:**

The updated OSVT is set to go live on August 1, 2026. QMR will be looking for the 2026 version starting in August.

**"Contact Note":**

The new version of the OSVT refers to a contact note, this refers to the corresponding note that aligns with the completed OSVT on that date. Your board may refer to the corresponding note as a progress note or F2F note, but it refers to the same thing.

**The OSVT and the contact notes are companion documents – utilizing a checklist in the OSVT makes the contact notes especially important. The note holds the details and will be looked at when considering the information in the OSVT.**

It is critical that the contents of the note match the results contained in the OSVT.

### Availability of OSVT versions and training material:

Q1: Will the updated OSVT be available on the DBHDS website?

A1: Yes. The finalized version of the OSVT will be available on the website. The website now has a search function, so you can search from the homepage for OSVT. The 2026 version of the OSVT and training video will be sent to CSBs following this session and posted to the DBHDS website by August 1st.

Q2: Is the OSVT required to be uploaded in WAMS for people with non-waiver Targeted Case Management (TCM)?

A2: Per the OSVT memo uploading applies to people with DD waiver.

Q3: For those of us using Credible System will OSVT be directly uploaded into WaMS upon completion or will we still need to attach?

A3: At this time, manual uploading of the OSVT is required. DBHDS is working with CSBs and EHR vendors to draft specifications for direct data exchange of the OSVT beginning in 2027.

Q4: Format question: Can we check the boxes once on the form rather than opening a box that we have to then select and de-select from? In the interest of optimization of resources and efficiency of time.

A4: You may simply type over the formatted checkboxes and replace them with an "x." What's important is that the selections are clearly indicated on the tool regardless of how the answers are marked.

Q5: Can you provide additional about the training for providers?

A5: DBHDS is implementing a Quality Improvement Initiative (QII) related to 10 case management indicators. Two of these indicators relate to the elements determined through the OSVT – assessing for change in status and appropriately implemented services. One video on how-to achieve the indicators will be produced for SCs and one for providers. The second video for providers will focus on provider awareness and how they can support efforts to achieve these indicators.

Q6: Why does the OSVT need to be uploaded in WAMS if it is already in our EHR?

A6: The OSVT is used by DBHDS in completing desk audits related to the Settlement Agreement and Permanent Injunction. These reviews completed are related to nursing and behavioral requirements and are needed to sustain compliance.

Q7: This training would be better if offered in person at each CSB. It is hard to follow the presentation while asking questions and looking for answers in the chat. Is this possible?

A7: You may reach out to your assigned System Team CRC to request training and support as needed.

Q8: If a person lives at home and is not receiving services at the time of visit (they receive services, just not at home), do we write NA in slot for "service being provided" or would we write support coordination?

A8: The updated version does not have the “Service being provided” question at the top line of the OSVT. It has been replaced with “Is a service being observed?” question. If the person is at home and not receiving a service during your F2F, you can note that at the top of the first page in "location of visit." You would answer the questions that are possible to answer based on the location. Support Coordination is not a service that would be observed during the completion of the OSVT.

Q9: Are waiver providers being given this form by DBHDS to know what case managers will be reviewing?

A9: We do not specifically give this to providers. The form and all related guidance live on the DBHDS website and related information has been communicated through the public listserv.

Q10: If case managers are getting any resistance from providers with completing this form should they report it to licensing or CRC's?

A10: You should follow your policies and can certainly contact licensing and CRCs as needed.

## Change in Status Questions: (OSVT Q1 – Q6)

Q11: When the person rents their home and has dirty carpet, how do we address this concern?

A11: Question 1 asks “Are there new or increased concerns with the environment being clean, safe and appropriate to the person’s needs?” This would be related to change in status. If the carpet is a health concern, the SC would answer “no,” discuss with their supervisor, report as necessary, and support the individual/family, as needed, to establish a plan to resolve the concern.

Q12: If I am called and notified about a health issue (surgery, increased seizures, ER visit, etc.) in advance of a F2F visit, how would you suggest I answer question #3 at the F2F "Are there new or increased concerns with the person’s health and safety? " Specifically, if the health issue is resolved? What if a person is diagnosed with cancer and is undergoing radiation and/or chemotherapy? Does that question get answered yes throughout the treatment?

A12: The completion of the OSVT applies to the visit that is occurring. If there are health issues already known and being addressed, they don't relate to this question unless the needs are new or have increased since the last OSVT.

Q13: Would a provider asking for a customized rate due to behavioral changes be considered a change in status?

A13: Possibly. If the request relates to newly identified or intensifying needs, it would be considered a change in status and could support seeking a customized rate.

Q14: If an individual loses one of his parents, but still lives with the other, would that be considered a change in status?

A14: This would be viewed as a change in "status" due to the potential for trauma and grief that could affect the person's well-being.

