STATE OF ALASKA

CORRECTIVE ACTION PLAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES – DIVISION OF SENIOR AND DISABILITIES SERVICES – JANUARY 2010

SDS
1/15/2010

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SIGNATURES

I, Commissioner Bill Hogan of the State of Alaska Department of Health and Social Services have reviewed and support the Senior and Disabilities Services' action items and deadlines within the attached Corrective Action Plan. To the extent possible, timelines will be adhered to and, in the event an action item and/or deadline change, reasonable explanation will be provided to CMS.

_____ _____
Signature Date

I, the undersigned, on behalf of Centers for Medicare and Medicaid Services, Central Office, hereby acknowledge acceptance of the State of Alaska Department of Health and Social Services' Corrective Action Plan as requested. I further acknowledge that the Corrective Action Plan is Senior and Disabilities Services' attempt to set forth their goals and target dates and that future circumstances may require adjustment to those action items and target dates.

_____ _____
Signature Date

I, the undersigned, on behalf of Centers for Medicare and Medicaid Services, Region X Office, hereby acknowledge acceptance of the State of Alaska Department of Health and Social Services' Corrective Action Plan as requested. I further acknowledge that the Corrective Action Plan is Senior and Disabilities Services' attempt to set forth their goals and target dates and that future circumstances may require adjustment to those action items and target dates.

_____ _____
Signature Date

LIST OF DOCUMENTS TO BE DELIVERED TO CMS

CAP Page #	Document	Responsible Person	Target Submittal Date
33	Waiver amendment re: changes to eliminate waiver within a waiver.	SDS Deputy Director	1/29/10
37	LOC Performance Measure monitoring tool	QA Unit Manager	4/26/10
40, 93	Remediation policy	QA Unit Manager	4/28/10
44	Annual reassessment LOC monitoring tool	QA Unit Manager	4/26/10
49	Summary of analysis of alternate staffing plans will be reported to CMS.	SDS Chief of Programs	4/26/10
51	If new LOC determination tool is identified, chosen tool will be submitted	Systems Development and Support Manager	5/3/10
51	Action plan for new model to conduct initial and annual assessments, if chosen	Systems Development and Support Manager	5/28/10
52	Plan for SDS to begin to perform CCMC assessments for initial and annual LOC evaluations	Assessment Unit Manager	4/11/10
53	Findings and analysis of comprehensive business process analysis	Division Director	9/1/11
53	Implementation plan of actions in response to comprehensive business process analysis	Division Director	9/1/11
55	LOC process/instruments monitoring tool	QA Manager	4/26/10
58	Implementation data from the LOC monitoring tool	QA Manager	TBD
58	Eligibility for Waiver policies to CMS for review and feedback.	Systems Development Manager	2/8/10
61	Concept paper re: models of conducting annual MRDD reassessments	Waiver Unit Manager for MRDD	2/19/10

64	Fair Hearing policy	OIU Manager	1/15/10
67	Service Plan monitoring tool	QA Unit Manager	4/26/10
72	Data from the Service Plan monitoring tool	QA Manager	TBD
75	Curriculum on person-centered service planning	OIU Manager	10/15/10
76	Demonstration of automated service plan monitoring tool	ITS Manager	12/13/10
85	Training curriculum re: Choice requirements	OIU Manager	2/26/10
86	Health & Welfare performance measures monitoring tool	QA Unit Manager	4/26/10
95	Routine periodic reports of provider training on the critical incident report system and mortality review for scheduled CMS teleconferences	QA Unit Manager	As scheduled
95	Critical Incident Policy implemented 7/1/09	QA Unit Manager	1/15/10
99	Draft Quality Assurance Referral policy	OIU Manager	4/16/10
102	Qualified Provider performance measures monitoring tool re: licensure/certification	QA Unit Manager	4/26/10
110	Qualified Provider performance measures monitoring tool re: Policies and Procedures	QA Unit Manager	4/29/10
119	Submit new rate methodology to CMS.	Division Director	7/1/10

INTRODUCTION

Attached please find Alaska's Corrective Action Plan (CAP) submitted in response to CMS's request. The CAP is separated into six sections that respond to each of the six 1915 (c) Waiver Assurances preceded by an Introduction. This version of the CAP incorporates responses to comments received from CMS as well as technical guidance received from the National Quality Enterprise (NQE) subsequent to drafts of some sections submitted by the Division of Senior and Disabilities Services to CMS and the NQE for initial review and comment.

The CAP has been developed by the Division of Senior and Disabilities Services with input from the Department of Health and Human Services (DHSS) stakeholders outside of SDS, as appropriate, for action items within the CAP. The DHSS Commissioner's Office, through the Project Coordinator is the entity responsible to oversee all components of the CAP to assure accountability and timeliness across all business lines.

Brief description of each Waiver:

- **Older Alaskans (OA):** This waiver provides care coordination and in-home services to eligible Medicaid recipients age 65 and older who are living at home or in home-like settings in Alaska. The program is managed by SDS. SDS staff conduct the assessments/reassessments, determine whether applicant/participant meet a Nursing Facility level of care, approve service plans, and issue prior authorizations for payment. Care coordinators are certified by SDS and either work independently or with a service-delivery organization. They are required to have twice-monthly contacts with participants, one of which must be face-to-face with limited exception.

- **Adults with Physical Disabilities (APD):** This program serves eligible Alaskans between the ages of 21 and 64 in their home or home-like setting. Participants receive care coordination and approved services according to the waiver plan. Care coordinators are certified by SDS and either work independently or with a service-delivery organization. They are required to have twice-monthly contacts with participants, one of which must be face-to-face with limited exception. The program is managed by SDS. SDS staff conduct the assessments/reassessments, determine level of care, approve service plans and issue prior authorizations for payment.

- **Children with Complex Medical Conditions (CCMC): This program** serves children ages 0 to 21 with severe chronic physical conditions who meet eligibility criteria. These children receive care coordination and approved services according to the waiver plan. The care coordinators are certified by SDS and either work independently or with a service-delivery organization. They are required to have twice-monthly contacts with participants, one of which must be face-to-face with limited exception. The program is managed by SDS. The assessments/reassessments are conducted by community registered nurses who work with the service delivery agencies. The assessments are submitted to SDS who determine the level of care, approve the service plans, and issue the prior authorization for payment.

- **Persons with Mental Retardation / Developmental Disabilities (MRDD):** This program serves eligible Alaskans of all ages who meet the level of care for an Intermediate Care Facility for the Mentally Retarded (none of which exist in Alaska). They receive care coordination and services in their home or home-like setting. Care Coordinators are required to have twice-monthly contacts with participants, one of which is face-to-face, with limited exception. The assessments/reassessment determinations are conducted by SDS staff. SDS also approves the service plans and issues the prior authorization for payment.

OVERARCHING GOALS AND PRINCIPLES OF WAIVER QUALITY IMPROVEMENT STRATEGIES

- All Quality Improvement Strategies will be equally applied to each of the four 1915 (c) waiver programs, with limited variance as required to meet unique program needs.
- Performance measures will extend across all waivers whenever possible.
- Collaboration and education with identified stakeholders will be employed whenever possible as performance measures, policies, regulations, and remediation activities are developed.
- Quality Improvement Strategies will be founded upon data-driven discovery activities.
- Remediation and System Improvement activities will be developed and employed to address individual and systemic problems identified as part of SDS's quality monitoring and improvement activities.
- A long term goal is to establish ADRCs that not only provide information about and assistance for long term care programs as they do currently, but integrating the initial point of contact for all long term care services into a single point of entry, streamlining eligibility, providing options counseling and conducting assessments. Alaska is in the early stages of developing a full-functioning ADRC statewide system.

Acronyms/Abbreviations

APD	Adults with Physical Disabilities	**OA**	Older Alaskans
CCMC	Children with Complex Medical Conditions	**OIU**	Operations Integrity Unit
DHSS	Alaska Department of Health and Social Services	**ORR**	Office of Rate Review
DSDS or SDS	Division of Senior and Disabilities Services	**POC**	Plan of Care
ITS	Information Technology Systems	**QISC**	Quality Improvement Steering Committee – Identified DHSS staff who meet quarterly to review concerns/recommendations raised by QIW and provide oversight to the SDS quality assurance strategy. Current composition includes: Deputy Commissioner, State Medicaid Director, LTC Medical Assistance Administrator, DHSS QA/Audit, SDS Director, SDS Deputy Director, SDS Chief of Programs, SDS QA Manager
MRDD or MR/DD	Persons with Mental Retardation / Developmental Disabilities	**QIW**	Quality Improvement Workgroup – SDS Unit Managers who meet weekly to review quality data, develop and refine quality improvement strategies and make referrals/recommendations to the QIS. Current membership includes: SDS Director (Chair), SDS Deputy Director, Information Technology Project Manager, SDS QA Manager, Assessment Unit Manager, Waiver Unit Manager, Personal Care Unit Manager, OIU Manager, RAT Manager, Grants, Personal Care Assistance, Systems Development Manager, Adult Protective Services, Administrative Operations, Chief of Programs, content experts on invitation.
$	Action item is dependent upon funding	**QIP**	Quality Improvement Plan. This SDS document is developed to outline the elements of the Quality Improvement Strategy. It is one component of SDS's

			QIS.
	Action item is dependent on regulatory changes.	**RAT**	Research and Analysis Team. Provides reporting and analytical services to all units within SDS.
MMIS	Medicaid Management Information System.	**NQE**	National Quality Enterprise
	Material to be submitted to CMS for review and feedback.	**DS3**	Division of Senior and Disabilities Services Data System. The DS3 is a collection of components contained within a single web-based data system that was developed in-house by Senior and Disabilities Services in an effort to manage the many programs that it oversees. This system provides user interfaces, processing logic, and role-based data access, all of which allows division staff to conduct and oversee day-to-day program activities. While DS3 is used to manage Medicaid programs it is also used to manage Adult Protective Services investigations, state-funded general relief programs, and other grant-funded programs that fall outside the scope of Medicaid

WAIVER PROGRAM MANAGEMENT

INTRODUCTION

The State Medicaid Agency for Alaska is the Department of Health and Social Services (DHSS). DHSS, under the direction of the Commissioner, retains ultimate administrative authority and responsibility for the operation of the waiver program. The Division of Senior and Disabilities Services (SDS) is the unit within the DHSS that administers and operates all Home and Community Based Waivers. Additional units within DHSS such as Office of Rate Review, Divisions of Public Assistance and Health Care Services provide support services related to financial eligibility and service rates. SDS operates under the SDS Division Director. The SDS Division Director reports to the DHSS Deputy Commissioner for Family, Community & Integrated Services, who reports to the DHSS Commissioner.

The following illustration shows the chain of authority from the level of the Governor of the State of Alaska through the level of senior management within SDS ***as it pertains to Waiver administration and operations***. The red boxes denote individual members of the SDS Quality Improvement Steering Committee:

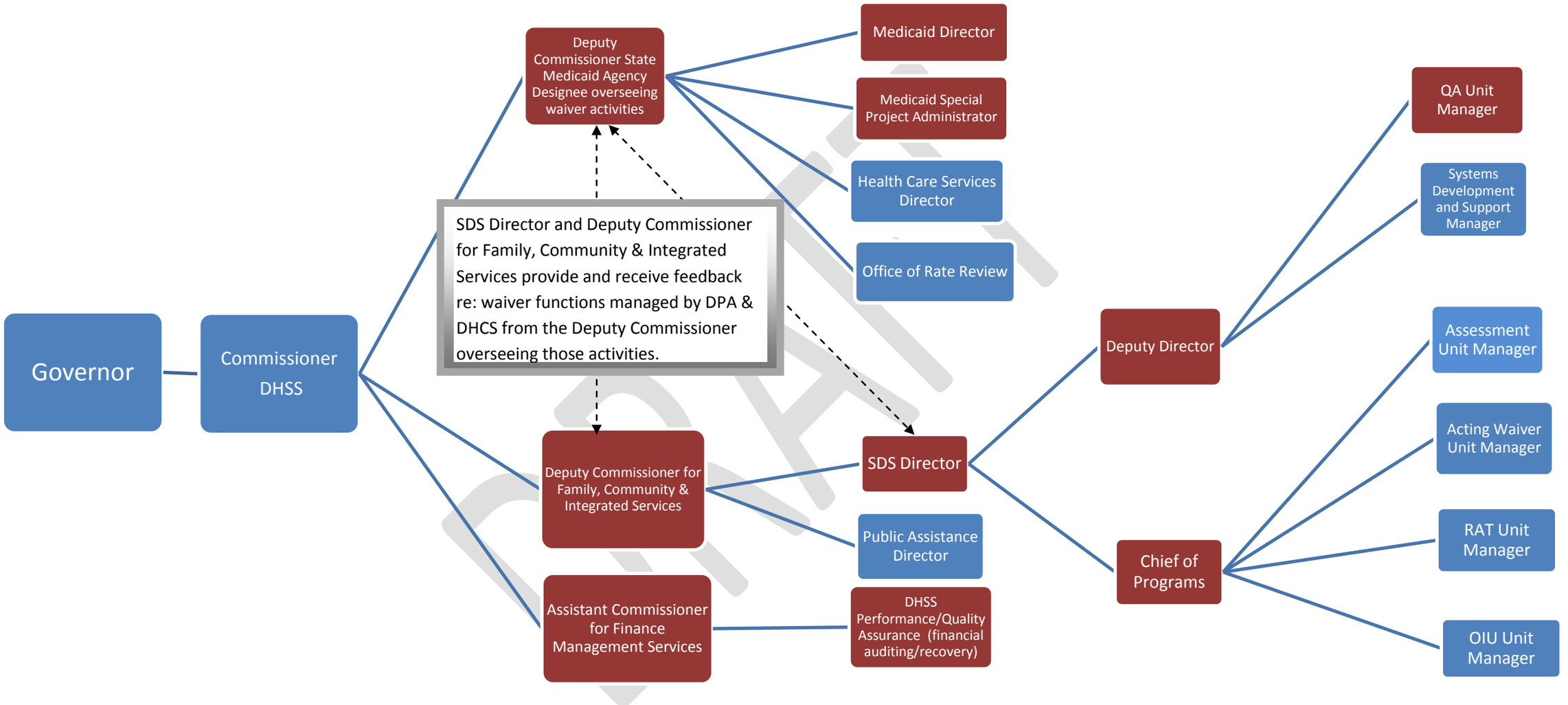


Figure 1: ORGANIZATIONAL STRUCTURE FOR WAIVER ADMINISTRATION

All of the following critical waiver functions are performed by DHSS:

1. Participant waiver enrollment;
    - Division of Public Assistance (DPA) and Division of Senior and Disabilities Services (SDS) (both are Divisions within DHSS). DPA determines Medicaid Eligibility and SDS determines waiver eligibility.
2. Waiver enrollment managed against approved limits;
    - Division of Senior and Disabilities Services
3. Waiver expenditures managed against approved levels;
    - Division of Senior and Disabilities Services
4. Level of care evaluation;
    - Division of Senior and Disabilities Services
5. Review of participant service plans;
    - Division of Senior and Disabilities Services
6. Prior authorization of waiver services;
    - Division of Senior and Disabilities Services and Division of Health Care Services
7. Utilization management;
    - Division of Senior and Disabilities Services and Division of Health Care Services
8. Qualified Provider enrollment;
    - Division of Senior and Disabilities Services
9. Execution of Medicaid provider agreements;
    - Division of Senior and Disabilities Services certifies all waiver service providers and Division of Health Care Services administers the payments to providers.
10. Establishment of Statewide Rate Methodology;
    - Office of Rate Review determines the rates and Division of Health Care Services administers the payments.
11. Rules, policies, procedures and information development governing the waiver program; and
    - Division of Senior and Disabilities Services
12. Quality assurance and quality improvement activities
    - Division of Senior and Disabilities Services

Figure 2: WAIVER FUNCTION PARTNERS WITHIN DHSS

Entity within DHSS	Liaison within SDS Who Is Accountable For Deliverables	Waiver Function Deliverable Accountable For	Formal Interagency Relationship, If Any (e.g., MOU)
Division of Public Assistance	Waiver Unit Manager	Financial eligibility determination	None
Division of Health Care Services	OIU Manager	Oversight of MMIS and fiscal agent functions and fiscal reporting; provider enrollment with fiscal agent; provider financial audits	None
Office of Rate Review	OIU Manager	Determination of provider rates	None

SDS Quality Improvement Strategy

Senior and Disabilities Services embraces a continuous quality improvement model focused on three areas of activity: Discovery, Remediation/System Improvement and Evaluation.

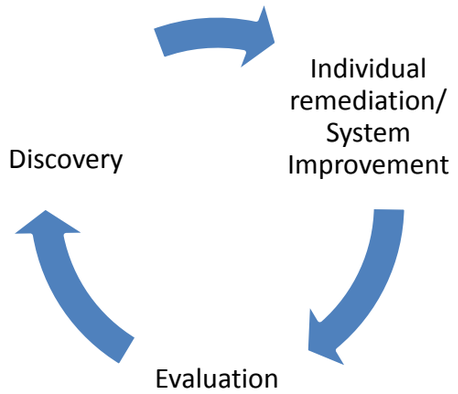


Figure 3: QUALITY IMPROVEMENT CYCLE

SDS is in the process of developing and adopting an enhanced Quality Improvement Plan ("Plan"). This document is one element of the Division's Quality Improvement Strategy and serves as a guideline for quality improvement activities that culminate in the Quality Improvement Strategy.

This Plan sets forth the reporting structure on quality improvement matters from all levels of Task Committees to the Commissioner of the Department of Health and Social Services who holds the ultimate authority to ensure an adequate and effective quality improvement strategy. Under the revision to this Plan, the DHSS Commissioner will receive monthly reports of key indicators of program function as well as the quarterly Quality Improvement Steering Committee reports providing a status on waiver assurances and any high level actions taken as remediation and systems improvement.

The following chart illustrates the quality improvement structure established by the newly developed Plan:

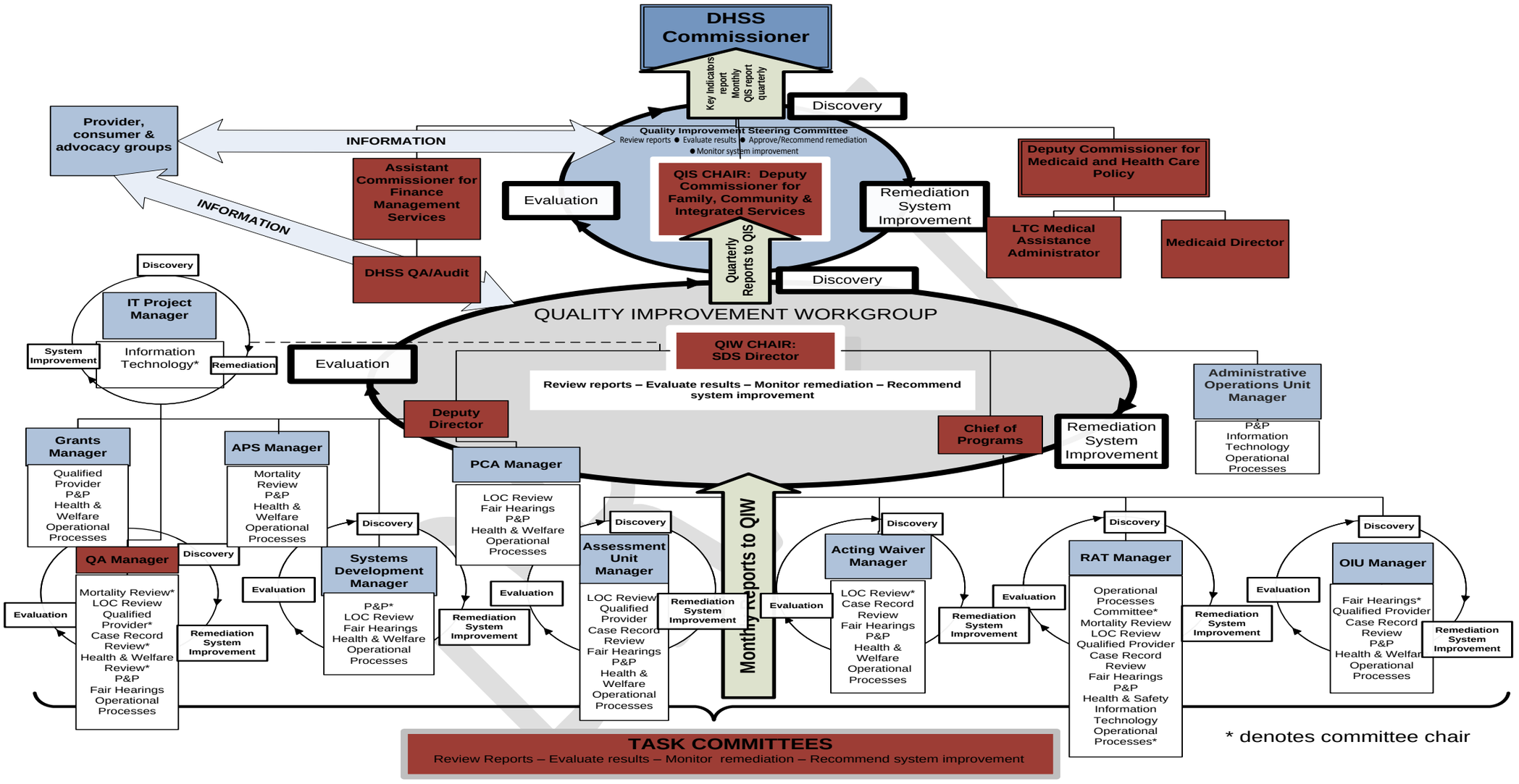


Figure 4: QUALITY IMPROVEMENT STRUCTURE

Quality Improvement Steering Committee

The **Quality Improvement Steering Committee (QISC)** provides oversight to SDS's continuous quality improvement activities. This is a multi-divisional group within DHSS that includes, at a minimum:

a. Deputy Commissioner for Medicaid and Health Care Policy;
b. Deputy Commissioner for Family, Community and Integrated Services, Committee Chair;
c. Director, SDS;
d. Deputy Director, SDS;
e. Chief of Programs, SDS;
f. State Medicaid Director;
g. Program Integrity Manager, Finance and Management Services;
h. Medicaid Special Project Administrator; and
i. Additional Division or Department staff at the invitation of the committee.