Q15: If a parent is interested in trying a communication device for the individual, and they are on a 6-month waitlist for Therapeutic Consultation for speech, how do I document this need on the OSVT until the communication device is obtained?

A15: If a person is waiting (on a waitlist) for a service needed to obtain a communication device, the answer would be Yes for question 2 related to assistive technologies until the device is obtained. Following a delay, the individual/SDM might prefer choosing an alternate provider.

Q16: Changes in status occur between visits and are reported to us and responded to by us before the visit even occurs. Are we noting changes here or checking "no" because they are already being addressed?

A16: The completion of the OSVT applies to the visit that is occurring. If changes have been reported prior to the visit and have been documented and addressed, they don't relate to this question unless the needs are new or have escalated since the last OSVT.

## ISP Implemented Appropriately Questions: (OSVT Q7 – Q14)

Q17: Does the person express satisfaction with services and the progress being made? When visiting the home, do we have to say "unable to assess" even if the parent/individual reports that services are going well?

A17: This question has been modified to include satisfaction with “the observed service,” which clarifies that the question applies to a service occurring at the time of the visit. If there is no service being observed, the appropriate response would be unable to assess.

Q18: I have had providers that tell DSPs not to provide an answer to question eight "Are the paid supporters knowledgeable about the person and understand their role in providing support?" Do we just say unable to assess?

A18: This question can be answered based on what is being observed during the time of the visit. The SC should consider the environment, any supports they observe, and other evidence to help with deciding for this question.

Q19: Regarding question 9 on the OSVT. If I, as the SC, feel the individual needs professional behavioral services, but SDM disagrees, do I answer yes or no?

A19: If the person or SDM declines a professional behavioral service, then the SC should mark the answer as No, not needed. The guidance indicates that an answer of No, not needed means that the person does not need**, or does not want,** professional behavior services. It is important to note that a person and their SDM always have the right to decline a service regardless of the SCs opinion.

Q20: If the person receives ABA through private insurance or through the school system, do we need to say yes already provided? Because it’s not a waiver service and not monitored by us.

A20: Yes. Question 9 is looking generally at behavioral service needs, not just those provided through DD Waivers.

Q21: OSVT question 9a relates to behavioral services being implemented in this setting. Is this in general or at the time of visit? What if provider only provides telehealth methods for service?

A21: This question, “Are the professional behavioral services being implemented in this setting?”, is asking if services are needed at any time in the setting. Telehealth is a way services can be provided, which would count as services being provided in the setting.

Q22: Should we physically check all the behavioral support documentation, during each visit, specifically for ECM visits, as we are visiting monthly?

A22: Continue to review, as necessary, the information available to answer the related questions.

Q23: What if I am observing two services at once? Visiting while there is a behavior consultant in a group home? Or, at home, mom is personal assistant and the behavioral provider is present.

A23: Complete the service questions related to the primary service being provided in the setting. The question related to behavioral services would apply to therapeutic consultation in either scenario.

Q24: For question #11, "Has the service observed during this visit been occurring as authorized in the plan?" If at an ISP meeting, what service is being provided?

A24: The OSVT is designed to assist in the evaluation of a specific setting, and service if one is being provided. An annual meeting does not lend itself to completing the tool as intended. Any visit in the setting (e.g. group home, family home, etc.), before or after the meeting, might be an appropriate time to complete the OSVT.

Q25: What if the request for specific hours for nursing services was lowered by the Service Authorization Consultant? Do we answer the question "Are the hours sufficient to ensure health and safety?" as no?

A25: Service Authorization approves hours where they can confirm sufficient documentation to support the request. If the approved hours are believed to be insufficient, additional documentation may be necessary for approval. You would indicate "no" and proceed to document changes and actions that will be taken to request additional service units. Please reach out to service authorization with any questions you have.

Q26: How do you answer number 9 if there are multiple therapeutic consultation services in place at once (e.g. behavior, speech, OT) and answers to number 9 are not same for each provider.

A26: Question 9 is only related to the provision of behavioral services.

Q27: Is this form relevant if we are meeting an individual in the offices of agencies out in the field?

A27: The form is intended to be used in all settings. However, for the SC to complete their role and responsibility correctly, the SC would typically be observing the person in a setting where services are provided. In exceptions, where visits occur in locations without services, such as a community location with natural supports, the OSVT is completed using "unable to assess" responses where appropriate. Agency office visits do not provide the opportunity to complete the OSVT as intended.

## HCBS Questions: (Q15, Q16, Q16a, Q17)

Q28: How best to document "provided a key to home?" for an individual unable to leave the bed?