As the Committee Chair, the Deputy Commissioner for Family, Community and Integrated Services has the authority to make administrative/programmatic decisions in response to information received by the QISC and to report any findings, outcomes and/or corrective actions taken to the DHSS Commissioner. The QISC provides monitoring to the Quality Improvement Workgroup.

The Steering Committee may invite additional DHSS staff representatives as necessary to accomplish the work of the committee. This committee meets quarterly and more often if necessary to address concerns of SDS. They review the Quarterly Quality Improvement Steering Committee Report submitted by the Quality Improvement Workgroup (QIW). This report provides the status of performance measures, remediation efforts, system improvement efforts and action plans. The QISC reviews the reports, evaluates the results, approves the actions of the QIW and/or makes recommendations for augmenting remediation or system improvement efforts that were initiated at the program level by Unit Managers and monitors system improvement efforts.

The QISC is responsible for approving, implementing and monitoring the Quality Improvement Strategies. The QISC assumes responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver recipients and the provision of quality services to these recipients. The QISC monitors, recommends, and implements changes in the Quality Improvement Strategy to assure the health, safety and welfare of waiver recipients and improve the quality of services provided to recipients. The QISC reviews and approves the development of Performance Measures and reviews data collection processes to ensure that useful information is gathered to improve quality of service delivery and to assure the health, safety and welfare of waiver recipients. The QISC identifies training, technical assistance or other activities based upon analysis of Quality Improvement Workgroup data or other available information sources. The QISC ensures that information obtained from analysis of Performance Measures data is disseminated, as appropriate, to stakeholders and staff. The QISC interfaces with the DHSS Audit Committee to participate in implementation of financial accountability monitoring.

Quality Improvement Workgroup

The monitoring committee of SDS's daily processes and activities is SDS's ***Quality Improvement Workgroup (QIW)***. During this monthly meeting, Unit Managers, who also serve as Task Committee Chairs, present data on performance measures and remediation activities initiated by individual Unit Managers. QIW reviews the data collected through quality assurance task committees and programs to discover what system changes may be necessary to meet performance measures and what remediation efforts have been undertaken. The QIW applies the continuous quality improvement strategy through discovery by analyzing and trending data, identifying problems, recommending and requiring system changes and ensuring that the individual problem was remediated by the Unit Manager. They monitor remediation and system improvement activities to determine the effectiveness of changes made. This workgroup is comprised of the following:

a. Director, SDS, Workgroup Chair
b. Chief of Programs, SDS;
c. Deputy Director, SDS;
d. Information Technology Project Manager, DHSS; and
e. Program/Unit managers
    1. Home and Community Based Waivers
    2. Assessments
    3. Research and Analysis
    4. Grants
    5. Personal Care Assistance
    6. Systems Development Manager
    7. Quality Assurance (QA)
    8. Adult Protective Services
    9. Operation Integrity Unit
    10. Administrative Operations

As the Committee Chair, the SDS Director is accountable for all of the QIW activities.

External Parties/Self-Advocates/Advocates

The QISC and QIW coordinate efforts and exchange information with organizations such as: Health Facility Certification Licensing Unit, Long-Term Care Ombudsman's Office, Board of Nursing, Board of Social Work Examiners, Division of Occupational Licensing, and the Governor's Council on Special Education and Disabilities, the Alaska Commission on Aging, and other stakeholders and partner agencies.

Program Managers

Assessment Unit Manager is responsible to manage the assessment, reassessment and level of care determination processes for CCMC, OA, and APD waivers as well as quality control for those three waiver assessments and reassessments. This manager is responsible for the delivery of timely assessments and reassessments, remediation of performance problems and reporting of system improvement needs to the QIW.

Waiver Unit Manager is responsible for timely service plan reviews for all four waivers, including review of service plans for congruency with assessed needs. This manager is also responsible for timely MRDD waiver assessments and redeterminations, quality control of MRDD waiver assessments and redeterminations, remediation of performance problems and reporting of system improvement needs to the QIW.

The Quality Assurance Unit Manager is responsible for monitoring of performance measures related to Qualified Providers, Health and Welfare, Financial Accountability and participant choice safeguards.

The Research and Analysis Team (RAT) Unit Manager is responsible for developing data reports and analysis. This individual (or designee) is integrated into all aspects of the Quality Improvement Strategy to address data needs and facilitates communication with System Technology for programming and IT needs.

The Operations Integrity Unit (OIU)Manager is responsible for provider training and Fair Hearing data and analysis.

Task Committees

Several ***Task Committees (TC)*** have been developed to focus on specific areas of performance. These committees are comprised of program/unit staff or mixed program/unit staff based upon the needs and topic. Each group is Chaired (or Co-Chaired) by a unit manager(s) who is also a member of the QIW. ***These managers are the first line of discovery and remediation***. They are the charged with monitoring and evaluating data, providing or directing individual remediation, identifying need for system improvement and managing system improvement processes for the areas they manage. The Chair (or Co-Chair) for each committee is accountable for the activities of the Task Committee. As such, they will compile information and make final decisions. In addition, the Deputy Director and Chief of Programs closely monitor each TC and participate as applicable.

The TC's, through their respective Chair, submit their findings and analysis to the Quality Improvement Workgroup (QIW) via the monthly reports created by the respective task committees. In addition to reviewing the findings and taking action when necessary, the QIW is responsible to identify when new or additional task committees are required to meet the Division's needs. Task Committees may include, but are not limited to:

a. Mortality Review;
    1. Qualified Mental Retardation Professional (QMRP)
    2. Registered Nurse (RN)
    3. Quality Assurance Unit Manager (Committee Chair)
    4. Mortality Review Coordinator
    5. Adult Protective Services (APS) staff (serve protection and advocacy agency role)
    6. Expansion of the Mortality Review Committee to others will be researched prior to Alaska's Waiver renewal submission to determine the need/desire to included individuals external to the State. Public reporting and feedback loop will be developed.

As the Committee Chair, the Quality Assurance Unit representative is responsible for compiling the information and making final decisions regarding the mortality review process.

b. Level Of Care Review;
    1. Waiver Unit Manager (Committee Co-Chair)
    2. Assessment Unit Manager (Committee Co-Chair)
    3. Research and Analysis Team Manager
    4. Quality Assurance Unit Manager
    5. System Development and Support Unit Manager
    6. Personal Care Assistance Unit Manager

c. Qualified Provider Review;
    1. Certification staff

2. Quality Assurance Unit Manager (Committee Chair)
3. Operations Integrity Unit Manager
4. Training Coordinator
5. System Development and Support Unit Manager
6. Grants Unit Manager

d. Case Record Review;
   1. Quality Assurance Unit Manager (Committee Chair)
   2. Waiver Unit Manager
   3. Assessment Unit Manager
   4. Operations Integrity Unit Manager
   5. Research and Analysis Team Manager

e. Fair Hearings
   1. Fair Hearing Coordinator
   2. Operations Integrity Unit Manager (Committee Chair)
   3. Assessment Unit Manager
   4. Waiver Unit Manager
   5. Personal Care Assistance Unit Manager
   6. System Development and Support Manager
   7. Quality Assurance Unit Manager

f. Policy and procedures
   1. Waiver Unit Manager
   2. Assessment Unit Manager
   3. Quality Assurance Unit Manager
   4. System Development and Support Unit Manager (Committee Chair)
   5. Research and Analysis Team Manager
   6. Grants Unit Manager
   7. Operations Integrity Unit Manager
   8. Personal Care Assistance Unit Manager
   9. Adult Protective Services Unit Manager
   10. Administrative Operations Unit Manager

g. Health and Welfare Review
    1. Waiver Unit Manager
    2. Quality Assurance Unit Manager (Committee Chair)
    3. Operations Integrity Unit Manager
    4. Adult Protective Services Manager
    5. Assessment Unit Manager
    6. Personal Care Assistance Unit Manager
    7. Grant Unit Manager
    8. System Development and Support Unit Manager

h. Information Technology Committee
    1. IT Project Manager (Committee Chair)
    2. RAT Unit Manager
    3. Deputy Director
    4. Chief of Programs
    5. Administrative Operations Manager
    6. IT Business Analysis staff
    7. IT Programming Contractor, as applicable

i. Operational Processes Committee
    1. RAT Manager (Committee Chair)
    2. Waiver Unit Manager
    3. Assessment Unit Manager
    4. Quality Assurance Unit Manager
    5. System Development and Support Unit Manager
    6. Research and Analysis Team Manager
    7. Grants Unit Manager
    8. Operations Integrity Unit Manager
    9. Personal Care Assistance Unit Manager
    10. Adult Protective Services Unit Manager
    11. Administrative Operations Unit Manager

Reporting Activities

a. The Task Committees, through their designated Chairs, and the QA Manager, or designee, prepare standardized monthly (with the exception of mortality review, which is quarterly) reports for the QIW based on the performance measures approved by the QISC. QIW Reports include at minimum:
   1. Monthly, quarterly and annual cumulative aggregated data of findings and corrective actions taken at the program/ unit levels as identified through the task committee review activities
   2. Historical data for use in comparing similar reporting periods
   3. Summary of findings and recommended action, including preliminary trends identified by the task committee or individual program/ unit assigned to monitoring performance measures
   4. Assignments of tasks associated with completing identified corrective action
   5. Summary of system changes implemented based on recommendations of the QIW and QISC
   6. Summary status reports on any outstanding system changes in process
   7. Assessment of effectiveness of changes

b. The QA Unit Manager, or designee, prepares reports for the QISC. QISC reports synthesize the activities of the QIW and report the overall status of performance measure outcomes, indentified trends, and recommendations of the QIW.

c. The QISC, through the Chair, or designee, prepares a quarterly report that is submitted to members and the DHSS Commissioner on key indicators of program performance. In addition, a monthly report is provided from QIW, through the Chair, or designee, on specific identified performance measures (e.g., LOC review and Critical Incident).

SDS REPORTS LIBRARY

A summary of SDS reporting activities is found in the following chart:

SDS REPORTS LIBRARY						
QISC = Deputy Commissioner, State Medicaid Director, LTC Medical Assistance Administrator, DHSS QA/Audit, SDS Director, SDS Deputy Director, SDS Chief of Programs, SDS QA Manager **QIW =** SDS QA Manager, Waiver Unit Manager, Personal Care Unit Manager, OIU Manager, RAT Manager, Systems Development Manager, Chief of Programs, Deputy Director, Director, Grants Unit Manager, Adult Protective Services Manager, content expert on invite						
Name of Report	**Purpose**	**Data Origin**	**Frequency**	**Owner**	**Shared With**	**Remediation**
LOC Evaluation Status Report	Assess status of each reassessment due (can also look at those coming due for any future period)	DS3	Weekly	Created and analyzed by Assessment Unit Manager (OA/APD/CCMC) & Waiver Unit Manager (MR/DD)	Chief of Programs	Remediation efforts are undertaken by the Assessment Unit Manager & Waiver Unit Manager. If budget is implicated, remediation requirements are reported to Director
Forward-Looking Reassessment report	Analyze reassessments coming due each week and incorporate into staffing.	DS3	Weekly	Created and analyzed by Assessment Unit Manager (OA/APD/CCMC) & Waiver Unit Manager (MR/DD)	Chief of Programs	Remediation efforts are undertaken by the Assessment Unit Manager & Waiver Unit Manager. If budget is implicated, remediation requirements are reported to Director
SDS Quality Monitoring Report	Single source for QA to include: performance measure monitoring: • Discovery • Remediation	QA staff/DS3	Monthly	Quality Assurance Manager	Quality Improvement Workgroup. Recommendations and concerns are shared with: Process owners and Quality Improvement Steering Committee	Remediation efforts are undertaken by the Unit Manager responsible for the particular performance measure of concern. Upon review of the remediation actions taken by the respective manager, the QIW may make recommendations of systemic improvements relay them to the Director. Concerns identified by QISC are conveyed to the Deputy Commissioner &/or Commissioner.

Staffing Management Reports	Identified metrics to assist with identification of staffing adequacy	Assessment Unit Manager, Waiver Unit Manager, DS3	Monthly	Division Director	Deputy Director, Chief of Programs, Deputy Commissioner	Remediation efforts are decided upon by the Division Director and/or Unit Manager, in consultation with the Deputy Commissioner when required.
LOC Variance Report	Identify when there is no LOC date in DS3 and the rationale.	DS3	Monthly	Quality Assurance Manager	Assessment Unit Manager, Waiver Unit Manager & QIW. Recommendations and concerns are shared with: Process owners Quality Improvement Steering Committee	Remediation efforts are decided upon by the Unit Manager responsible for the particular process at issue. Recommendations for system improvement, additional remediation, and concerns identified by QIW are relayed to the Director. Concerns identified by QISC are conveyed to the Deputy Commissioner &/or Commissioner.
Fair Hearing Data and Analysis Report	Monitoring frequency of fair hearing request, by program and dispute type as well as monitoring outcome. Analysis of data to provide program and process improvement opportunities.	Office of Hearings and Appeals, SDS Fair Hearing Coordinator	Monthly	Operations Integrity Unit Manager	Quality Improvement Workgroup Recommendations and concerns are shared with: Process owners Quality Improvement Steering Committee Department of Law	Remediation efforts are decided upon by the Unit Managers responsible for the process at issue. Recommendations and concerns identified by QIW are relayed to the Director.
Mortality Review Report	Track and aggregate mortality review activities including agency reporting timelines, response and outcomes of reviews (causes, manner of death) to identify trends in agency behavior or response	Mortality review team reports; bureau of vital statistics	Quarterly	Quality Assurance Manager	Quality Improvement Workgroup	Remediation efforts are decided upon by the Unit Managers for the processes at issue. Recommendations and concerns identified by QIW are relayed to the Director. Concerns identified by QISC are conveyed to the Deputy Commissioner &/or Commissioner.

QIW Strategy Report	To inform QIW of the status of key program operations. Monthly, quarterly and annual aggregate data of findings and remediation taken at the program/unit levels.	Program Managers through Deputy Director then Director	Monthly	Division Director	Quality Improvement Workgroup	QIW reviews individual remediation actions taken by Unit Managers and agrees with actions or recommends additional actions. Recommendations for system improvements are made by QIW, through the Chair (SDS Director), after analysis of findings. Summary status reports on any outstanding system changes in process will be requested by QIW, through the Chair (SDS Director).
Quarterly Quality Improvement Steering Committee Report	QA unit prepares report for QISC. Report synthesizes the activities of the QIW and reports the overall status of performance measure outcomes, identified trends and recommendations of QIW.	Program Managers through QA/QIW	Quarterly	Quality Assurance Manager	QISC, DHSS Commissioner	QISC, through the Chair (Deputy Director) may request further study by a task committee and/or QIW and make recommendations for incorporating knowledge gained to improve upon standards and practices. Recommendations for system improvements are made by QISC after analysis of findings.
Task Committee Reports • Mortality Review • Level of Care • Qualified Providers • Case Record Review • Fair Hearing Review	Task Committees develop monthly reports to QA. These reports contain the relevant data to the task committee, summary of findings and remediation actions.	Task Committee through participating Program Manager	Monthly or Quarterly depending upon Task Committee	Task Committee Chair	Quality Improvement Workgroup	Individual remediation is performed by Unit Manager responsible for relevant subject matter.

• Policy & Procedure • Health and Safety Review • IT • Operational Processes Committee						
Monthly Key Indicator Report to DHSS Commissioner	QA unit prepares a monthly report for the DHSS Commissioner on key indicators as determined by QISC (e.g., measure of LOC currency and timeliness of response to Critical Incident Reports).	QA Unit	Monthly	QA Unit, reviewed by Division Director	DHSS Commissioner	DHSS Commissioner may require corrective action, study or additional information based on report information.
SDS Annual Report	Summary of CQI activities.	QA Unit, Program Managers, QIW	Annual	SDS	QISC approves	Summary report.

SPECIFIC QUALITY IMPROVEMENT STRATEGIES

Discovery and Remediation Activities

DHSS administers the key elements of the Waiver programs. Community Care Coordinators are certified by SDS and oversight is provided by SDS's quality assurance unit. Performance measures and remediation strategies are components of the Quality Improvement Strategy. Activities or processes related to discovery and remediation that provide the foundation for quality improvement include:

1. ***Performance Measures are Established and Communicated***
   - Performance measures are documented and serve as the framework for discovery and remediation activities.
   - The Quality Assurance unit collects, aggregates and analyzes data on compliance with performance measures.
   - The individuals/units responsible for collecting data, the mechanism and frequency of collecting data and reporting are documented.

2. ***Daily - Division Program Managers Quality Assurance***
   - Remediation strategies are being identified and a protocol for collecting, aggregating and reporting the data is being developed.
   - Responsible entities for conducting remediation are being identified.
   - Remediation strategies will be documented in a remediation policy.
   - A reporting structure for remediation needs/efforts is being developed.

3. ***Daily - Division Quality Assurance***
   - The Quality Assurance unit submits a monthly SDS Quality Assurance report on all performance measures to the Quality Improvement Workgroup (QIW) on a monthly basis. The QIW is comprised of the SDS Unit Managers, Chief of Programs, Deputy Director and others as defined in the QIP.

4. ***Monthly - Division Level QIW***
   - The QIW analyzes and discusses the monthly, quarterly and annual cumulative aggregated data, identifies opportunities for improvement, makes a request for a corrective action(s) / process improvement plan to the unit manager for the identified concern related to program, process, operation or outcome and submits a report of findings to the Quality Improvement Steering (QIS) committee in their quarterly meetings. The QISC is comprised of DHSS leadership including: DHSS Deputy Commissioner overseeing SDS, State Medicaid Director, LTS Medical Assistance Administrator, DHSS QA/Audit representative, SDS Director, SDS Deputy Director, SDS Chief of Programs, and SDS QA Manager.

5. ***Quarterly - Department Level QISC***
   - On a quarterly basis, the QISC reviews the submissions of the QIW and makes recommendations for improvements to programs, processes, operations or outcomes.

Supplemental Quality Improvement Strategy Action Items

In developing the Corrective Action Plan, SDS came to understand that there were elements of a comprehensive Quality Improvement Strategy that did not correlate with a specific assurance/sub-assurance therefore; the following table of action items was created to capture those additional activities to be accomplished for SDS's evolving Quality Improvement Strategy. The following table represents action items specific to Quality Improvement Strategies that are not reflected in other areas of the Corrective Action Plan.

In addition to the Quality Improvement Strategy elements described elsewhere in the Corrective Action Plan as they relate to specific assurances/sub-assurances, the Quality Improvement Strategy employed by Alaska will be augmented by the following actions. These actions will support all four Waiver Programs: Older Alaskans, Adults with Physical Disabilities, Children with Complex Medical Conditions and Persons with Mental Retardation/Developmental Disabilities.

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
1.	Engage the participant and provider community in talking forums to elicit feedback and forge collaborative relationships re: employing quality improvement strategies.	Director Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Managers, Deputy Director, Systems Development and Support Manager	9/3/09	Forums have been conducted.	8/28/09 – 6 provider forums have been conducted.
2.	Work with NQE as required in initial and continued corrective action plan development and implementation.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	8/17/09	Ongoing collaboration.	DSDS has worked with Thomson Reuter onsite and in an ongoing fashion will continue to work with their designated team.

3.	Incorporate continual quality improvement analysis in QIW and QISC functions to ensure ongoing monitoring and analysis of system design changes and monitoring methods employed.	QA Unit Manager Quality Improvement Steering Committee	2/1/10	Quality Improvement Plan, one element of the SDS Quality Improvement Strategy, is updated.	11/9/09 Quality Improvement Plan has been updated and submitted to QIW and QISC for feedback. 11/20/09 – Feedback is incorporated and will be resubmitted for final adoption.
4.	a. Analyze the continued use of PES tool to elicit participant feedback in relation to the staffing resources required to utilize this tool meaningfully vs. an alternate method of engaging participants in providing feedback to enhance quality strategies.	QA Unit Manager	2/25/10	Recommendation is reported to QIW.	11/20/09 – Investigation of tools is underway. Will work with NQE to obtain additional information from other states. 12/17/-09 – meeting with NQE re: survey requirements and options
	b. Develop and implement chosen strategy to elicit participant feedback.	QA Unit Manager	5/27/10	New chosen strategy is in place and feedback is being elicited.	12/17/09 – Teleconference with NQE regarding best practice.
5.	Establish a process for how reports will be distributed, who will review, who will approve, who will ensure that necessary system improvements are made.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	2/1/10	Process is documented in the Quality Improvement Plan, a component of the Quality Improvement Strategy.	11/1/09 – SDS reports library created.
6.	Conduct gap analysis for data control and staff education needs regarding data entry procedures and data definitions.	RAT Unit Manager Others involved: QA Unit Manager	2/25/10	Educational needs are reported to QIW.	1/4/10 – IT Committee created to manage SDS IT needs • RAT Unit role redefined to remove efforts related to DS3 programming and emphasize SDS staff training related to data integrity and process documentation • Operational Processes committee created to facilitate documentation of business processes to ensure consistent data definitions • Standardized process mapping method adopted by SDS (StarUML) • Weekly StarUML trainings implemented for SDS

					staff
7.	Reevaluate and implement changes to the quality review activities conducted by OIU to reduce duplication and directly tie activities to the DSDS QIS.	OIU Manager Others involved: Waiver Unit Manager, QA Unit Manager, Chief of Program	1/28/10	Workgroup feedback to QIW is documented in minutes.	8/28/09 – Formulate workgroup and evaluate feasibility of project.
8.	Develop monthly report of specific measures to Commissioner.	QA Unit Manager	12/17/09	First report is drafted and delivered to DHSS Commissioner.	
9.	DHSS Commissioner will provide input on the composition of the QISC Key Indicator report	DHSS Commissioner	1/11/10	Commissioner has provided input on report.	
10.	Review current QISC to assess strengths and identify any gaps that need to be addressed.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	3/1/10	Review findings are documented in QISC minutes.	Gap analysis has been conducted. Initial discussions with QISC have occurred and will continue as Quality Improvement Plan is finalized.
11.	Develop an updated SDS organization chart and publish on SDS website.	Administrative Operations Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	2/12/10	Organizational chart is documented.	

12.	Updated SDS organizational chart will be reviewed by the Deputy Commissioner for Family, Community and Integrated Services with final approval by SDS Director.	SDS Director	2/10/10	Organizational chart is approved.	
13.	Develop updated SDS descriptions of units/teams/committees/work-groups and functions related to quality improvement.	Administrative Operations Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	2/26/10	Descriptions are documented	
14.	DHSS Commissioner will provide input on the composition of the QISC Key Indicator report	DHSS Commissioner	2/10/10	Commissioner has provided input on report.	
15.	Establish valid sampling approaches for each performance measure where less than 100% of population will be reviewed.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	2/25/10	Sampling approach is reflected in performance measures approved by QISC.	Preliminary discussions with NQE have occurred.
16.	Develop a comprehensive plan for trending, prioritizing and implementing system improvements founded on evidence created by monitoring performance measure compliance/variances and remediation activities.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	10/1/10	Comprehensive plan is documented.	8/28/09 – Formulated workgroup and evaluated feasibility of project.

17.	Analyze feedback from participant and provider community and develop a plan to incorporate relevant and contemporary feedback into quality improvement strategies.	System Development Manager Others involved: QA Unit Manager, Deputy Director, Chief of Programs, Director	7/1/10 and ongoing	Feedback is reflected in QIW and/or QISC discussions.	
18.	Develop a description of cross-waiver Quality Improvement Strategies to be included in the waiver renewal applications.	QA Unit Manager Others involved: Chief of Programs, Assessment Unit Manager, Waiver Unit Manager, RAT Unit Manager, ITS Manager, OIU Manager	10/1/10	Description is documented.	
19.	Establish a system for generating performance reports. Identify necessary IT changes and staff development needed for producing reports.	ITS Manager Others involved: QA Unit Manager, RAT Manager	2/18/11	System is documented.	

ADMINISTRATIVE AUTHORITY

Sub-assurance 1: the Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Realign coverage of habilitation services to avoid appearance of "waiver inside a waiver" as identified in the APD waiver.					
1.	Address the current issues identified in the APD Waiver regarding habilitation services.	Systems Development Manager Others involved: RAT Unit Manager, QA Unit Manager, Waiver Unit Manager, Chief of Programs, OIU Manager	10/20/10	"Waiver within a waiver" is eliminated.	
	a. Conduct management meeting(s) to determine remediation strategy.	Deputy Director	1/22/10	Meeting(s) are documented, including program decision as to method of restructuring waiver plan to avoid "waiver within a waiver".	12/15/09 – Meeting conducted.
	b. Submit waiver amendment to CMS for review and approval, if required.	Deputy Director	1/29/10	Waiver amendment is submitted.	
	c. Develop implementation plan for waiver change.	Deputy Director	2/15/10	Implementation plan is documented.	

	d. Implement selected policy change regarding habilitation services available/not available for all APD waiver participants. Plan "B" – if regulatory change is required prior to implementation, start date is 10/20/10.	Waiver Program Manager Others involved: Chief of Programs	5/14/10	Implementation per plan has been initiated.	
	i. Provide education/communication to key stakeholders on policy change.	OIU Manager	4/15/10	Identified media distribution has occurred.	
	e. Secure regulatory amendments as required to address APD waiver participants with MR diagnoses to access habilitation service.	System Development Manager Others involved: RAT Unit Manager, QA Unit Manager, Waiver Unit Manager, Chief of Programs, OIU Manager	10/20/10	Regulations have been put into effect.	
Goal #2: Current CMS approved Waiver Plans and amendments will be communicated to providers, recipients and the public through the SDS website.					
1.	Update the SDS website to reflect current public information and develop process for maintaining currency with this information.	System Development Manager	1/25/10	Current waiver with amendments is reflected on SDS website.	
Submit to CMS: Waiver amendment re: habilitation services, if required					

LEVEL OF CARE

Sub-assurance 1: **Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual level of care (LOC) evaluation.**

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Complete initial LOC evaluations prior to the delivery of Waiver services.					
1.	Develop a LOC Evaluation Status Report to be reviewed weekly by the Assessment Unit Manager (OA/APD/CCMC) and the Waiver Unit Manager (MRDD) that portrays the status of each pending assessment including whether or not the application is complete; if the assessment is scheduled and when; if the assessment is completed and when; if the assessment is in quality control for review; and if the completed assessment has been submitted and LOC determination made.	RAT Manager	10/15/09	LOC Evaluation Status Report is drafted and the Assessment Unit manager and Waiver Unit manager have each received first weekly copy.	LOC Evaluation Reports are available. Still to be developed is the ability to track whether or not a Medicaid waiver application has been completed.
2.	Analyze weekly initial LOC Evaluation Status Report findings and report to Chief of Programs. Develop remediation plan, if required.	Assessment Unit Manager for APD/OA/CCMC Waiver Unit for MRDD	11/2/09 and ongoing	Findings are analyzed and shared, in writing, from the Manager to the Chief of Programs, if required, to the Director and to the QIW.	Weekly reports are available. Process of reviewing weekly is being developed.

	a. If analysis of weekly data reveals that initial LOC evaluations are not being conducted timely, written notice will be immediately provided to the Division Director with a written plan of correction. b. The Division Director will respond promptly to the proposed plan of correction regarding adjustments to the proposed plan or concurrence that it be followed as developed. c. A QIW Program Report reflecting key indicators of program operations, to include LOC completion data, will be provided to QISC for review and analysis. • QISC will review data on a quarterly basis, or more often if required.	a. Assessment Unit Manager / Waiver Unit Manager b. Chief of Programs c. Division Director			
Goal #2: Establish a systematic, data-driven Quality Improvement Strategy to monitor defined performance measures related to initial LOC evaluations, discover concerns, remediate issues and re-measure effectiveness of interventions.					
A.	**Define Performance Measures related to initial LOC evaluation and implement data-driven monitoring strategy to monitor Performance Measures and discover process concerns related to initial LOC evaluation.**				
1.	Develop performance measures related to initial LOC evaluations	QA Unit Manager	2/25/10	Performance measures are documented.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to SDS.
2.	Develop monitoring process for performance measures regarding initial assessments for individual LOC evaluations.	QA Unit Manager	4/26/10	Monitoring process is documented in Quality Assurance unit guidelines.	

	a. Identify data source for performance measures related to initial LOC evaluation.	QA Unit Manager	2/25/10	Data source is documented.	9/11/09 - Data source identified for proposed performance measures.
	b. Identify responsible person/unit to generate data for performance measure related to initial LOC evaluation.	QA Unit Manager Others involved: RAT Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - RAT is unit identified as responsible for generating data for performance measures.
	c. Determine sampling method for performance measures related to initial LOC evaluation.	QA Unit Manager	2/25/10	Sampling method is documented.	9/11/09 - Sampling method of 100% review for all Waiver programs established for proposed performance measures.
	d. Determine monitoring frequency for performance measures related to initial LOC evaluation.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring frequency is documented as monthly for proposed performance measures.
	e. Develop monitoring tools for performance measures regarding initial LOC evaluation.	QA Unit Manager	4/26/10	Monitoring tool is in place.	8/20/09 - identified as a need in GAP analysis.
	f. Submit LOC Performance Measure monitoring tool to CMS for review and feedback.	QA Unit Manager	4/26/10	Feedback is received from CMS re: monitoring tool	
3.	Provide quality assurance and assessment unit staff education re: initial LOC evaluation performance measures and process.	OIU Manager	4/5/10	100% of assessment unit staff and waiver unit staff who manage any portion of applications, including but not limited to: applications received, scheduling and conducting assessments and QA staff who collect, analyze and/or report data will be educated.	
4.	Begin to collect data required to monitor initial LOC evaluation performance measures. This data will be collected in ongoing fashion and	QA Unit Manager	4/26/10	Monitoring tool is being populated with data.	

	will be presented in monthly SDS Quality Monitoring Report.				
	a. Data points related to LOC are defined and documented to ensure data is valid and reliable. Data elements such as "date of completed application", "date of assessment", "date of level of care determination", etc. are identified and clearly defined in order to provide a basis for accurate reporting on timeliness of level of care processing by all parties involved.	RAT Manager	2/25/10	Data points are documented	Initial data points have been defined for OA, APD, and MRDD. CCMC to be defined. LOC determination for CCMC will be defined by the use of the "Level of care" date that is currently used. This will continue until the CCMC assessment system has been deployed into production
	b. Data is tracked and trended and presented in monthly, quarterly and annually aggregated fashion for analysis.	RAT Manager	4/26/10	Report format is developed and implemented.	Initial data points have been defined for OA, APD, and MRDD. CCMC to be defined. LOC determination for CCMC will be defined by the use of the "Level of care" date that is currently used. This will continue until the CCMC assessment system has been deployed into production
5.	Submit first monthly SDS Quality Monitoring Report on discovery and remediation of LOC performance measures to QIW for review and analysis.	QA Unit Manager	6/24/10	Meeting minutes document review of monthly SDS Quality Monitoring Report and any recommendations made by QIW.	
	a. In their monthly review activities, QIW conducts discovery by critically analyzing the monthly/quarterly/annually aggregated discovery and remediation data for the following: i. *individual problems have been addressed* ii. *Identify specific opportunities for*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	

	systemic improvement				
	b. If QIW discovers specific opportunities for remediation and system improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* ii. *Implement system improvement* iii. *Evaluate efficacy of system improvement* iv. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Meeting minutes reflect action taken.	
B.	**Develop and implement remediation strategies and system improvement strategies to address problems with performance measures found through monitoring and discovery.**				
1.	Develop and implement remediation policy to address concerns discovered during ongoing monitoring of initial LOC evaluations.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager, Chief of Programs, Deputy Director, Division Director	6/15/10	Policy is drafted, approved and implementation begun.	
	a. Provider Remediation i. Develop remediation policy.	QA Unit Manager Others involved: System Development Manager, OIU Manager, Division Director, Deputy Director, Chief of Programs	4/2/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review	Policy is signed and placed into effect.	

			5/28/10 – public comment closes 6/15/10 – signed by SDS Division Director and put into implementation		
	ii. Submit remediation policy to CMS for review and feedback.	QA Unit Manager	4/28/10	Policy has been submitted to CMS for review and feedback.	
	b. Identify who tracks and trends the aggregated data and analyzes performance measure data related to initial LOC evaluation remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	c. Identify frequency of initial LOC evaluation performance measure remediation data aggregation and analysis.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	9/11/09 - Data aggregation and analysis frequency is documented as monthly.
	d. Identify person responsible to address individual issues related to initial LOC performance measures.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	e. Identify individual/group responsible to address systemic issues.	QA Unit Manager Others involved: QIW	2/25/10	Responsible individual/group is documented.	9/11/09 - Responsible group is documented as QIW.
2.	Provide staff training to Assessment Unit Manager, Waiver Unit Manager, and QA staff that collect, aggregate and/or analyze remediation data re: initial LOC evaluations. (Provider training will be reflected in Qualified	OIU Manager	5/20/10	100% Assessment Unit Manager, Waiver Unit Manager, QA staff who collected, aggregate, and/or analyze remediation data	

	Provider section.)			re: initial applications/ evaluations, OUI and QA staff who provide technical assistance and QA staff who deliver provider oversight staff will be trained.	
3.	Begin to collect data on remediation efforts related to LOC performance measure failures. Data collection will be ongoing and will be reflected in the Monthly SDS Quality Monitoring Report.	QA Unit Manager	6/15/10	Data collection tool is being populated re: remediation efforts for initial LOC evaluation performance measures.	
4.	Submit first SDS Monthly Quality Monitoring Report to QIW regarding discovery and remediation efforts for performance measure failures.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first SDS Quality Monitoring Report.	

Level of Care

Sub-assurance 2: The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

ACTION ITEM		RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Eliminate the backlog of reassessments overdue and conduct timely LOC reevaluations annually and complete all future reassessments within 1 year of prior LOC evaluation.					
1.	Develop weekly (and as needed) Waiver Participant Backlog Status Report identifying each waiver program participant (by waiver type) who has a reassessment due or overdue.	RAT Manager	8/20/09	Reports are available to the Assessment Unit Manager for OA/APD and CCMC waivers and the Waiver Manager for MRDD waiver participants on a weekly basis.	8/20/09 - Reports of the "backlog list" and those "coming due (forward-looking)" have been created and are accessible by managers within DS3 for OA & APD waiver programs. Ad hoc manual reports are created upon request for MRDD and CCMC.

2.	a. Create a projected timeline for completion of reassessment backlog of 10/15/09 based on resources available; adjusting concurrently with changing resources and institute weekly monitoring and reporting through 12/15/09.	Deputy Director	12/15/09	Timeline created and revisited weekly.	9/23/09 - Serial timelines have been created/edited for OA/APD since 8/2/09.
	b. Explore alternative approaches to adjust projected reassessment work load to even out spikes created by accomplishing reassessment backlog in 2009 and obtain CMS approval to implement chosen adjustment.	SDS Director	1/25/10	Readjustment plan is deployed.	1/7/10 2nd proposal submitted to CMS
3.	Identify the current status (i.e., scheduled for assessment, in the hospital, unresponsive to attempts to schedule reassessment, etc.) of each waiver participant with a reassessment due or overdue on a weekly basis.	Assessment Unit Manager for OA/APD/CCMC Waiver Unit Manager for MRDD	12/15/09	Weekly status reports are prepared.	8/20/09 - weekly status reports are submitted 9/3/09 - weekly reports revised for OA/APD to show increased specificity 9/15/09 - weekly reports for MRDD revised to show individuals coming due for reassessment.
4.	Develop an automated LOC Evaluation Status report to replace the manually created report utilized beginning 8/20/09 to be reviewed weekly by the Assessment Unit Manager (OA/APD/CCMC) and the Waiver Unit Manager (MRDD) that portrays the status of reassessments including any overdue and those coming due in the next week (or otherwise specified time period).	RAT Manager	10/15/09	Report is drafted and Assessment Unit manager has received first weekly copy.	LOC Evaluation Status reports are available on the reporting server. Email subscriptions can be set up that automatically notify managers.
5.	Analyze weekly LOC Evaluation Status Report and provide discovery findings to Deputy Director/Director and/or Chief of Programs and develop remediation plan, if required to prevent backlog development. (Monthly, quarterly and annual data re: compliance with	Assessment Unit Manager for APD/OA/CCMC Waiver Unit for MRDD	11/2/09	Findings are analyzed and shared, in writing, with Deputy Director/Director and/or Chief of Programs.	Weekly reports are available. Process of reviewing weekly is being developed.

	LOC assessment/reassessment timelines is presented in the QIW Monitoring Report and the SDS Quality Monitoring Report as reflected elsewhere in this section of the CAP.)				
	a. If analysis of weekly data reveals that annual LOC evaluations are not being conducted timely, resulting in a backlog written notice will be immediately provided to the Division Director with a written plan of correction. b. The Division Director will respond promptly to the proposed plan of correction. c. A QIW Strategy Report reflecting key performance measures, to include LOC completion data, will be provided to QISC for review and analysis. • QISC will review data on a quarterly basis, or more often if required.	a. Assessment Unit Manager / Waiver Unit Manager b. Deputy Director, Chief of Programs c. Division Director	11/2/09 ongoing	Findings are analyzed and shared, in writing, with Deputy Director/Director and/or Chief of Programs.	Weekly reports are available. Process of reviewing weekly is being developed.
Goal #2: Establish a systematic, data-driven quality improvement strategy to monitor defined performance measures related to annual LOC evaluations, discover concerns, remediate issues and re-measure effectiveness of interventions.					
A.	**Define Performance Measures related to annual LOC evaluation and implement a data-driven monitoring program to monitor Performance Measures and discover process concerns related to annual LOC determination.**				
1.	Develop performance measures related to annual LOC evaluations	QA Unit Manager	2/25/10	Performance measures are documented.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to SDS.

2.	Develop monitoring process for performance measures regarding annual reassessments for individual LOC evaluations.	QA Unit Manager	4/26/10	Monitoring process is documented in Quality Assurance unit guidelines.	
	a. Identify data source for performance measure related to annual LOC evaluation.	QA Unit Manager	2/25/10	Data source is documented.	9/11/09 - Data source identified for proposed performance measures.
	b. Identify responsible person to generate data for performance measure related to annual LOC evaluation.	QA Unit Manager Others involved: RAT Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - RAT is unit identified as responsible for generating data for performance measures.
	c. Determine sampling method for performance measures related to annual LOC evaluation.	QA Unit Manager	2/25/10	Sampling method is documented.	9/11/09 - Sampling method of 100% review for all Waiver programs established for proposed performance measures.
	d. Determine monitoring frequency for performance measures related to annual LOC evaluation.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring frequency is documented as monthly for proposed performance measures.
	e. Develop monitoring tools for performance measures regarding annual LOC evaluation.	QA Unit Manager	4/26/10	Monitoring tool is in place.	8/20/09 - identified as a need in GAP analysis.
	f. Submit monitoring tool to CMS for review and feedback.	QA Unit Manager	4/26/10	Monitoring tool has been submitted to CMS.	
3.	Provide training to identified staff re: remediation policy for performance measures related to annual LOC evaluations.	OIU Manager	4/5/10	100% of assessment unit staff and waiver unit staff who manage any portion of annual evaluations, including but not limited to: applications received, scheduling and conducting assessments and QA staff who collect, analyze and/or report data will be	

				educated.	
4.	Begin to collect data required to monitor annual LOC evaluation performance measures. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Unit Manager	4/26/10	Monitoring tool is being populated with data.	
5.	Submit SDS monthly Quality Monitoring Report on annual LOC evaluation performance measures discovery and remediation to QIW for review and analysis.	QA Unit Manager	6/24/10	Meeting minutes document review of SDS Quality Monitoring Report and any recommendations made by QIW.	
B.	**Develop and implement remediation strategies to address performance measures and process failures related to annual LOC evaluations.**				
1.	a. Develop remediation policy to address concerns discovered during ongoing monitoring of annual LOC evaluations.	QA Unit Manager/Systems Operations Manager Others involved: Division Director, OIU Manager, Chief of Programs, Deputy Director, System Development and Support	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by SDS Division Director and put into implementation	Policy is drafted.	

	b. Identify who aggregates and analyzes remediation data related to annual LOC evaluation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	c. Identify frequency of annual LOC evaluation remediation data aggregation and analysis.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	9/11/09 - Data aggregation and analysis frequency is documented as monthly.
	d. Identify person responsible to address individual issues related to annual LOC remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	e. Identify individual/group responsible to address systemic issues related to annual LOC performance measures.	QA Unit Manager Others involved: QIW	2/25/10	Responsible individual/group is documented.	9/11/09 - Responsible group is documented as QIW.
2.	Provide staff training re: remediation policy.	OIU Manager	5/20/10	100% of the following: Assessment Unit Manager, Waiver Unit Manager, QA staff who collected, aggregate, and/or analyze remediation data re: annual evaluations, OUI and QA staff who provide technical assistance and QA staff who deliver provider oversight will be trained.	
3.	Begin to collect data on remediation efforts related to annual LOC performance measure failures. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Unit Manager	6/15/10	Data collection tool is being populated re: remediation efforts for annual LOC evaluation performance measures.	