A28: HCBS requires that each individual be given a key to their home and bedroom, and documentation must show they received it and can access it. Individuals choose where their key is kept. Providers may not hold or lock up an individual's key unless the individual or guardian specifically requests it. The only other exception is when a documented health or safety concern requires a modification in the person-centered plan. SCs can ask to review supporting documentation maintained by the provider when a key is not in the individual's possession.

Q29: What if one of the behaviors they exhibit is food seeking and the provider has the locks for that reason?

A29: In order to have access to food restricted, the provider must follow Human Rights regulations and the HCBS Modifications process and document in the Provider's Part V in WaMS. The restriction has to be due to a health and safety concern.

*Q30: For question 15 (related to all settings meeting HCBS standards), if a group home setting is HCBS approved, but the person has a rollator and cannot access the laundry room (in the basement). What is done there?*

A30: That would not be compliant with the HCBS regulation on accessibility, and a complaint needs to be filed with office of Human Rights.

Q31: Is a group home allowed to put visitation hours within their lease or just in the ISP? If there has been identified issues?

A31: No. The provider must follow the HCBS Modification process by completing the Part V Safety Restrictions section.

Q32: Can a person we support have a roommate living in the same room?

A32: Some people do share a bedroom, and this is permissible. The SC should ensure that the person has been given choice in this matter, which is documented and with regularly checking for satisfaction with the arrangement.

Q33: For adaptations needed to ensure privacy, such as allowing an individual to lock their door without using a key in a group home setting, is it the responsibility of the group home to provide these adaptations, given that Environmental Modifications are not covered in these settings?

A33: Correct. The group home is mandated to follow the HCBS regulation.

Q34: I am uncertain how to respond to question 16 (related to individuals having visitors at any time) in group settings because some legal guardians are opposed to overnight guests. What should I do when providers are not allowing visitors at any time for this reason?

A34: Having visitors at any time is a HCBS right. While we understand that guardians may not feel comfortable with HCBS rights and regulations, it is a federal regulation. Providers are required to follow the HCBS regulations. The Office of Community Network Supports (OCNS) at DBHDS provides training to individuals and families, as well as guardians on the HCBS regulations.

Q35: How do we answer questions for 16a (related to HCBS rights) if we visit someone who is in a REACH Therapeutic Crisis Home for only 1 or 2 weeks? for example-decorating room, given keys?

A35: The HCBS requirements would not apply to the short-term stay Crisis Therapeutic Home, but it would apply to the longer-term stay where there is a lease in an Adult Transition Home (ATH).

Q36: If the purpose of the HCBS key requirement is to meet the intent of the standard, how is that intent achieved for individuals who cannot physically use a traditional key due to limited fine motor skills?

A36: There are alternative ways to ensure privacy and that the individual can lock their door. There are other types of locks like thumbprint, codes, etc. Consult with the HCBS CRC, Ronnitta Clements for additional support on specific situations. The group home provider has to follow the HCBS settings rule.

Q37: I was informed that group homes reserve the right to have "house rules." Is this acceptable under HCBS regulations?

A37: Providers are required to follow their own policies and procedures. All policies/procedures/ house rules **must** comply with HCBS regulations.

Q38: Does Question 17 (related to HCBS restrictions) apply to restrictions in family homes? (e.g. I am visiting an individual in their home and mother is the PA). Can they have special locks or cameras without LHRC approval or safety restrictions noted in the plan?

A38: HCBS restrictions do not apply in family homes. If a Medicaid-paid DSP is providing services in the home, HCBS expects the DSP to follow HCBS regulations. However, when the family chooses to use locks or cameras in their own private residence, HCBS does not have authority to regulate this. A family home is not considered a licensed service location when the individual lives with family and the parent is the PA. These requirements only apply in licensed service settings. For example, a family home may be considered a licensed location if it is approved as a Sponsored Residential service.

## Crisis Risk Assessment Tool Questions: (Q18, Q18a, Q18b)

Q39: What/how do I document if the individual is seeking attention and enjoys going to hospital or contacts Crisis frequently just to chat with them?

A39: If the person regularly makes hospital visits and communicates with Crisis for attention, then a referral can be made to REACH, and the team can work on ways to reduce using the crisis/hospital stays as a support system. Some REACH programs offer regular preventive stays to reduce this kind of system use. Also consider additional service options to expand the person's social network.

## Reporting and Plan Changes Questions (Q19 – Q22)

Q40: For question 22 (related to unmet needs from the last OSVT that require action) - What if the SC feels that action is needed and the provider or SDM disagree?

A40: The person (SDM if applicable) has the right to decline any suggested service or action. Providers should not be deciding what service(s) the person has or does not have. If you have concerns about the need, document your observations regarding the need. If the concern is related to health and safety, the planning team must address the concern so that health and safety can be ensured for continuation of DD Waiver services. If you are unable to address the issues, follow your CSB policies for reporting the concerns.