4.	Submit first monthly SDS Quality Monitoring Report to QIW regarding discovery and remediation efforts for performance measure failures related to annual LOC evaluations.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first SDS Quality Monitoring Report.	

Level of Care

Sub-assurance 3: The processes and instruments described in the approved waiver are applied to LOC determinations.

ACTION ITEM		RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Sufficient resources are in place to conduct processes described in the approved waiver for LOC determinations.					
A.	**To address short-term needs, evaluate immediate, short-term staffing needs based on current model of conducting initial and annual LOC evaluations, address identified GAP in needs, and establish an on-going process for monitoring staffing needs to conduct LOC assessments.**				
1.	Conduct initial and ongoing assessment of resource needs to schedule and conduct initial and annual LOC evaluations based on current practices.	Assessment Unit Manager; Waiver Unit Manager Others involved: Deputy Director; Chief of Programs	6/26/09 and ongoing	Determination is made regarding need for additional staff to schedule assessments.	6/26/09 - Staffing projections were developed for assessor needs based upon backlog numbers. 8/20/09 - Interim staffing analysis was conducted by assessment and waiver unit managers, project coordinator, SDS Deputy Director, SDS Director with input from Deputy Commissioner to specifically evaluate assessor staffing needs including initial LOC evaluations when moratorium is lifted, backlog, reassessments coming due, amendments, expedite/emergency evaluations and other assessor duties and clerks. .
2.	Implement staffing changes based upon evaluation of current model of conducting initial and annual LOC evaluations.	Division Director	6/26/09 and ongoing	Staff is being reassigned, vacant positions are being filled.	8/2/09 - Permanent and temporary staff added to the assessment unit. 8/20/09 - Vacant staff positions being filled. Call out to other Divisions to donate staff to assist. 8/28/09 - Additional staff added and reassigned as

					needs are identified and funding is available. Work flow processes being refined to promote efficiencies. 9/2/09 - 8 temporary clerk and 30 temporary assessor positions were approved.
3.	Develop a Forward-Looking Reassessment report to analyze reassessments coming due each week and incorporate into staffing analysis. This report looks weekly into the future, up to 12 months. The overall program census data is available for quarterly and annual trending data to project longer-term staffing needs.	RAT Manager	10/15/09	Report of applications for prior 2 years, by week, is submitted to Assessment Unit Manager.	8/20/09 - reports created to project OA/APD reassessments coming due. 9/16/09 - Report created to project MRDD reassessments coming due.
4.	Identify metrics and develop Staffing Management Reports to evaluate adequacy of staffing levels to conduct initial and annual LOC evaluations.	Deputy Director & Chief of Programs	2/26/10	First publication of first generation of Staffing Management Report.	9/1/09 - Identified initial data elements to comprise management reports.
5.	Staffing Management Reports are utilized to continuously monitor staffing needs to conduct initial and annual LOC evaluations in a timely manner.	Division Director	2/26/10	First management report is analyzed with the Assessment Unit Manager to evaluate adequacy of staffing based on identified metrics.	
6.	Identify and implement efficiencies to enhance productivity in daily operations for conducting initial and annual LOC determinations.	Division Director	6/26/09 and ongoing	Identified efficiencies are analyzed, put into effect and reanalyzed for efficiency.	Efficiencies have been identified by SDS and deployed and continue to be evaluated.

7.	Identify and analyze alternative staffing models to enhance productivity.	Deputy Director & Chief of Programs	3/26/10	Documented efforts to analyze staffing methods to enhance productivity.	11/12/09 & 11/13/09: Meeting with NQE re: staffing models.
	a. Discuss staffing options with NQE.	Deputy Director & Chief of Programs	3/26/10	Conversation occurs.	11/12/09 & 11/13/09: Meeting with NQE re: staffing models.
	b. Summary of analysis will be reported to CMS.	Deputy Director & Chief of Programs	4/26/10	Summary of factors evaluated and general findings will be provided to CMS.	
8.	Implement chosen staffing changes based on analysis of staffing models to conduct initial and annual assessments.	Deputy Director & Chief of Programs	10/25/10	A staffing plan is documented.	
9.	Evaluate effectiveness of chosen staffing changes to conduct initial and annual assessments.	Deputy Director	5/2/11	Review weekly and aggregated reports demonstrating assessment timelines/backlog data.	
B.	**Evaluate alternative models for delivery of initial and annual LOC evaluations (i.e., initial assessments conducted by SDS vs. contractor vs. Care Coordinator, etc).**				
1.	Develop task force of SDS staff to define key program components to evaluate.	Deputy Director	10/5/09	Task force is created and has established regular meeting schedule.	Task force met with NQE and InterRAI. 7/28/09 – Preliminary teleconference re: program overview with Washington programs. 8/4/09 – Preliminary teleconference re: quality program overview with South Carolina programs. 8/17/09 – Begin discussions with NQE re: alternative models of program delivery. 9/10/09 – Preliminary teleconference re: program overview with Ohio programs. 11/09 – meeting with NQE

					1/10/10 – meeting with InterRAI
2.	Survey Waiver programs in other States and incorporate findings for a side-by-side comparison of the selected key program components.	Systems Development and Support Manager Others involved: Director, Deputy Director, Chief of Programs, Waiver Manager, Assessment Unit Manager, QA Manager	3/26/10	Task force has surveyed a sufficient sampling (as they determine it) of States and has created a spreadsheet of program characteristics by State.	
	a. Contact other state program managers/directors/coordinators, schedule and conduct telephone interviews and collect written materials.	Systems Development and Support Manager Others involved: Deputy Director, Director, QA Manager, Project Coordinator, Waiver Unit Manager, QA Unit Manager	3/26/10	Teleconferences are being conducted.	7/28/09 – Preliminary teleconference re: program overview with Washington programs. 8/4/09 – Preliminary teleconference re: quality program overview with South Carolina programs. 8/17/09 – Begin discussions with NQE to identify states to interview. 9/10/09 – Preliminary teleconference re: program overview with Ohio programs. 10/2/09 – Minnesota program approached to set up interview.
	b. Engage NQE in identifying states to interview.	Project Coordinator Others involved: Deputy Director, QA Manager, Project, Director Coordinator, Waiver Unit Manager, QA Unit Manager	3/26/10	States have been identified and contact information provided.	8/17/09 – Begin discussions with NQE to identify states to interview. 9/3/09 – Ohio contact information provided. 10/7/09 – Scheduled follow-up meetings with NQE re: alternative model of program delivery and staffing
3.	Compile research on Best Practice/ LOC determinations and any applicable tools.	Systems Development and Support Manager Others involved: Director, Deputy Director, Chief of Programs, QA Manager,	4/29/10	Results of research are documented.	7/28/09 – Preliminary teleconference re: program overview with Washington programs. 8/4/09 – Preliminary teleconference re: quality strategy overview with South Carolina programs. 8/17/09 – Begin discussions with NQE re: alternative models of program delivery.

		Assessment Unit Manager			9/10/09 – Preliminary teleconference re: program overview with Ohio programs.
4.	Analyze findings of survey and best practices and tools and submit a recommendation and prioritization of model, with pros/cons of each to the Division Director.	Systems Development and Support Manager Others involved: Deputy Director, Chief of Programs, QA Manager, Assessment Unit Manager	5/3/10	Document is submitted to Division Director.	
	a. Team meets and engages NQE in assessment of survey findings.	Systems Development and Support Manager Others involved: Deputy Director, Chief of Programs	4/5/10	Document is submitted to Division Director.	
	b. If new LOC determination tool is identified, tool is submitted to CMS for review and feedback.	Systems Development and Support Manager Others involved: Director, Deputy Director, Chief of Programs, QA Manager	5/3/10	Proposed tool is submitted to CMS.	
5.	Make decision regarding model for delivery of initial and annual LOC determinations.	Director	5/28/10	Memorandum to managers outlines decision regarding new model.	
6.	a. Develop an action plan for implementation of the chosen model to pursue for conducting initial and annual assessments for determination of LOC.	Systems Development Manager	5/21/10	Action Plan is developed and submitted to Unit Managers.	
	b. Submit action plan to CMS for review and feedback.	Systems Development Manager	5/28/10	Action plan is submitted to CMS for review and feedback.	

7.	c. Develop plan for SDS to begin to perform CCMC assessments for initial and annual LOC evaluations.	Assessment Unit Manager	3/18/10	Written plan is submitted to Deputy Director/Director.	
	d. Submit plan for SDS to begin to perform CCMC assessments for initial and annual LOC evaluations to CMS for review and feedback.	Assessment Unit Manager	4/9/10	Plan is submitted to CMS for review and feedback.	
8.	SDS staff begin to perform CCMC assessments for initial and annual LOC determinations.	Assessment Unit Manager	7/1/10	SDS assessor staff submit first assessments for LOC evaluations.	
9.	Submit waiver amendment if required.	Systems Development Manager	5/21/10	Waiver amendment is submitted.	
C.	**For long term planning, conduct a comprehensive business process analysis including staffing efficiencies, streamlining job functions, role definitions and job classification alignment, as they impact the initial and annual LOC determination processes. [This analysis, although it will reflect upon the short-term "Interim Staffing Analysis" addressed in Goal 1, A. i above, is far more detailed and will build upon the long-term strategies of the Division, as will be defined in the intervening months.]**				
1. 	Secure funding to conduct a third party business process analysis. Plan B: If there is no funding source identified by 5/3/10, a planning meeting will occur to identify alternate funding sources/solutions.	Division Director	5/3/10	Legislative approval of SDS budget request.	9-2-09: Request for supplemental to cover third party staffing analysis submitted.
	a. Identify SDS staff responsible to manage business process analysis contract.	Division Director	5/3/10	Role has been created and documented, including reporting requirements.	
	b. Define scope of project and timelines. Establish performance measures and completion date.	Division Director	5/3/10	Request for proposal or similar document is created to establish project parameters.	

	c. Post request for proposal/contract bids	Administrative Operations Manager	6/1/10	RFP or contract bid is posted.	
	d. Select contractor.	Division Director	8/1/10	Contract awarded (mutual signatures obtained).	8/13/09 - Research of contractor initiated.
	e. Completion of contract deliverables. (Anticipated to take anywhere from 6 to 12 months.)	Contractor (tbd)	2/1/11 to 8/1/11	Final report of analysis with recommendations has been submitted.	
	f. Work with NQE to develop a back-up plan in the event necessary funding is not available.	Division Director	5/3/10	Back-up plan is developed	
D.	**Develop detailed work plan to implement strategies identified in comprehensive business process analysis.**				
1.	Establish work group to address business process analysis findings. Identify work group composition, goals and project leader responsible for reporting progress.	Division Director	8/1/11	Charter is drafted including roles and responsibilities.	
	a. Group meets and reviews findings.	Division Director	8/1/11	Findings are analyzed and analysis is documented	
	b. Findings and analysis are reviewed with CMS.	Division Director	9/1/11	Findings are reviewed with CMS.	
2.	Prioritize business process analysis findings.	Division Director (Work group project leader when identified)	9/1/11	Project document is drafted to establish and communicate priorities.	
3.	a. Develop implementation plan for prioritized business process strategies.	Division Director (Work group project leader when identified)	9/1/11	Implementation plan is drafted and submitted to Division Managers.	
	b. Submit implementation plan to CMS for review and feedback.	Division Director (Work group project leader when identified)	9/1/11	Implementation plan is submitted to CMS for review and feedback.	

4.	Begin to implement strategies from business process implementation plan.	Division Director	9/1/11	Implementation plan is updated to illustrate implemented strategies.	
	a. Prepare and submit budget reflecting business process resource needs in relation to implementation plan.	Division Director	9/1/11	Budget is submitted.	
	b. As budget allows, fill identified vacancies.	Division Director	7/1/12	Hire for vacancies.	
	c. Incorporate identified efficiencies into operations.	Division Director	9/1/11	Plan is developed and documented to incorporate efficiencies.	
5.	Apply monitoring methods to new business process model and analyze effectiveness.	Deputy Director	7/1/12	Monitoring findings are documented and shared with Division Managers.	
Goal #2: Establish a systematic, data-driven quality improvement strategy to monitor defined performance measures related to application of the processes and instruments described in the approved waiver to LOC determinations.					
A.	**Define Performance Measures and implement data-driven monitoring strategy to monitor Performance Measures and discover individual/system concerns related to LOC determination processes and instruments.**				
1.	SDS staff working with Waivers will attend Version 3.5 Web Based Application and 372 Reporting Form training as offered by CMS.	OIU Manager	12/8/09	Identified staff have completed the mandatory online training.	August 18, 2009 - 104 DHSS/SDS staff completed the training.
2.	Develop performance measures	QA Unit Manager	2/25/10	Performance measures are documented.	8/17/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to SDS.
3.	Develop monitoring process for performance measures regarding LOC determination processes and instruments.	QA Unit Manager	4/26/10	Monitoring process is documented in Quality Assurance unit guidelines.	

	a. Identify data source for performance measure related to LOC determination processes and instruments.	QA Unit Manager	2/25/10	Data source is documented.	9/11/09 - Data source identified for proposed performance measures.
	b. Identify responsible person to generate data for performance measure related to LOC determination processes and instruments.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - responsible entities for generating data for performance measures identified.
	c. Determine sampling method for performance measures related to LOC determination processes and instruments for each waiver.	QA Unit Manager	2/25/10	Sampling method is documented	9/11/09 – Sampling method established for all waivers, where less than 100% sampling size, valid sampling approaches by waiver will be utilized.
	d. Determine monitoring frequency for performance measures related to LOC determination processes and instruments.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring method is documented.
	e. Develop case file review procedure and monitoring tool elements for reviewing use of approved forms.	QA Unit Manager	4/26/10	Procedure and monitoring tool are developed and is being populated with data.	
	f. LOC Performance Measures monitoring tool is submitted to CMS for review and feedback.	QA Unit Manager	4/26/10	Tool is submitted to CMS.	
4.	Provide SDS staff training to identified SDS staff who are involved in conducting initial and annual assessments from the waiver unit and the assessment unit and the unit managers as well as QA staff collecting, reporting and analyzing related data re: LOC processes and instruments.	OIU Manager	4/5/10	100% staff who are involved in conducting initial and annual assessments from the waiver unit and assessment unit and the unit managers as well as QA staff collecting, reporting, and analyzing related data will be trained in the performance measures related to processes and	

				instruments.	
5.	Begin to collect data required to monitor annual LOC evaluation performance measures.	QA Unit Manager	6/15/10	Monitoring tool is being populated with data.	
6.	Submit first SDS Quality Monitoring Report on annual LOC evaluation performance measure discovery and remediation to QIW for review and analysis.	QA Unit Manager	7/26/10	Meeting minutes document review of SDS Quality Monitoring Report and any recommendations made by QIW.	
B.	**Develop and implement remediation strategies to address performance measure and process failures.**				
1.	Develop Provider Remediation Policy to address concerns discovered regarding use of processes and instruments when conducting LOC assessments.	QA Unit Manager Others involved: Division Director, Deputy Director, Chief of Programs, System Development and Support	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by SDS Division Director and put into implementation		

	a. Identify who aggregates and analyzes performance measure data related to processes and instruments used when conducting LOC assessments.	QA Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified.
	b. Identify frequency of performance measure data aggregation and analysis related to processes and instruments used when conducting LOC assessments.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	9/11/09 - Data aggregation and analysis frequency is documented as monthly.
	c. Identify person(s) responsible to address individual issues related to processes and instruments used when conducting LOC assessments.	QA Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified.
	d. Identify individual/group responsible to address systemic issues related to processes and instruments used when conducting LOC assessments.	QA Unit Manager	2/25/10	Responsible individual/group is documented.	9/11/09 - Responsible group is documented as QIW.
2.	Provide training to identified SDS staff re: remediation policy for performance measures related to processes and instruments of initial and annual LOC evaluations. (Education for providers will be reflected in Qualified Providers section.)	OIU Manager	5/20/10	100% Assessment Unit Manager, Waiver Unit Manager and all staff whose performance will be monitored related to processes and instruments of initial and annual LOC evaluations, as well as QA staff collecting, reporting and analyzing data will be trained.	
3.	Begin to collect data on remediation efforts related to processes and instruments used when conducting LOC assessments.	QA Unit Manager	6/15/10	Data collection tool is being populated.	

4.	Submit first monthly SDS Quality Monitoring Report to QIW regarding discovery and remediation efforts for processes and instruments used for LOC assessments.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first report.	
	During the quality review process, CMS will request implementation data from the monitoring tool to see whether the QI Strategy is working. This will be the culmination of the CAP and a test of its effectiveness.	QA Manager	TBD	Implementation data will be submitted as evidence of the QI Strategy efficacy.	
C.	**Develop automated IT solutions to capture/track remediation actions for initial and annual LOC evaluation remediation activities.**				
1.	Develop Medicaid waiver application system to track waiver applicants/recipients from application to denial/approval of eligibility. Development process to include: requirements gathering, design review, data migration, data structure/business logic design, user interface development, systems testing, and deployment.	ITS Manager	2/15/10	Automated tool will be deployed and first data report provided to QIW for analysis.	Item included in current DS3 task order (8/17/09-1/31/10). 9/16/09 - Work group identified to meet weekly and draft charter developed.
	a. Implement policy defining specific requirements and processes for the four current waiver programs related to applying for a Medicaid waiver including when and how assessments are required and the roles of SDS staff involved in the processes.	Systems Development Manager	2/8/10	Policy is drafted and posted on the internet for public comment.	8/20/09 – Draft policy developed
	b. Submit Eligibility for Waiver policies to CMS for review and feedback.	Systems Development Manager	2/8/10	Policy is submitted to CMS for review and feedback.	
	c. Build interfaces that collect applicant information and place the applicant into a formal processing channel.	ITS Manager	6/16/10	Written report to Director that indicates interfaces are built.	

	d. Build processing reports that queue SDS staff to take action on application	ITS Manager	6/16/10	First reports are generated and delivered to identified stakeholders.	
	e. Develop letter generators that are tied into key process points (denial/approval/documentation required, etc.)	ITS Manager	6/16/10	Letters are in place and being generated appropriately.	
	f. Link application process to other key processes such as the ICAP or CAT assessment processes within DS3.	ITS Manager	6/16/10	Linkage is demonstrated to key stakeholders.	
D.	**Automate CCMC monitoring functions related to application of the processes and instruments.**				
1.	Develop CCMC assessment system to facilitate the scheduling, conduction of assessments, and level of care determinations.	ITS Manager	6/16/10	Completed system is demonstrated to key stakeholders.	
	a. Develop an automated tool to monitor the status of CCMC applications and redeterminations.	ITS Manager	6/16/10	Designed mechanism is demonstrated to key stakeholders.	
	b. Develop interfaces to capture assessment details such as date, nurse assessor and related info.	ITS Manager	6/16/10	Interfaces are demonstrated to key stakeholders.	
	c. Develop LOC Evaluation Status Reports identifying CCMC recipients requiring annual reassessment.	ITS Manager	6/16/10	Reports are generated and produced to Assessment Unit Manager.	

E.	**Automate MRDD monitoring functions related to application of the processes and instruments.**				
1.	Review of ICAP assessment system in DS3/gaps analysis.	ITS Manager	2/15/10	GAP analysis is completed and addresses ICAP assessment system gaps.	9/16/09 - Work group identified and preliminary meeting held.
	a. Enhance existing electronic scheduling tool in DS3 to include ICAP reviews to assure that assessment interviews are completed in a timely manner.	ITS Manager	6/16/10	Scheduling tool is in place and being utilized to schedule assessments.	
F.	**Automate a new system to capture LOC assessment performance measure failures.**				
1.	Develop new system to capture reasons that LOC assessments are not conducted.	ITS Manager	4/30/10	System is demonstrated to key stakeholders and reports generated.	
	a. New DS3 task order item created for continued development and support from IT Services.	ITS Manager	2/15/10	Task order has been created and funding has been approved.	
	b. System will track specific Medicaid waiver recipients and will connect to CAT, CCMC, and ICAP waiver assessment processes in data system.	ITS Manager	6/16/10	System is demonstrated to key stakeholders and reports generated.	
	c. LOC Variance Reports identifying no LOC and reason for to accommodate remediation.	ITS Manager	6/16/10	Reports are generated and produced identified stakeholders.	
G.	**Develop and implement new model for MRDD LOC annual determinations.**				
1.	Compile research on Best Practice / LOC determinations and any applicable tools	Waiver Unit Manager for MRDD	11/30/09	Findings of research are documented.	Assigned Lead 9/3/09 Researched other state methods and established a contact list 9/11/09 Met with Thompson Reuters to explore ideas 9/16/09 Arranged a meeting with Oregon contact for 9/21/09 9/21/09 – Met with Oregon, obtained materials for review Week of 9/28 – meeting with Idaho, obtained materials for review

					10/5 – scheduled meeting with Louisiana 11/6/09 – meetings with InterRAI re: assessment tools available 11/6/09 – meeting with Center for Information Management re: software system to assist with MDS-HC and possible development for Intellectual Disabilities tool adaptation 11/23/09 – research InterRAI assessment tool for MRDD waiver population. 1/9/8/10 – demonstration of InterRAI assessment tool and software.
2.	Compile a draft concept paper on models to conduct MRDD LOC annual determinations.	Waiver Unit Manager for MRDD	2/1/10	Submit concept paper on desired model to Division Director.	
3.	Present concept paper to Division Director, Chief of Programs, Deputy Director and QA Program Manager and Thompson Reuters for review and discussion	Waiver Unit Manager for MRDD	2/1/10	Concept paper submitted.	
4.	a. Revisions to concept paper and prepare final draft for submission to CMS.	Waiver Unit Manager for MRDD	2/15/10	Revised concept paper completed and prepared for submission to CMS.	
	b. Submit concept paper to CMS for review and feedback.	Waiver Unit Manager for MRDD	2/19/10	Concept paper submitted to CMS for review.	
5.	Deliver action plan for development and implementation of the chosen alternate model of conducting LOC determinations and the functional component of MRDD LOC.	Waiver Unit Manager	3/3/10	Action plan is provided to Unit Managers.	
6.	Conduct a gap analysis to explore training, policy, roll-out of alternate model to develop a plan for implementation.	Waiver Unit Manager for MRDD	3/3/10	Gap analysis is presented to Unit Managers.	

7.	Develop a curriculum for training for staff and providers on the alternate system.	Waiver Unit Manager for MRDD	3/3/10	Training curriculum is published.	
8.	Draft policies to reflect new method of LOC determinations for MRDD Waiver.	Waiver Unit for MRDD	3/3/10	Policies are developed.	
9.	Present proposed method of training, policy changes, and plan for roll-out to Senior Management Team and Thompson Reuters.	Waiver Unit for MRDD	3/3/10	Materials are presented.	
10.	Finalize policy for implementation of new method of LOC determinations for MRDD Waiver.	Systems Development Manager	4/2/10	Policy is posted for public comment.	
11.	If needed, submit waiver plan amendment to reflect modifications to annual redetermination tool/process when developed.	Systems Development Manager	5/14/10	Waiver plan amendment, if required, is submitted.	
H.	**Communicate and codify required timelines for completion of initial and annual LOC evaluations**				
1.	Meet with stakeholders (providers, special interest groups, consumers) to review current regulations relevant to initial and annual LOC determination and share proposed changes pertaining to required elements of LOC initial and annual evaluations.	Deputy Director	10/12/09	Meeting with stakeholders has occurred and comments obtained have been compiled and submitted to SDS Managers group.	The first 2-day meeting with stakeholders occurred on 10/1 and 10/2. The comments will be accumulated by 10/12. 5 follow-up teleconferences are being scheduled.
2. 	Submit regulatory language for approval regarding the initial and annual LOC evaluation process and remediation. Plan B: We are currently exploring, with the Department of Law, ways to engage the CFRs as leverage to enforce the process.	Deputy Director	10/6/10	Regulations are enacted.	

Submit to CMS:
Initial LOC Performance Measure monitoring tool & Implementation data
Remediation Policy
Annual Reassessment LOC monitoring tool & Implementation data
LOC determination tool, if new one chosen
Summary of analysis of alternate staffing plans
Action plan for new model to conduct initial and annual assessments
Plan for SDS to begin to perform CCMC assessments
Findings and analysis of comprehensive business process analysis
Implementation plan in response to comprehensive business process analysis
LOC process/instruments monitoring tool & Implementation data
Eligibility for Waiver policies
Concept paper re: models of conducting annual MRDD reassessments

FAIR HEARINGS

ACTION ITEM		RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Fair Hearing data will be collated and evaluated as one metric for identification of process improvement needs and successes.					
A.	**Establish a policy and procedure for the collection, distribution and analysis of Fair Hearing data.**				
1.	Identify individual within SDS responsible for overseeing fair hearing activities	Chief of Programs	10/12/09	Staff has been identified and role defined.	Individual has been identified.
2.	a. Publish policy re: the fair hearing process that includes quality assurance elements such as: i. evaluate the hearing process, recommend changes in the reporting process, and discuss outcomes with intent to resolve identified issues, ii. recommend policy or procedures changes affecting **the health, safety, and welfare** of recipients and the provisions of quality services, iii. identify and recommend related training and technical assistance.	OIU Manager Others involved: System Development and Support	12/15/09	Policy is approved and put into effect.	Policy has been submitted for review. 12/14/09 – Policy approved and signed by Director.
	b. Submit developed policy to CMS for review and feedback.	OIU Manager	1/15/10	Policy submitted to CMS for review and feedback.	

3.	Provide SDS staff training to assessment and waiver unit managers and assessment unit staff involved re: fair hearing process policy.	OIU Manager	1/4/10	100% of the identified SDS staff will be trained to include: Assessment Unit Manager, Waiver Unit Manager, waiver and assessment unit staff involved in sending notices for fair hearing, providing witness testimony for fair hearings, OIU staff involved in collecting, analyzing, reporting fair hearing data.	
4.	Develop Fair Hearing Data and Analysis Report and submit to QIW for review and analysis.	OIU Manager	10/15/09	QIW minutes reflect that first fair hearing report has been submitted and analyzed.	QIW has received first fair hearing report.
5.	Establish defined Fair Hearings performance standards.	OIU Manager	3/15/10	Performance standards are documented	
Submit to CMS: Fair Hearing Policy					

SERVICE PLAN

Sub-assurance 1: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
Sub-assurance 2: The state monitors service plan development in accordance with its policies and procedures.
Sub-assurance 3: Service Plans are updated/revised at least annually or when warranted by changes in waiver participation needs.
Sub-assurance 4: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
Sub-assurance 5: Participants are afforded choice between waiver services and institutional care and between / among waiver services and providers.

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Establish a systematic, data-driven quality improvement strategy to monitor Service Plans using defined performance measures, discover concerns, remediate issues and re-measure effectiveness of remediation and system improvement.					
A.	**Define Performance Measures related to Service Plans and implement data-driven monitoring strategy to track Performance Measures and discover concerns related to Service Plans.**				
1.	Develop performance measures related to Service Plans •	QA Unit Manager	2/25/10	QISC has approved performance measures.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to DSDS. 11/9/09 – performance measures have been reviewed by QIW and QISC. Suggested edits are incorporated and the document. 11/17/09 – edits submitted to NQE for feedback.
2.	Develop monitoring process to track performance measures regarding Service Plans.	QA Unit Manager	4/5/10	Monitoring process is documented in Quality Assurance unit guidelines. Process documentation will include description of monitoring tool, data	

				source, case record review protocol, sampling method, frequency of review and responsible individual.	
	a. Identify data source for performance measures related to Service Plans.	QA Unit Manager	2/25/10	Data source is documented.	9/11/09 - Case record review was identified for proposed performance measures.
	b. Identify responsible person/unit to generate data for performance measure related to Service Plans.	QA Unit Manager Others involved: RAT Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - RAT is unit identified as responsible for generating data for performance measures.
	c. Determine sampling method for performance measures related to Service Plans.	QA Unit Manager	2/25/10	Sampling method for case record review is developed, using NQE suggested thresholds.	
	d. Determine monitoring frequency for performance measures related to Service Plans.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring frequency is documented as monthly for proposed performance measures.
	e. Develop monitoring tools to generate data for performance measures regarding Service Plans.	QA Unit Manager	2/25/10	Monitoring tool is drafted.	8/20/09 - identified as a need in GAP analysis.
	f. Submit Service Plan monitoring tool to CMS for review and feedback.	QA Unit Manager	2/25/10	Draft monitoring tool is submitted to CMS for review and feedback.	
3.	Provide Quality Assurance, OIU, RAT, and Waiver Unit managers and/or supervisors staff education re: Service Plan performance measures and monitoring process.	OIU Manager	4/5/10	100% of QA, OIU, RAT and waiver managers and/or supervisors will be trained. RAT and Quality Assurance have been identified as responsible units for collection of data for the	

				preliminary performance measures identified for Service Plan assurances. The supervisors will conduct and/or oversee data collection within their units. The OIU and waiver unit managers/supervisors will be included in the training as they will be involved in remediation of identified problems.	
4.	Begin to collect data required to track Service Plan performance measures. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Unit Manager	4/26/10	Case record review is developed using NQE suggested thresholds.	
	a. Data points related to service plans are defined and documented to ensure data is valid and reliable. Data elements such as "Date of service plan receipt", "Date of service plan approval", etc. are identified in order to provide a basis for reporting on timeliness of service plan processing by all parties involved. Other data elements such as service/procedure codes, provider codes, and service unit types (hourly, weekly, daily, etc.) will be defined and documented to insure that the data collected can be used across systems (MMIS, DS3, etc.), and that services are delivered as identified in the service plan.	RAT Manager	2/25/10	Case record review is developed using NQE suggested thresholds.	

	b. Data is tracked and trended and presented in monthly, quarterly and annually aggregated fashion for analysis.	RAT Manager	4/26/10	Case record review is developed using NQE suggested thresholds.	
5.	Submit first monthly SDS Quality Monitoring Report on Service Plan performance measures, discovery and remediation to QIW for review and analysis.	QA Unit Manager	6/24/10	Meeting minutes document review of monthly SDS Quality Monitoring Report and any recommendations made by QIW.	
	a. In their monthly review activities, QIW critically analyzes the monthly/quarterly/annually aggregated discovery and remediation data for the following: i. *Compare with established goals* ii. *Identify specific opportunities for systemic improvement*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	

	b. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* ii. *Implement system improvement. Evaluate efficacy of system improvement* iii. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Meeting minutes reflect action taken.	
B. Develop and implement remediation strategies to address performance issues and process failures.					
1.	a. Provider Remediation i. Develop remediation policy to address problems discovered during ongoing monitoring of Service Plans.	QA Unit Manager Others involved: System Development Manager, OIU Manager, Division Director, Deputy Director, Chief of Programs	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by SDS Division Director and put into implementation	Policy is signed and placed into effect.	

	b. Identify who tracks and trends the aggregated remediation data and analyzes performance measure data related to Service Plans remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented in approved Performance Improvement Plan, a component of SDS's QI Strategy.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	c. Identify frequency of Service Plans performance measure remediation data aggregation and analysis.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	9/11/09 - Data aggregation and analysis frequency is documented as monthly.
	d. Identify person responsible to address individual remediation related to Service Plans performance measures.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	e. Identify individual/group responsible to address system improvement.	QA Unit Manager Others involved: QIW	2/25/10	Responsible individual/group is documented.	9/11/09 - Responsible group is documented as QIW.
2.	Provide supervisor training to OIU, QA and waiver unit supervisors re: remediation policy for performance measures related to Service Plan.	OIU Manager	5/20/10	100% OIU, QA and waiver unit supervisors will be trained on remediation policy for performance measures related to Service Plan.	
3.	Begin to collect data on remediation efforts related to Service Plan performance measure failures. Data collection will be ongoing and will be reflected in the Monthly SDS Quality Monitoring Report.	QA Unit Manager	6/15/10	Data collection tool is being populated re: remediation efforts for Service Plans performance measures.	
4.	Submit first SDS Monthly Quality Monitoring Report to QIW regarding discovery and remediation efforts for performance measure failures.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first SDS Quality Monitoring Report.	

5.	During the quality review process, CMS will request implementation data from the remediation monitoring tool to see whether the QI Strategy is working. This will be the culmination of the CAP and a test of its effectiveness.	QA Manager	TBD	Implementation data will be submitted as evidence of the QI Strategy efficacy.	
SERVICE PLAN **Sub-assurance 1: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.** **Sub-assurance 2: The state monitors service plan development in accordance with its policies and procedures.**					
Goal #1: Assessments are sufficient to identify individuals' needs and goals that will be addressed in individualized service plans.					
1.	Revise service plan standards, investigate best practices.	Waiver Unit Manager Others involved: RAT Unit Manager, QA Unit Manager, Chief of Programs, OIU Manager, Systems Development	7/19/10	Service Plan standards are documented and reflect best practices.	
	a. Conduct research on best practices in other states.	Waiver Unit Manager	4/20/10	Draft of best practices in concept paper.	
	b. Collaborate with NQE on identifying and implementing best practices.	Waiver Unit Manager	4/9/10	Meetings are scheduled and occur.	

	c. Develop service plan standards	Waiver Unit Manager	4/29/10	Submit standards to Division Director.	
	d. Develop process for implementation.	Waiver Unit Manager	4/29/10	Submit plan to Division Director.	
	e. Train providers and SDS staff.	OIU Manager	6/17/10	100% waiver unit staff trained. Communication to provider regarding standards.	
	f. Educate participants and families on any revisions to the service planning process i. Coordinate with Family Waiver Training provided through Center for Human Development ii. Update brochures, trainings, website information to incorporate changes.	OIU Manager	7/19/10	Training sessions have been offered.	
2.	Analyze and refine current assessment and reassessment tools and processes to ensure that participant risks are identified and mitigation strategies are addressed in the service plan.	Assessment Unit Manager/Waiver Unit Manager QA Unit Manager, OIU Manager, ITS Manager, RAT Manager, Chief of Programs	9/30/10	Tool/s is in place, staff is educated and process is documented.	

	a. Develop a process for implementation	Assessment Unit Manager/Waiver Unit Manager QA Unit Manager, OIU Manager, ITS Manager, RAT Manager, Chief of Programs	9/30/10	Documentation of process.	
	b. Implement and train to the identified tool.	Assessment Unit Manager/Waiver Unit Manager QA Unit Manager, OIU Manager, ITS Manager, RAT Manager, Chief of Programs	10/29/10	Implementation of process	
3.	Analyze and refine current tools and processes to ensure that person-centered planning is carried out.	Waiver Unit Manager QA Unit Manager, OIU Manager, ITS Manager, RAT Manager, Chief of Programs, Assessment Unit Manager	9/30/10	Tool is identified and training has occurred.	
	a. Research tools that can be used to facilitate person-centered planning goals and objectives.	Waiver Unit Manager/Assessment Unit Manager	7/16/10	Identified tool/s to use.	
	b. Develop a process for implementation, including testing phase to ensure consistency of application.	Waiver Unit Manager	9/30/10	Submitted to Division Director with dates of implementation	
	c. Implement and train SDS staff to the identified tool	Waiver Unit Manager	10/8/10	100% training for waiver staff. Information/change	

				instructions to outside providers.	
4.	Develop and begin delivering provider training regarding person-centered service planning consistent with newly-developed service plan.	OIU Manager	10/15/10	Provider training schedule is publicized and training has begun.	
	a. Develop curriculum on person-centered service planning and submit to CMS for review.	OIU Manager	10/15/10	Curriculum is submitted to CMS.	
5.	Develop and implement automated service plan.	ITS Manager Others involved: RAT Unit Manager, Waiver Unit Manager, Chief of Programs	11/1/10	Automated service plan is developed, automated, providers are trained and target date for use has arrived.	
	a. Develop work team to research options for automating service plan.	Waiver Unit Manager/RAT Unit Manager	5/5/10	Identified participants and meetings scheduled.	
	b. Automate the new service plan model.	ITS Manager Others involved: RAT Unit Manager, Waiver Unit Manager, Chief of Programs	8/18/10	Service plan is automated.	
	c. Pilot test the model to identify any technical issues and make changes as necessary.	ITS Manager Others involved: RAT Unit Manager, Waiver Unit	9/20/10	Pilot testing is complete.	

		Manager, Chief of Programs			
	d. Introduce the product to providers and lay out plan for delivery of training.	OIU Manager Others involved: RAT Unit Manager/Waiver Unit Manager	10/4/10	Meeting to work out issues and revise system for 11/1/10 implementation.	
Goal #2: Develop automated service plan monitoring tool.					
1.	Develop automated monitoring tool for service plan standards to monitor service plans for adequacy and appropriateness, ensuring person-centered planning based on identified needs and risks is occurring.	ITS Manager Others involved: RAT Unit Manager, Waiver Unit Manager, Chief of Programs, OIU Manager, Systems Development Manager, QA Unit Manager	11/1/10	Data is generated from automated monitoring tool.	
2.	Provide CMS with demonstration of automated service plan monitoring tool.	ITS Manager Others involved: RAT Unit	12/13/10	Tool is demonstrated for CMS.	
SERVICE PLANS **Sub-assurance 3: Service Plans are updated/revised at least annually or when warranted by changes in waiver participant needs.**					
Goal #1: All service plans will be current.					

1.	Eliminate existing backlog of annual service plan reviews for all Waiver programs and implement strategies to prevent future backlog.	Waiver Unit Manager Others involved: Assessment Unit Manager, OIU Manager	2/15/10	All plans of care received prior to 12/2/09 are reviewed and approved or remediation efforts are underway.	8/20/09 - Changed data entry to date stamp received in real time. 9/1/09 cross-trained all office assistants to data entry across waiver types Changed review process to incorporate date received instead of POC renewal date. Identifying gaps across all waivers for workflow process, training and staffing issues.
	a. Develop weekly (and ad hoc) Service Plan Review Status Reports identifying each waiver program participant (by waiver type) who has a Service Plan due or overdue.	RAT Manager	11/1/09	Reports are available to the Waiver Unit Manager for all waivers on a weekly basis.	Service plan reports are in place and will continue to be developed and refined.
	b. Create a projected timeline for completion of Service Plan Reviews based on resources available; adjusting concurrently with changing resources and institute weekly monitoring and reporting.	Waiver Unit Manager	12/15/09	Timeline created and revisited weekly.	
	c. Analyze weekly Service Plan Review Status Report and provide findings to Deputy Director/Director and/or Chief of Programs. Develop remediation plan, if required to prevent backlog development.	Waiver Unit Manager Others involved: OIU Manager	12/15/09	Findings are analyzed and shared, in writing, with Director and/or Chief of Programs.	

	i. If analysis of weekly data reveals that Service Plan reviews are not being conducted within 5 business day of receipt of a completed service plan, on average, on the same date of discovery the Division Director will receive a written notice from the Waiver Unit Manager identifying a) the number of service plan reviews out of compliance; b) a timeline and plan for correcting the backlog; and c) a plan for preventing the reoccurrence of the problem. ii. The Division Director will respond promptly to the proposed plan of correction. iii. A QIW Program Report reflecting key indicators of program operations, to include Service Plan review data, will be provided to QISC for review and analysis. iv. QISC will review data on a quarterly basis, or more often if required.	i. Waiver Unit Manager ii. OIU Manager, Chief of Programs iii. Division Director iv. Deputy Commissioner as Chair of QIS	1/31/10		

2.	Conduct Interim Staffing Analysis based on current model of conducting annual service plan reviews for all Waiver programs.	Division Director Others involved: Assessment Unit Manager, Deputy Director, Waiver Unit Manager, Chief of Programs	6/26/09 and ongoing	Staffing analysis has been conducted.	8/28/09 – Interim Staffing Analysis has been conducted by Waiver Unit Manager and supervisor, Chief of Programs, SDS Director, and project coordinator. Analysis conducted considered knowing and projected workload, staff vacancies, backlog, and current processes.
3.	Begin to implement staffing measures based upon evaluation of staffing needs to conduct annual service plan reviews for all Waiver programs.	Division Director Others involved: Assessment Unit Manager, Deputy Director, Waiver Manager, Chief of Programs	8/20/09	Adjustments made to staffing.	8/28/09 – Staffing needs are being addressed with the addition of staff as needs are identified and funding is available.
4.	Develop and implement a process to continuously monitor staffing needs to conduct annual service plan reviews in a timely manner.	Division Director Others involved: Assessment Unit Manager, Deputy Director	2/1/10	Process documented.	9/1/09 – Begin to define data elements to incorporate into manager report.
5.	Begin to implement staffing measures to meet the identified staffing needs in the business process analysis for conducting annual service plan reviews in a timely manner.	Division Director Others involved: Assessment Unit Manager, Deputy Director, Waiver Unit Manager, Chief of Programs, Administration Operations Manager	7/1/11	Staffing plan identified and implemented.	Service Plan review work process/flow efficiencies have been identified by SDS

6.	Develop SDS policy defining "due date" for annual service planning and monitoring process. (Eligibility for Waiver Policies)	Systems Development Manager Others involved: Waiver Unit Manager, Chief of Programs, OIU Manager, RAT Manager	2/8/10	Policy is drafted.	
7.	Publish policy defining “due date” and provide education to staff and key stakeholders, outlining the implications of the due date definition to work flow and performance timelines.	Systems Development Manager Others involved: OIU Manager, Chief of Programs	2/8/10	Policy is published. Staff training conducted.	
8.	a. Define criteria, develop and implement waiver service plan amendment policy and procedure.	Systems Development Manager Others involved: Waiver Unit Manager, Chief of Programs.	4/12/10	Policy is drafted.	
	b. Train providers on waiver service plan amendment policy and procedure.	OIU Manager Others involved: Waiver Unit Manager, Chief of Programs	8/9/10	Provider training is complete.	
9.	Develop long term staffing plan for quality assurance unit that includes subject matter experts such as nursing staff and program experts.	QA Unit Manager Others involved: Chief of Programs, OIU Manager, Waiver Unit Manager, RAT Manager	4/12/10	Staffing plan has been submitted to SDS Director	

10. 	Identified staffing plan is implemented if budget passes through the legislature and is approved by the Governor.	QA Unit Manager	7/1/10	Identified positions have been requested through SDS Director.	
SERVICE PLANS **Sub-assurance 4: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**					
1.	Analyze and refine current assessment and reassessment tools and processes to ensure that identified needs are reflected, including type, scope, amount, duration and frequency and that services are delivered in accordance with the service plan.	Waiver Unit Manager/QA Unit Manager	5/26/10	Analysis is presented to QIW with recommendations for change, if any.	
	a. Research how other states monitor service delivery.	Waiver Unit Manager/QA Unit Manager	4/2/10	Summary of findings is documented.	

	b. Monitoring process is developed to compare the information in the assessment compared to the services enumerated in the service plan.	QA Unit Manager	5/14/10	Monitoring process is documented n Quality Assurance Unit guidelines.	
	c. Provide Quality Assurance, OIU, and Waiver Unit supervisors education re: assessment driven service plan is delivered.	OIU Manager	5/31/10	100% of QA, OIU, and Waiver Unit supervisors are trained.	
	d. Begin to collect data required to track that assessment driven service plan is delivered. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Unit Manager	5/31/10	Monitoring tool is being populated monthly with data according to State process.	
	e. Data points are defined and documented to ensure data is valid and reliable. Data points related to service plans are defined and documented to ensure data is valid and reliable. Data elements such as “Date of service plan receipt”, “Date of service plan approval”, etc. are identified in order to provide a basis for reporting on timeliness of service plan processing by all parties involved. Other data elements such	RAT Manager	5/14/10	Data points are documented	

	as service/procedure codes, provider codes, and service unit types (hourly, weekly, daily, etc.) will be defined and documented to insure that the data collected can be used across systems (MMIS, DS3, etc.), and that services are delivered as identified in the service plan.				
	f. Data, including discovery and remediation data, is tracked and trended and presented in monthly, quarterly and annual aggregated fashion for analysis.	RAT Manager	5/26/10	Report format is developed and implemented.	
	g. In their monthly review activities, QIW critically analyzes the monthly/quarterly/annually aggregated discovery and remediation data for the following: i. Compare with established goals ii. Identify specific opportunities for systemic improvement.	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	7/29/10and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
	h. If QIW identifies specific opportunities for system improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	7/29/10 and ongoing	Meeting minutes reflect action taken.	

	applicable ii. Implement system improvement iii. *E*valuate efficacy of system improvement iv. Repeat cycle if necessary until problems are resolved or improvement achieved.				
2.	Review section IX of the Plan of Care and revise the language to include an affirmative statement by the participant or their representative that they have received information regarding choice of services and providers.	Waiver Unit Manager Others involved: QA Unit Manager, Chief of Programs, Waiver Unit Manager, OIU Manager	2/26/10	New client choice form completed.	
	a. Revise client choice form (section IX of the Plan of Care)	Waiver Unit Manager	2/17/10	New form is in draft format.	
	b. Share revised Plan of Care re: choice requirements with Governor's Council for feedback.	Waiver Unit Manager	2/26/10	Draft document is shared and feedback received.	
3.	Submit training curriculum on Choice requirements to CMS for review and feedback.	OIU Manager	2/26/10	Curriculum is submitted to CMS	
4.	Begin training of providers on Choice requirements.	OIU Manager	5/4/10	Provide training to providers.	

5.	Develop safeguards to address the potential issue of conflict of interest by assuring that the service providers' status is disclosed to the participant and the participant is aware of the choices available for alternative care providers.	Waiver Unit Manager Others involved: RAT Unit Manager, QA Unit Manager, Chief of Programs, OIU Manager, Systems Development	5/4/10	Waiver staff can identify documentation of discussion of choice in participant service plan.	
	a. Outline process of review of provider Choice Form by POC Review staff.	Waiver Unit Manager	5/4/10	Written review process is finalized.	
	b. Develop a brochure describing available services and a plan for brochure distribution.	Waiver Unit Manager Others involved: Chief of Programs	3/1/10	Brochure completed and available on SDS website.	Currently in process.
	c. Develop a process/expectation for the care coordinators to utilize an SDS search tool to locate and print a list of local providers of a service, present it to the participant and have them sign an acknowledgement that the participant understands they have choices available.	Waiver Unit Manager Others involved: Chief of Programs	10/20/10	Process is defined, providers have access to SDS search tool and signed acknowledgements are being submitted to SDS.	
	d. Submit safeguards to assure freedom from conflict of interest to CMS for review and feedback.	Waiver Unit Manager	11/22/10	Safeguards have been submitted to CMS.	
Submit to CMS for review and feedback: Service plan monitoring tool Curriculum re: person-centered service planning Demonstration of automated service plan monitoring tool Curriculum re: Choice requirements. Safeguards to assure freedom from conflict of interest.					

HEALTH AND WELFARE

Sub-assurance 1: On an ongoing basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Establish Mortality Review Process.					
1.	Establish mortality review committee and conduct weekly meetings.	QA Unit Manager	8/24/09 and ongoing	Committee composition is documented and weekly meetings are occurring as documented in meeting minutes.	8/24/09: Mortality review committee has been established and weekly meetings are occurring.
	a. Identify Mortality Review Committee members.	QA Unit Manager	9/29/09	Committee composition is documented in draft Mortality Review policy and CQI plan.	9/29/09: Mortality review committee has been defined as: SDS registered nurse, SDS Qualified Mental Retardation Professional, Adult Protective Services Representative, SDS Quality Assurance representative, SDS Mortality Review Coordinator.
	i. SDS will continue to look for opportunities to refine its process and will consider the CMS recommendation to expand the Mortality Review Committee composition to include appropriate others outside SDS for their technical expertise	Division Director	10/1/10	Decision to expand the mortality review to include others outside SDS will be documented in QIW minutes.	
	b. Work with NQE to identify best practices in other states and basic components recommended in the 2008 GAO report and incorporate into final process.	QA Unit Manager	8/19/09 and ongoing	Policy incorporating research is in effect.	8/19/09: Initial discussions with NQE on establishing mortality review process and policy. 10/7/09: Mortality review draft policy submitted to NQE for review and feedback. 10/8/09: HCBS conference materials provided from NQE on mortality review processes.

	c. Draft Mortality Review policy that incorporates guidance for Mortality Review Committee re: roles and responsibilities, definitions and procedures.	QA Unit Manager	2/26/10 posted for public comment 3/26/10 public comment closed 4/2/10 – Division Director signs	Mortality Review policy is drafted and approved for SDS use.	10/7/09: Mortality review draft policy submitted to NQE for review and feedback. 10/8/09: HCBS conference materials provided from NQE on mortality review processes.
	d. Develop reporting format to submit aggregated data and analysis quarterly to QIW re: quarterly and annual data and findings.	QA Unit Manager	5/3/10	Report is drafted and submitted to QIW for first monthly review.	
2.	Incorporate Mortality Review Report into Monthly QIW meetings for review, analysis, issue identification and action planning, if required.	QA Unit Manager	5/27/10 and thereafter	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data.	
	a. In their monthly review activities, QIW critically analyzes the monthly / quarterly / annually aggregated discovery and remediation data for the following: i. *trends in data such as community of residence, diagnoses, age, gender, place of death, date of last assessment, service provider, and/or OCS/APS involvement.* ii. *Identify specific opportunities for systemic improvement*	QIW/QA Unit Manager	5/27/10 and thereafter	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data.	

	b. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable, including when additional remediation by the unit manager is required.* ii. *Implement system improvement* iii. *Evaluate efficacy of system improvement* iv. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QIW/QA Unit Manager	5/27/10 and thereafter	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
Goal #2: Establish a systematic, data-driven quality improvement strategy to monitor defined performance measures related to Health & Welfare, discover concerns, remediate issues and re-measure effectiveness of interventions.					
A.	**Define Performance Measures related to Health & Welfare and implement data-driven monitoring strategy to monitor Performance Measures and discover process concerns related to Health & Welfare**				
1.	Develop performance measures related to Health & Welfare	QA Unit Manager	2/25/10	Performance measures are documented.	8/18/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to DSDS. 11/9/09 – performance measures have been reviewed by QIW and QISC. Suggested edits are incorporated and the document. 11/17/09 – edits submitted to NQE for feedback.
2.	Develop monitoring process for performance measures regarding Health & Welfare.	QA Unit Manager Others involved: Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	4/26/10	Monitoring Process is documented in Quality Assurance unit guidelines.	

	a. Identify data source for performance measures related to Health & Welfare.	QA Unit Manager`	2/25/10	Data source is documented	9/11/09 - Case record review, DS3 and complaint tracking are identified as data sources for proposed performance measures.
	b. Identify responsible person to generate data for performance measures related to Health & Welfare.	QA Unit Manager Others involved: RAT Unit Manager	2/25/10	Responsible individual/unit is documented.	9/11/09 - QA and RAT are identified units responsible for data collection for proposed performance measures.
	c. Determine sampling method for performance measures related to Health & Welfare.	QA Unit Manager	2/25/10	Sampling method for case record review is developed, using NQE suggested thresholds.	
	d. Determine monitoring frequency for performance measures related to Health & Welfare.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring frequency is documented as monthly for proposed performance measures.
	e. Develop review tool for performance measures regarding Health & Welfare.	QA Unit Manager	4/26/10	Monitoring tool is in place.	
	f. Submit Health & Welfare performance measures monitoring tool to CMS for review and feedback.	QA Unit Manager	4/26/10	Monitoring tool has been submitted to CMS.	
3.	Provide training to identified staff re: performance measures related to Health & Welfare.	OIU Manager	4/5/10	100%of unit managers and supervisors will be trained.	
4.	Begin to collect data required to monitor Health & Welfare performance measures. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Unit Manager	4/26/10	Monitoring tool is being populated with data.	

	a. Data points related to health and welfare are defined and documented to ensure data is valid and reliable. Data points to be defined include types of critical incidents and frequencies for abuse, neglect and exploitation.	RAT Manager	2/25/10	Data points are documented	OK
	b. Data is tracked and trended and presented in monthly, quarterly and annually aggregated fashion for analysis.	RAT Manager	4/26/10	Report format is developed and implemented.	OK
5.	Submit SDS monthly Quality Monitoring Report on Health & Welfare performance measures discovery and remediation to QIW for review and analysis of aggregated monthly, quarterly and annual data.	QA Unit Manager	6/24/10 and ongoing	Meeting minutes document review of SDS Quality Monitoring Report and any recommendations made by QIW.	
	a. In their monthly review activities, QIW critically analyzes the monthly / quarterly / annually aggregated discovery and remediation data for the following: i. *trends related to performance measures* ii. *Identify specific opportunities for systemic improvement*	QIW/QA Unit Manager	6/24/10 and ongoing	Meeting minutes document review of SDS Quality Monitoring Report and any recommendations made by QIW.	

	b. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* i. *Implement system improvement* ii. *Evaluate efficacy of system improvement* iii. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QIW/QA Unit Manager	6/24/10 and ongoing	Meeting minutes document review of SDS Quality Monitoring Report and any recommendations made by QIW.	
B.	**Develop and implement remediation strategies to address performance measures and process failures.**				
1.	Provider Remediation a. Develop remediation policy.	QA Unit Manager Others involved: System Development Manager, OIU Manager, Division Director, Deputy Director, Chief of Programs	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed SDS Division Director and put into implementation	Policy is drafted.	

	b. Submit draft provider remediation policy to CMS for review and feedback.	QA Unit Manager	4/28/10	Policy is submitted to CMS for review and feedback.	
	c. Identify who tracks and trends the aggregated data and analyzes performance measure data related to Health & Welfare remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	
	d. Identify frequency of Health & Welfare performance measure remediation data aggregation and analysis.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	
	e. Identify person responsible to address individual issues related to Health & Welfare remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	
	f. Identify individual/group responsible to address systemic issues.	QA Unit Manager Others involved: QIW	2/25/10	Responsible individual/group is documented.	
2.	Provide staff training to identified SDS staff re: remediation policy for performance measures related to Health & Welfare.	OIU Manager	5/20/10	Unit Managers and supervisors	
3.	Begin to collect data on remediation efforts related to Health & Welfare performance measures and process failures: a. Data collection will be ongoing and will be reflected in the Monthly SDS Quality Monitoring Report.	QA Unit Manager	6/15/10	Data collection tool is being populated re: remediation efforts for initial LOC evaluation performance measures.	

	b. Collect and aggregate data to measure trends in performance.	QA Unit Manager	6/15/10	Data collection tool is being populated.	
	c. Identify negative trends and develop system improvement strategies.	QA Unit Manager	6/15/10	QA Unit Manager analyzes patterns and trends in remediation.	
	d. Collect and code types of reasons why remediation did not occur.	QA Unit Manager	6/15/10	Data collection tool is being populated.	
	e. Collect and code types of actions taken to remediate the identified problems.	QA Unit Manager	6/15/10	Data collection tool is being populated.	
4.	Submit first SDS Monthly Quality Monitoring Report to QIW regarding discovery and remediation efforts for performance measure failures related to Health & Welfare.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first SDS Quality Monitoring Report.	
5.	a. Develop IT solution to capture/track remediation actions related to Health & Welfare performance measures.	ITS Manager Others involved: QA Unit Manager, RAT Manager	6/16/10	Electronic tool is developed and in use.	

Goal #3: Refine Critical Incident Reporting Process and Provider Training Strategy					
1.	Draft and submit routine periodic reports of provider training on the critical incident report system and mortality review for scheduled CMS teleconferences.	QA Unit Manager	8/20/09	Evidenced by weekly submission to CMS.	8/20/09: Weekly reports are generated and submitted weekly to CMS.
	a. Implement Critical Incident Policy	QA Unit Manager	7/1/09	Policy in place and providers are submitting critical incident reports.	7/1/09: Critical Incident Policy was put into effect.
	b. Submit Critical Incident Policy implemented 7/1/09 to CMS.	QA Unit Manager	1/15/10	Copy of policy has been submitted to CMS.	This was submitted 9/3/09 via email attachment with weekly teleconference documents.
	c. Train providers on new policy. i. Send e-alert regarding training ii. Develop mailing list to providers iii. Incorporate message re: training in remittance advice iv. Include requirement for training in certification letters to providers	QA Unit Manager	6/29/09 and ongoing	Identified communication tools are deployed.	11/20/09 - Provider training is offered on a weekly basis. Notification of this training has been accomplished on multiple fronts, including RA, eAlert, SDS website.
	v. Develop language to be included in curriculum to convey obligation of provider to train their staff.	OIU Manager	6/29/09 and ongoing	Provider training is scheduled and training records reflect provider attendance.	As of 11/25/09 348 individuals representing 81 provider entities have completed training.

2.	Review policy and refine as needed quarterly at QIW meetings.	QIW/QA Unit Manager	10/12/09 ongoing	Reflected in QIW meeting minutes.	9/14/09: Review of Critical Incident Policy and suggested refinement documented in QIW minutes.
3.	Develop critical incident database that can be used to generate data on performance measures (for example, includes data fields related to required remediation and system improvement and documentation of completed actions necessary to assure the health and welfare of a waiver participant).	ITS Manager Others involved: Quality Assurance Unit Manager, Chief of Programs, Waiver Unit Manager, ITS Manager	4/15/10	Data is developed and reports are being generated.	Critical incident management system in development.
4.	Refine the process for analyzing critical incident reporting data to identify gaps in response to critical incidents and implement remedial measures.	QA Unit Manager Others involved: Chief of Programs, RAT Unit Manager, Waiver Unit Manager	12/15/10 and ongoing	Refinements are evidenced in the database as gaps are identified and corrected.	8/20/09 - Emergency and back-up plans drafted.
	a. Develop IT solution to submit critical incident reports from providers and others.	ITS Manager Others involved: QA Unit Manager, RAT Manager	6/16/10	Electronic tool is available and in use.	
5.	Draft and implement restraint use and reporting policy	QA Manager	8/26/10	Policy is drafted, approved and implemented.	

	a. Draft policy (or supplement existing policy) re: restraints and restrictive interventions and reporting, submit for publication and approval through SDS Division Director.	QA Manager	7/1/10	Policy is drafted and submitted for publication upon approval by Division Director.	
	b. Educate Unit Managers on restraints and restrictive intervention and reporting policy	OIU Manager	7/1/10	Unit Managers have completed training.	
	c. Educate providers on restraint use and reporting policy	OIU Manager	7/15/10	Provider training has been developed and offered.	
	d. Develop a data collection monitoring tool to collect data on policy compliance for providers.	QA Manager	7/1/10	Data collection tool is developed and ready for population.	
	e. Implement remediation when problems are discovered re: restraint and restrictive intervention.	QA Manager Others involved: Waiver Unit Manager	7/1/10	Unit Managers will implement remediation when problems are discovered.	
	f. Begin monthly report of restraints and restrictive intervention discovery and remediation to QIW.	QA Manager	8/26/10	Monthly reports are being submitted to QIW.	
vi.	Draft and implement medication management and administration policy	QA Manager	9/1/10	Policy is drafted, approved and implemented.	Meet with NQE.
	a. Draft policy (or supplement existing policy) re: medication management and administration, submit for publication and approval through SDS Division Director.	QA Manager	8/2/10	Policy is drafted and submitted for publication upon approval by Division Director.	
	b. Educate SDS Unit Managers on medication management and administration policy	OIU Manager	9/10/10	Unit Managers have completed training.	

	c. Educate providers on medication management and administration policy	OIU Manager	9/24/10	Provider training has been developed and delivered.	
	d. Develop a data collection monitoring tool to collect data on medication management and administration policy compliance.	QA Unit Manager	9/10/10	Data collection tool is developed and ready for population.	
	e. Implement remediation when problems are discovered re: medication management and administration.	QA Manager	8/2/10	Unit Managers will implement remediation when problems are discovered.	
	f. Begin monthly report of medication management and administration discovery and remediation to QIW.	QA Manager	9/30/10	Monthly reports are being submitted to QIW.	
Goal #4: Establish a policy and process to manage complaints and concerns received by SDS from any source that will be known as the Quality Assurance Referral process.					
1.	Develop Quality Assurance Referral Policy and process. The policy and process will be developed in such a manner that it will in no way impede an applicant or participant's ability to seek a fair hearing. [The QA Referral policy establishes a mechanism for reporting to the QA unit feedback including complaints or suspected improper use of an SDS program.]	QA Unit Manager	Draft policy out for public comment 3/19/10. Policy posted for public comments 4/16/01. Implement 5/28/10	QA Referral policy is drafted, posted for public comment and implemented.	
2.	Division Director signs policy signifying approval and readiness for implementation.	SDS Division Director	5/28/10	Division Director has signed policy in effect.	8/14/09 - Draft policy developed.

	Implement Quality Assurance Referral policy.	QA Unit Manager Others involved: RAT Unit Manager, Chief of Programs,	5/28/10	QA Referral Policy is in effect.	
	a. Submit draft Quality Assurance Referral policy to CMS for review and feedback.	QA Unit Manager	4/16/10	Draft policy is submitted to CMS.	
	b. Educate SDS staff on Quality Assurance Referral policy for communicating complaints or program concerns.	OUI Manager	6/17/10	100% of managers and supervisors will be trained 6/3//10. By 6/17/10 all SDS units will have received training.	
	c. Educate providers on Quality Assurance Referral policy.	OIU Manager	8/23/10	Provider training curriculum is developed and training is offered.	
	d. Develop an automated QA referral reporting system and tracking tool.	ITS Manager Others involved: RAT Unit Manager, QA Unit Manager, Chief of Programs, ITS Manager	2/18/11	Automated tracking tool is developed and the first report is generated.	
Items to be submitted to CMS: Safeguards to assure freedom from conflict of interest Routine critical incident report training Performance Measure monitoring tool Critical Incident Reporting Policy Draft Provider Remediation Policy Draft Quality Assurance Referral Policy Critical Incident Policy					

QUALIFIED PROVIDERS

Sub-assurance 1: The state verifies that providers initially and continually meet required licensure and / or certification standards and adhere to other standards prior to their furnishing waiver services.

(*Please note:* There are no unlicensed or uncertified providers across the waiver thus no action items addressing Sub-assurance #2 are included.)

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Establish performance measures related to providers initially and continually meeting licensure/certification standards, a process to discover problems and a system of remediation.					
A.	**Define Performance Measures related to providers initially and continually meeting licensure/certification standards and implement data-driven monitoring strategy to track Performance Measures and discover concerns related to Qualified Providers.**				
1.	Develop performance measures related to providers initially and continually meeting licensure/certification	QA Unit Manager	2/25/10	Performance measures are documented and approved by QIS.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to DSDS. 11/9/09 – performance measures have been reviewed by QIW and QISC. Suggested edits are incorporated and the document. 11/17/09 – edits submitted to NQE for feedback.
2.	Develop monitoring process to track performance measures regarding providers initially and continually meeting licensure/certification standards.	QA Unit Manager	4/26/10	Monitoring process is documented in Quality Assurance unit guidelines. Process documentation will include description of monitoring tool, data source, case record review protocol, sampling method,	

				frequency of review and responsible individual.	
	a. Identify data source for performance measures related to providers initially and continually meeting licensure/certification standards.	QA Unit Manager	2/25/10	Data source is documented.	9/11/09 – Data sources (DS3, site visit records, and MMIS) are identified for proposed performance measures.
	b. Identify responsible person/unit to generate data for performance measures related to providers initially and continually meeting licensure/certification standards.	QA Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 – QA, OIU, Health Care Services units identified as responsible for generating data for performance measures.
	c. Determine monitoring frequency for performance measures related to providers initially and continually meeting licensure/certification standards.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 – monitoring frequency is documented as Quarterly for: - % providers reviewed who are compliant with certification standards And Monthly for: - # of providers who are not certified prior to providing waiver services

	d. Develop monitoring tools to generate data for performance measures related to providers initially and continually meeting licensure/certification standards.	QA Unit Manager	4/26/10	Monitoring tool is developed and is being populated with data.	
	e. Submit Qualified Provider performance measures monitoring tool to CMS for review and feedback.	QA Unit Manager	4/26/10	Draft monitoring tool is submitted to CMS for review and feedback.	
3.	Educate QA Unit staff who will be collecting data related to providers initially and continually meeting licensure/certification standards on the performance measures, tools and reports.	OIU Manager	4/5/10	100% QA supervisors are trained.	
4.	Begin to collect data required to track performance measure related to providers initially and continually meeting licensure/certification standards. This data will be collected in ongoing fashion and will be presented in monthly SDS Quality Monitoring Report.	QA Manager	4/26/10	Data is being collected.	
5.	Submit first monthly SDS Quality Monitoring Report related to discovery and remediation of providers initially and continually meeting licensure/certification standards on the performance measures, tools and reports.	QA Unit Manager	6/24/10	Meeting minutes document review of monthly SDS Quality Monitoring Report and any recommendations made by QIW.	
	a. In their monthly review activities, QIW critically analyzes the monthly/quarterly/annually aggregated discovery and remediation data for the following: i. *Determination that individual provider*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be	

	problems have been addressed ii. *Identify specific opportunities for systemic improvement*			drafted.	
	b. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* ii. *Implement system improvement* iii. *Evaluate efficacy of system improvement* iv. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
6.	Refine provider standards by provider type and develop processes and tools for monitoring.	QA Unit Manager Others involved: Chief of Programs, OIU Manager, Waiver Unit Manager, Systems Development Manager, Deputy Director	8/25/10	Refined provider standards are documented.	
7.	Refine criteria and system for provider site visits and establish visit schedule.	QA Unit Manager Others involved: Chief of Programs, OIU Manager, Waiver Unit Manager	11/1/10	Refined criteria are documented and site visit schedule is developed.	

8.	Analyze and refine tools and processes used to monitor performance and integrate any necessary changes stemming from refined provider standards.	QA Unit Manager Others involved: Chief of Programs, OIU Manager, Waiver Unit Manager, Systems Development Manager, Deputy Director	10/1/10	Tools and processes are updated and documented, if necessary.	
9.	Integrate the refined performance standards into provider agreements.	QA Unit Manager Others involved: System Develop Manager, Chief of Programs	3/17/11	Provider agreements are redrafted and implemented.	
10.	Communicate refined performance standards and changes to provider agreements to providers.	QA Unit Manager Others involved: System Develop Manager, Chief of Programs	3/17/11	Provider communication has occurred.	
B. Develop and implement remediation strategies to address failure to meet Performance Measures.					
1.	a. Develop remediation policy to address problems discovered during ongoing monitoring of Qualified Provider Performance Measures.	QA Unit Manager Others involved: System Development Manager, OIU Manager, Division Director, Deputy Director, Chief of Programs	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by Division Director and put	Policy is signed and placed into effect.	

			into implementation		
	b. Identify who tracks and trends the aggregated remediation data and analyzes remediation data related to Qualified Providers remediation.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	c. Identify frequency of Qualified Providers performance measure remediation data aggregation and analysis.	QA Unit Manager	2/25/10	Data aggregation and analysis frequency is documented.	9/11/09 - Data aggregation and analysis frequency is documented as monthly.
	d. Identify person responsible to address individual remediation related to Qualified Providers performance measures.	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager	2/25/10	Responsible individual is documented.	9/11/09 - Responsible individuals are identified as Waiver Unit Manager for MRDD and Assessment Unit Manager for OA/APD/CCMC.
	e. Identify individual/group responsible to address system improvement.	QA Unit Manager Others involved: QIW	2/25/10	Responsible individual/group is documented.	9/11/09 - Responsible group is documented as QIW.
2.	Provide staff training to QA staff re: remediation policy for performance measures related to Qualified Providers.	OIU Manager	5/20/10	100% QA unit supervisors will be trained on remediation policy for performance measures related to Qualified Providers.	
3.	Begin to collect data on remediation efforts related to Qualified Providers performance measure failures. Data collection will be ongoing and will be reflected in the Monthly SDS Quality Monitoring Report.	QA Unit Manager	6/15/10	Data collection tool is being populated re: remediation efforts for Qualified Providers performance measures.	

4.	Explore feasibility of performance-based contracting with providers including care coordinators.	Deputy Director Others involved: Chief of Programs	10/8/10	Findings are documented and submitted to SDS Director.	
	a. Develop task committee to define scope of work and deliverables.	Deputy Director	7/5/10	Task Committee is developed and has developed meeting schedule.	
	b. Outline development plan/timeline.	Deputy Director	8/9/10	Plan is documented.	
	c. Implement action plan if performance based contracting with providers including care coordinators is adopted. i. Develop policy ii. Identify Roles and Responsibilities iii. Design incentives iv. Develop contracting process v. Develop 10/9performance measures including acceptable quality standards vi. Develop quality assurance and surveillance processes vii. Identify start date viii. Develop communication plan	Deputy Director Others involved: Chief of Programs	9/1/11	Plan, if adopted, is implemented.	
5.	Submit first SDS Monthly Quality Monitoring Report to QIW regarding discovery and remediation efforts for Qualified Provider performance measure failures.	QA Unit Manager	7/26/10	Minutes of QIW reflect review of first SDS Quality Monitoring Report.	

6.	Develop IT solution to capture/track remediation actions.	ITS Manager Others involved: QA Unit Manager, RAT Manager	6/16/10	Electronic solution is developed and implemented.	
	a. Develop task committee to define scope of work and deliverables.	ITS Manager	1/8/10	Task Committee is developed and has developed meeting schedule.	12/31/09 – IT Committee identified
	b. Outline development plan/timeline.	ITS Manager	1/22/10	Plan is documented.	
	c. Deploy electronic tool.	ITS Manager	6/16/10	Electronic tool is developed and reports are being generated.	
C. Develop viable staffing plan to meet waiver oversight requirements re: Qualified Providers.					
1.	Begin to analyze staffing needs to implement quality assurance measures including provider oversight and sanctions and develop strategy for increasing staffing required to conduct provider reviews as part of a comprehensive staffing analysis based upon refined processes.	QA Manager Others involved: Assessment Unit Manager, Deputy Director, Director, Waiver Unit Manager, Chief of Programs, Administration Operations Manager	4/12/10	Analysis is documented and submitted to Division Director.	
2.	Implement strategy for increasing staffing required to conduct provider reviews, track provider corrective action plans and verify that remediation	Director Others involved: Assessment	7/1/10	Staffing plan is implemented.	

	has occurred.	Unit Manager, Deputy Director, Director, Waiver Unit Manager, Chief of Programs, Administration Operations Manager			
QUALIFIED PROVIDERS **Sub-assurance 3: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and approved waiver.**					
A.	**Define Performance Measures related to policies and procedures for verifying that training is provided in accordance with State requirements and approved waiver.**				
1.	Develop performance measures regarding implementation of policies and procedures for provider training	QA Unit Manager Others involved: OIU Manager	2/25/10	Performance measures are documented and approved by QIS.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to DSDS. 11/9/09 – performance measures have been reviewed by QIW and QISC. Suggested edits are incorporated and the document. 11/17/09 – edits submitted to NQE for feedback.
2.	Develop monitoring process to track performance measures regarding implementation of policies and procedures for provider training.	QA Unit Manager Others involved: OIU Manager	4/26/10	Monitoring process is documented in Quality Assurance unit guidelines.	
	a. Identify data source for performance measures related to implementation of policies and procedures for provider training.	QA Unit Manager Others involved: OIU Manager	2/25/10	Data source is documented.	9/11/09 – Data sources (DS3 and training database) are identified for proposed performance measures.

	b. Identify responsible person/unit to generate data for performance measures related to implementation of policies and procedures for provider training	QA Unit Manager Others involved: OIU Manager	2/25/10	Responsible individual is documented.	9/11/09 – QA and OIU units identified as responsible for generating data for performance measures.
	c. Determine monitoring frequency for performance measures related to implementation of policies and procedures for provider training.	QA Unit Manager Others involved: OIU Manager	2/25/10	Monitoring frequency is documented and approved by QIS.	9/11/09 – monitoring frequency was identified as Monthly for proposed performance measure.
	d. Develop review tool for assessing implementation of policies and procedures for provider training.	QA Unit Manager Others involved: RAT Manager, Chief of Programs, Waiver Unit Manager	4/26/10	Tool is developed and being populated with data.	
	e. Develop provider monitoring review tool designed to discover problems with performance measures re: implementation of policies and procedures for provider training.	QA Unit Manager Others involved: Chief of Programs, OIU Manager, Waiver Unit Manager	4/26/10	Tool is developed and being populated with data.	
	f. Submit Qualified Provider monitoring tool re: policies and procedures for provider training to CMS for review and feedback.	QA Unit Manager	4/26/10	Tool has been submitted to CMS for review and feedback.	
3.	Educate QA Unit staff who will be collecting data related to implementation of policies and procedures for provider training.	OIU Manager	4/5/10	QA Unit staff are educated.	
4.	Begin data collection on performance measure compliance regarding implementation of policies and procedures for provider training	QA Unit Manager Others involved: Assessment Unit Manager, Waiver Unit	4/26/10	Data is being collected and documented.	

		Manager, Chief of Programs			
5.	Submit first monthly SDS Quality Monitoring Report related to discovery and remediation of implementation of policies and procedures for provider training.	QA Unit Manager	6/24/10	Meeting minutes document review of monthly SDS Quality Monitoring Report and any recommendations made by QIW.	
	a. In their monthly review activities, QIW critically analyzes the monthly/quarterly/annually aggregated discovery and remediation data for the following: i. *Assurance that individual provider problems have been addressed* ii. *Identify specific opportunities for systemic improvement*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
	b. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* ii. *Implement system improvement* iii. *Evaluate efficacy of system improvement* iv. *Repeat cycle if necessary until problems are resolved or improvement achieved*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	6/24/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
B. Develop and implement remediation strategies to address problems discovered regarding compliance with policies and procedures for provider training.					

1.	Develop remediation policy for variances from implementation of policies and procedures for provider training	QA Unit Manager Others involved: Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by SDS Division Director and put into implementation	Remediation policy is drafted.	
2.	Educate staff and key stakeholders on remediation policy related to variances on implementation of policies and procedures for provider training.	OIU Manager Others involved: QA Unit Manager Chief of Programs.	5/20/10	QA Unit staff and providers have received education/communication regarding remediation policy.	
3.	Begin to collect data on the remediation efforts for implementation of policies and procedures for provider training	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager, Chief of Programs	6/15/10	Data is being collected and documented.	
4.	Produce first report to QIW of remediation efforts for implementation of policies and procedures for provider training	QA Unit Manager Others involved: Waiver Unit Manager, Assessment Unit Manager, Chief of Programs	7/26/10	QA submits first report to QIW.	

5.	Develop IT solution to capture/track remediation actions.	ITS Manager Others involved: QA Unit Manager, RAT Manager, Chief of Programs	6/16/10	Tool is developed by IT.	
6.	Refine process for identifying provider training needs and develop a plan for addressing the needs and evaluate efficacy of training.	OIU Manager Others involved: QA Unit Manager, Chief of Programs, Waiver Unit Manager, Systems Development Manager	4/13/10	Process is documented.	
To be submitted to CMS: Performance measure monitoring tool re: licensure/certification Performance measure monitoring tool re: policies and procedures					

FINANCIAL ACCOUNTABILITY

FINANCIAL ACCOUNTABILITY

Sub-assurance 1: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specific to the approved waiver.

	ACTION ITEM	RESPONSIBLE PERSON	TARGET COMPLETION DATE	ACTION DEEMED SUCCESSFUL WHEN	STATUS
Goal #1: Establish a systematic, data-driven quality improvement strategy to monitor Financial Accountability using defined performance measures, discover concerns, remediate issues and re-measure effectiveness of remediation and system improvement.					
1.	Develop performance measures related to claim submission consistent with services provided	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager	2/25/10	Performance measures are documented and approved by QISC.	8/19/09 - Draft performance measures developed. 9/18/09 - performance measures reviewed by NQE and comments returned to DSDS. 11/9/09 – performance measures have been reviewed by QIW and QISC. Suggested edits are incorporated in the document. 11/17/09 – edits submitted to NQE for feedback.
2.	Develop process to compare claims against services provided to monitor waiver utilization and cost.	QA Unit Manager Others involved: OIU Manager, RAT Manager, Assessment Unit Manager	10/8/10	Case record review process is documented; procedure and form drafted. Claims review will be incorporated into case review process.	8/19/09 – preliminary meeting re: claims data availability from Health Care Services. 11/10/09 – follow-up meeting re: claims data reports with Health Care Services.

	a. Identify data source for performance measures related to Financial Accountability.	QA Unit Manager	2/25/10	Case record review form is drafted.	9/11/09 – MMIS, case record review and CMS 372 reports were identified as data sources for proposed performance measures.
	b. Identify responsible person/unit to generate data for performance measures related to Financial Accountability.	QA Unit Manager	2/25/10	Responsible person/unit is documented and approved by QIS.	9/11/09 QA and Health Care Services were identified as responsible for generating data for performance measures.
	c. Determine sampling method for performance measures related to Financial Accountability.	QA Unit Manager	2/25/10	Draft case record review procedure/form is developed. Sampling method for case record review, when utilized, is developed using NQE suggested thresholds.	
	d. Determine monitoring frequency for performance measures related to Financial Accountability.	QA Unit Manager	2/25/10	Monitoring frequency is documented.	9/11/09 - Monitoring frequency is documented as monthly for proposed performance measures: - # of claims submitted for services not provided - # of claims for services that were not included in the service plan Quarterly or semi-annually for respective performance measures.
	e. Develop data collection tool related to claim submission consistent with services provided.	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager	10/8/10	Monitoring tool is drafted.	

3.	Provide Quality Assurance Unit supervisor staff education re: Financial Accountability performance measures and monitoring process.	OIU Manager	10/8/10	100% Quality Assurance Supervisors have received training.	
4.	Begin collecting data on claims consistent with services provided.	QA Unit Manager Others involved: OIU Manager, RAT Manager, Assessment Unit Manager	10/8/10	Data collection tool is being populated re: remediation efforts for Service Plans performance measures.	
5.	Submit first report of monitoring data related to claim submission consistent with services provided to QIW.	QA unit Manager	11/19/10	Minutes of QIW reflect review of monitoring data re: claim submission consistent with services.	
	c. In their monthly review activities, QIW critically analyzes the monthly/quarterly/annually aggregated discovery and remediation data for the following: d. *Ensure that individual problems have been addressed.* e. *Identify specific opportunities for systemic improvement*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	11/19/10 and ongoing	Minutes of QIW reflect deliberation of the first monthly SDS report including aggregated data or a report of recommendations will be drafted.	
	f. If QIW identifies specific opportunities for improvement in their monthly review, QIW will: i. *Review the remediation activities implemented by the unit manager and offer constructive comments, when applicable.* ii. *Implement system improvement* *iii. Evaluate efficacy of system improvement*	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager, Chief of Programs	11/19/10 and ongoing	Meeting minutes reflect action taken.	

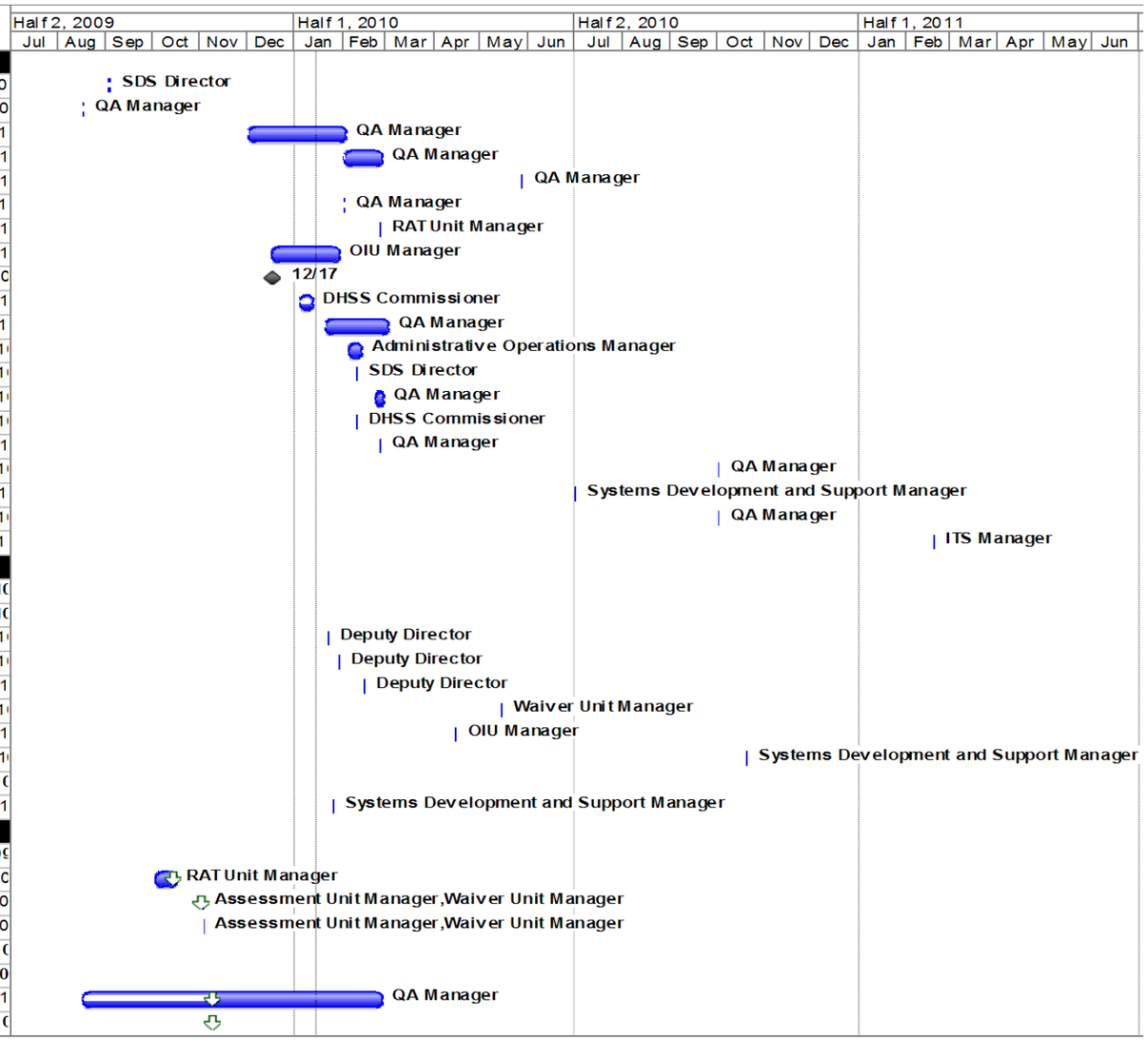
	iv. *Repeat cycle if necessary until problems are resolved or improvement achieved*				
B. Develop and implement remediation strategies to address problems identified in monitoring performance measures related to Financial Accountability.					
1.	Develop remediation policy to address problems identified in monitoring performance measures related to claim submission consistent with services.	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager	4/4/10 – policy drafted 4/28/10 – published for public comment and stakeholder committee review 5/28/10 – public comment closes 6/15/10 – signed by SDS Director and put into implementation	Remediation policy is drafted.	
	a. Identify who tracks and trends the aggregated remediation data and analyzes performance measure data related to Financial Accountability.	QA Unit Manager	2/25/10	Performance measures document responsible unit.	
	b. Identify frequency of Financial Accountability performance measure remediation data aggregation and analysis	QA Unit Manager	2/25/10	Performance measures document responsible unit.	
	c. Identify person responsible to address individual remediation related to Financial	QA Unit Manager`	2/25/10	Performance measures document responsible unit.	

	Accountability performance measures.				
	d. Identify person/group responsible to address system improvement.	QA Unit Manager	2/25/10	Performance measure document identified QIW as responsible to address any system improvement	
2.	Provide staff training to QA Unit supervisors re: remediation policy for performance measures related to Service Plan.	OIU Manager	5/20/10	100% QA unit supervisors will be trained on remediation policy for performance measures related to Financial Accountability.	
3.	Begin to collect remediation data related to performance variances in claim submission consistent with services provided to QIW.	QA Unit Manager Others involved: RAT Manager, Assessment Unit Manager, Waiver Unit Manager	6/15/10	Preliminary (before final approval of policy) remediation data is being collected.	
4.	Submit first report of remediation data collected related to performance variances in claim submission consistent with services provided to QIW.	QA unit Manager	7/26/10 and thereafter	Report of preliminary remediation data is reported to QIW	
Goal #2: Establish a uniform rate methodology.					
1.	Begin to implement new rate methodology developed subsequent to Myers and Stauffer's rate consultation and report to ensure uniform rate methodology across all Waivers and services.	Office of Rate Review Executive Director	7/1/10	Rate methodology has been approved and is in effect.	The State of Alaska contracted with Myers and Stauffer to conduct a rate consultation. A new rate calculation system stemming from that comprehensive review is targeted for implementation during the state fiscal year 2010.
	a. Submit new rate methodology to CMS.	Division Director	7/1/10	Approved rate methodology has been submitted to CMS	

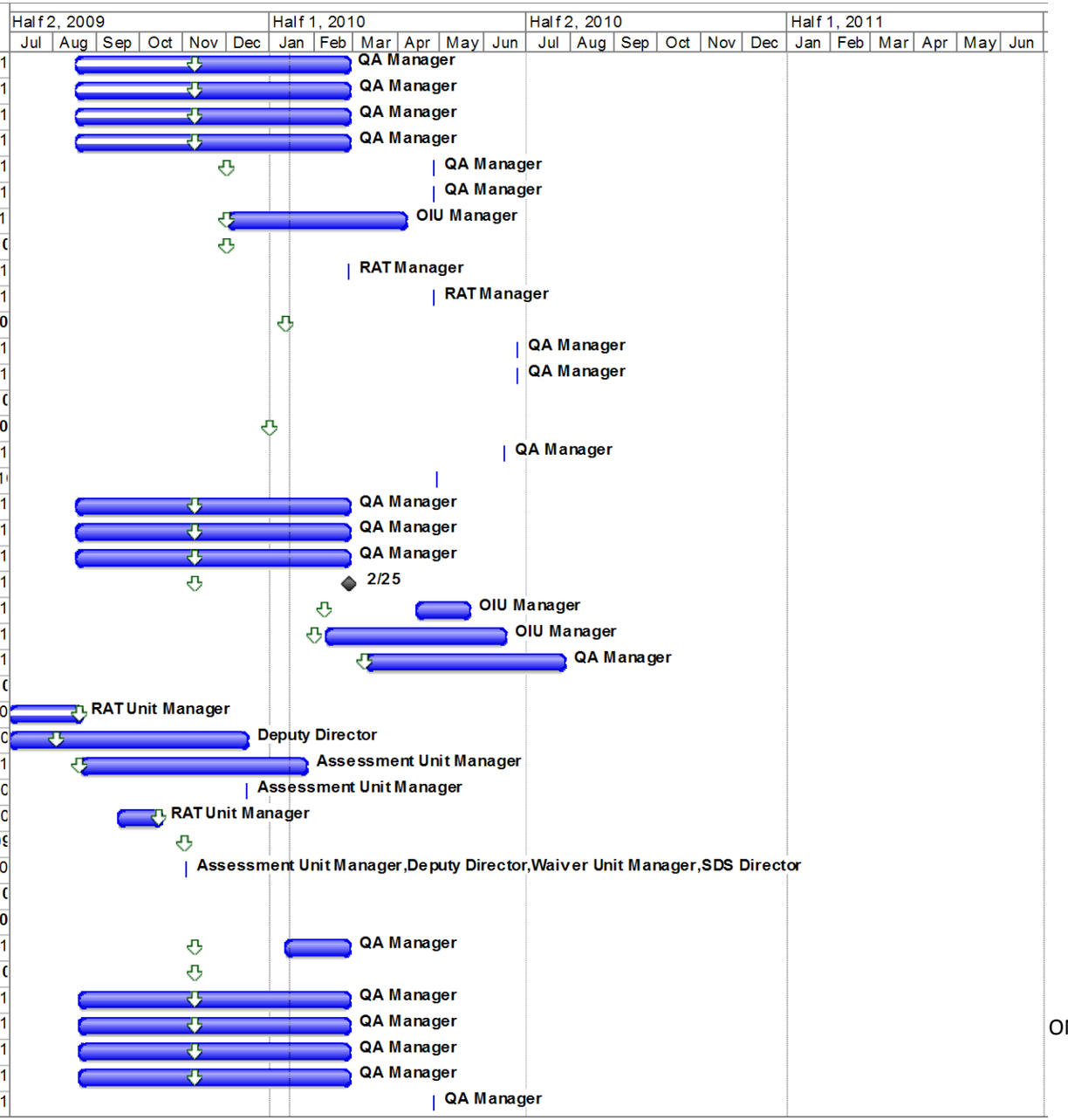
2.	If necessary, implement programming changes in DS3 to accommodate rate methodology. [DS3 is the Division of Senior and Disabilities Services Data System. The DS3 is a collection of components contained within a single web-based data system that was developed in-house by Senior and Disabilities Services in an effort to manage the many programs that it oversees. This system provides user interfaces, processing logic, and role-based data access, all of which allows division staff to conduct and oversee day-to-day program activities. While DS3 is used to manage Medicaid programs it is also used to manage Adult Protective Services investigations, state-funded general relief programs, and other grant-funded programs that fall outside the scope of Medicaid]	ITS Unit Manager Others involved: RAT Unit Manager, Office of Rate Review	7/1/10	Programming changes, if required, will be completed.	
Goal #3: When ICD-10 becomes effective as targeted in 2013, claims processing will continue with no or minimal interruption. (This was raised as a concern in the CMS 6/26/09 preliminary findings report.)					
1.	Verify implementation plan is in place for ICD-10 with targeted date of functionality in 2013.	RAT Unit Manager	10/1/09	Received confirmation that ICD-10 codes will be in place.	10/1/09 – Health Care Services has verified that it plans to be able to accommodate ICD-10 as required as of October 1, 2013.
To be submitted to CMS: Rate Methodology					

TIMELINE OF ACTIVITIES

ID	Task Name	Finish
1	QUALITY IMPROVEMENT STRATEGIES	
2	Engage the participant and provider community in talking forums to elicit fe	Thu 9/3/0
3	Work with NQE as required in initial and continued corrective action plan de	Mon 8/17/0
4	Incorporate continual quality improvement analysis in QIW and QISC functi	Mon 2/1/1
5	Analyze the continued use of PES tool to elicit participant feedback in rela	Thu 2/25/1
6	Develop and implement chosen strategy to elicit participant feedback	Thu 5/27/1
7	Establish a process for how reports will be distributed, who will review, who v	Mon 2/1/1
8	Conduct gap analysis for data control and staff education needs regarding c	Thu 2/25/1
9	Reevaluate and implement changes to the quality review activities conduct	Thu 1/28/1
10	Develop monthly report of specific measures to Commissioner.	Thu 12/17/0
11	DHSS Commissioner will provide input on the composition of the QISC Key	Mon 1/11/1
12	Review current QIS to assess strengths and identify any gaps that need to be	Mon 3/1/1
13	Develop an updated SDS organization chart and publish on SDS website	Fri 2/12/1
14	Updated SDS organizational chart will be reviewed by the Deputy Commiss	Wed 2/10/1
15	Develop updated SDS descriptions of units/teams/committees/work-groups a	Fri 2/26/1
16	DHSS Commissioner will provide input on the composition of the QISC Key	Wed 2/10/1
17	Establish valid sampling approaches for each performance measure where	Thu 2/25/1
18	Develop a comprehensive plan for trending, prioritizing and implementing	Fri 10/1/1
19	Analyze feedback from participant and provider community and develop a	Thu 7/1/1
20	Develop a description of cross-waiver QIS to be included in the waiver rene	Fri 10/1/1
21	Establish a system for generating performance reports. Identify necessary IT	Fri 2/18/1
22	ADMINISTRATIVE AUTHORITY	
23	Admin Authority Sub 1: Goal 1: Realign coverage of habilitation services	Wed 10/20/1
24	Address the current issues identified in the APD Waiver regarding habili	Wed 10/20/1
25	a. Conduct management meetings to determine remediation strategy	Fri 1/22/1
26	b. Submit waiver amendment to CMS for review and approval	Fri 1/29/1
27	c. Develop implementation plan for waiver change	Mon 2/15/1
28	d. Implement selected policy change regarding habilitation services	Fri 5/14/1
29	i. Provide education/communication to key stakeholders on change	Thu 4/15/1
30	e. Secure regulatory amendments as required to address APD waiver p	Wed 10/20/1
31	Admin Authority Sub 1: Goal 2: Current CMS approved Waiver Plans and am	Mon 1/25/1
32	Update the SDS website to reflect current public information and develop p	Mon 1/25/1
33	LEVEL OF CARE	
34	LOC Subassurance 1: Goal #1: Complete initial LOC evaluations prior to se	Mon 11/2/0
35	Develop LOC Evaluation Status Report	Thu 10/15/0
36	Analyze Evaluation Status Report x 1 wk	Mon 11/2/0
37	Take action based on analysis, if required.	Mon 11/2/0
38	LOC Subassurance 1: Goal #2: Establish systematic, data-drive quality imp	Mon 7/26/1
39	Define initial LOC Performance Measures and implement monitoring	Thu 6/24/10
40	Develop LOC PMs	Thu 2/25/1
41	Develop initial LOC PM monitoring process.	Mon 4/26/1



ID	Task Name	Finish
42	a. Identify data source for initial LOC PM.	Thu 2/25/1
43	b. Identify responsible QA person for initial LOC PM.	Thu 2/25/1
44	c. Determine sampling method for initial LOC PM.	Thu 2/25/1
45	d. Determine monitoring frequency for initial LOC PM.	Thu 2/25/1
46	e. Develop monitoring tools for initial LOC PM evaluation.	Mon 4/26/1
47	f. Submit monitoring tool to CMS for review and feedback	Mon 4/26/1
48	Provide staff education re: initial LOC PM and process.	Mon 4/5/1
49	**Begin to collect data on initial LOC evaluation PM.**	**Mon 4/26/1(**
50	a. Data points are defined and documented	Thu 2/25/1
51	b. Data is tracked and trended monthly, quarterly, annually	Mon 4/26/1
52	**Submit first monthly LOC Monitoring Report to QIW.**	**Thu 6/24/10**
53	QIW critically analyzes monthly/quarterly/annual data	Thu 6/24/1
54	QIW identifies improvement opportunities	Thu 6/24/1
55	**Develop and implement remediation strategies re: initial LOC PM.**	**Mon 7/26/1(**
56	**Develop remediation protocol re: monitoring of initial LOC evaluatio**	**Tue 6/15/10**
57	a. 1. Develop remediation Policy	Tue 6/15/1
58	2. Submit remediation policy to CMS	Wed 4/28/1(
59	b. Identify who aggregates and analyzes PM re: initial LOC evalua	Thu 2/25/1
60	c. Identify frequency of initial LOC evaluation PM data aggregatio	Thu 2/25/1
61	d. Identify person responsible to address individual issues related t	Thu 2/25/1
62	e. Identify individual/group responsible to address systemic issues.	Thu 2/25/1
63	Provide staff training to identified staff re: remediation protocol for PM r	Thu 5/20/1
64	Begin to collect data on remediation efforts related to LOC PM failures	Tue 6/15/1
65	Submit first report to QIW regarding remediation efforts for performance	Mon 7/26/1
66	**LOC Subassurance 2: Goal #1: Eliminate the backlog of reassessments ov**	**Mon 1/25/1(**
67	Develop weekly reports identifying each waiver program participant (by wai	Thu 8/20/0
68	a. Create a projected timeline for completion of reassessment backlog base	Tue 12/15/0
69	b. Explore alternative approaches to adjuust projected reassessment worklo	Mon 1/25/1
70	Identify status of each waiver participant with reassessment due or overdue	Tue 12/15/0
71	Develop automated LOC Evaluation Status report	Thu 10/15/0
72	**Analyze weekly reassessment LOC evaluation status report, report findi**	**Mon 11/2/09**
73	Implement corrective actions based on analysis	Mon 11/2/0
74	**LOC Subassurance 2: Goal #2: Establish a systematic, data-driven quality i**	**Mon 7/26/1(**
75	**Define Performance Measures related to annual LOC evaluation and imp**	**Thu 6/24/10**
76	Develop performance measures related to annual LOC evaluations, inc	Thu 2/25/1
77	**Develop monitoring process for performance measures regarding a**	**Mon 4/26/1(**
78	a. Identify data source for performance measure related to annual	Thu 2/25/1
79	b. Identify responsible person to generate data for performance me	Thu 2/25/1
80	c. Determine sampling method for performance measures related	Thu 2/25/1
81	d. Determine monitoring frequency for performance measures relat	Thu 2/25/1
82	e. Develop monitoring tools for PM re: annual LOC	Mon 4/26/1



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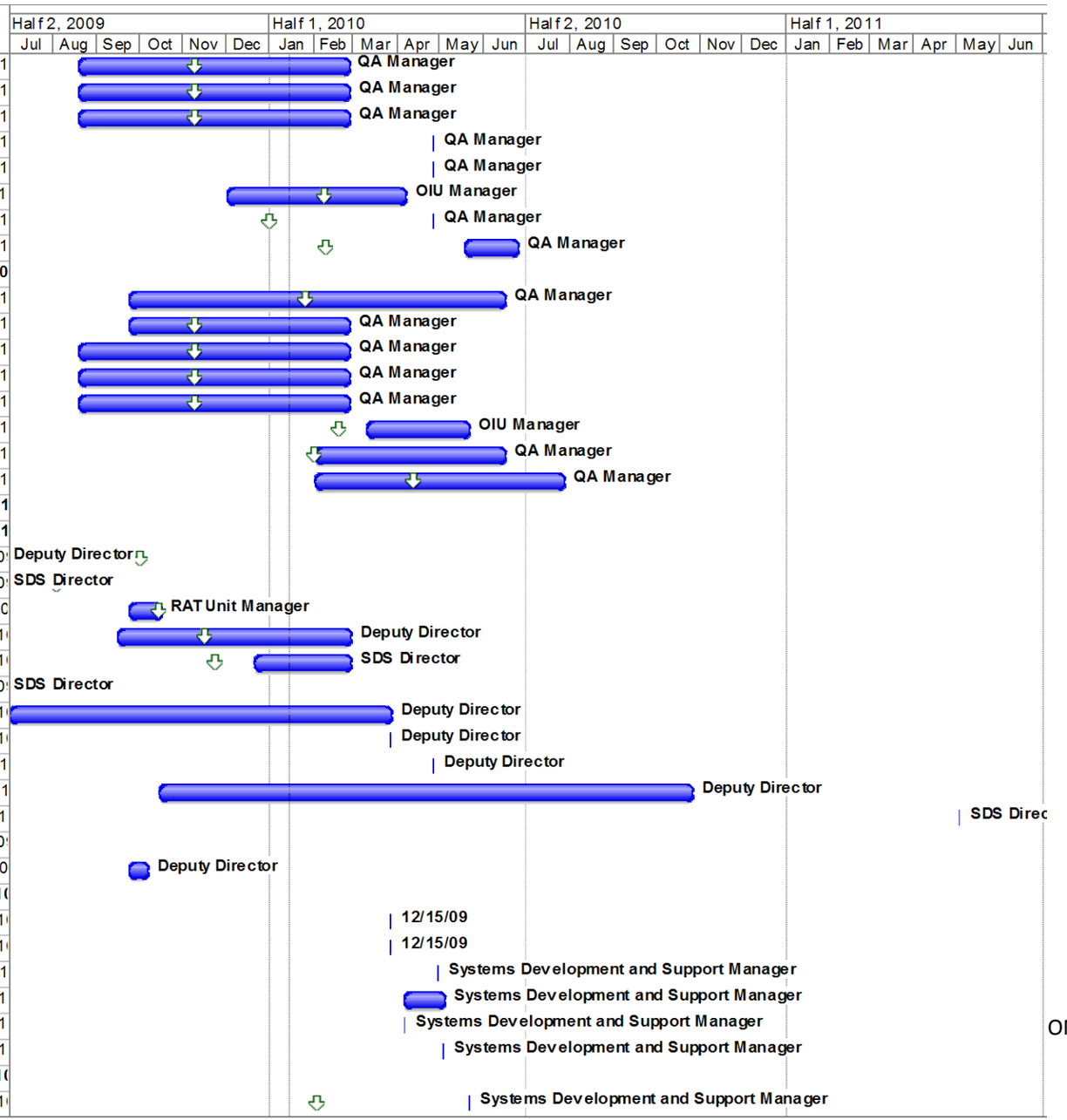
ID	Task Name	Finish
79	b. Identify responsible person to generate data for performance me	Thu 2/25/1
80	c. Determine sampling method for performance measures related	Thu 2/25/1
81	d. Determine monitoring frequency for performance measures relat	Thu 2/25/1
82	e. Develop monitoring tools for PM re: annual LOC	Mon 4/26/1
83	f. Submit monitoring tool to CMS for review and feedback	Mon 4/26/1
84	Provide training to identified staff re: remediation protocol for performa	Mon 4/5/1
85	Begin to collect data required to monitor annual LOC evaluation perfo	Mon 4/26/1
86	Submit first monitoring report on annual LOC evaluation performance r	Thu 6/24/1
87	**Develop and implement remediation strategies to address performance**	**Tue 6/15/10**
88	a. Develop and implement remediation policy	Tue 6/15/1
89	b. Identify who aggregates and analyzes performance measure data rel	Thu 2/25/1
90	c. Identify frequency of annual LOC evaluation performance measure c	Thu 2/25/1
91	d. Identify person responsible to address individual issues related to anı	Thu 2/25/1
92	e. Identify individual/group responsible to address systemic issues relate	Thu 2/25/1
93	Provide staff training re: remediation policy	Thu 5/20/1
94	Begin to collect data on remediation efforts related to annual LOC perform	Tue 6/15/1
95	Submit first report to QIW regarding remediation efforts for performance me	Mon 7/26/1
96	**Subassurance 3: Goal #1: Sufficient resources are in place to conduct proc**	**Mon 5/2/11**
97	**Evaluate staffing needs based on current model of conducting initial and**	**Mon 5/2/11**
98	Conduct initial assessment of resource needs to schedule and conduct i	Fri 6/26/0
99	Implement staffing changes based upon evaluation of current model of	Fri 6/26/0
100	Develop a report to analyze reassessments coming due each week and	Thu 10/15/0
101	Identify metrics and develop management reports to evaluate adequa	Fri 2/26/1
102	Staffing Management reports are utilized to continuously monitor staffi	Fri 2/26/1
103	Identify and implement efficiencies to enhance productivity in daily op	Fri 6/26/0
104	Identify and analyze alternative staffing models to enhance productivit	Fri 3/26/1
105	a. Discuss staffing options with NQE	Fri 3/26/1
106	b. Summary of analysis will be reported to CMS	Mon 4/26/1
107	Implement chosen staffing changes to conduct initial and annual asses	Mon 10/25/1
108	Evaluate effectiveness of chosen staffing changes	Mon 5/2/1
109	Evaluate alternative models for delivery of initial and annual LOC evaluati	Fri 6/26/0
110	Develop task force of DSDS staff to define key program components to evalu	Mon 10/5/0
##	**Survey Waiver programs in other States and incorporate findings for a s**	**Fri 3/26/1**
112	a. Contact other state program managers/directors/coordinators	Fri 3/26/1
113	b. Engage NQE in identifying states to interview	Fri 3/26/1
114	Compile research on Best Practice/LOC determinations and any applicable	Thu 4/29/1
115	Analyze findings of survey and submit a recommendation and prioritization	Mon 5/3/1
116	a. Team meets and engages NQE in assessment of survey findings	Mon 4/5/1
117	b. If new LOC determination tool is identified, tool is submitted to CMS for	Mon 5/3/1
##	**Make decision re: model for delivery of initial and annual LOC determina**	**Fri 5/28/1**
119	a. Develop an action plan for implementation of the chosen model to p	Fri 5/21/1



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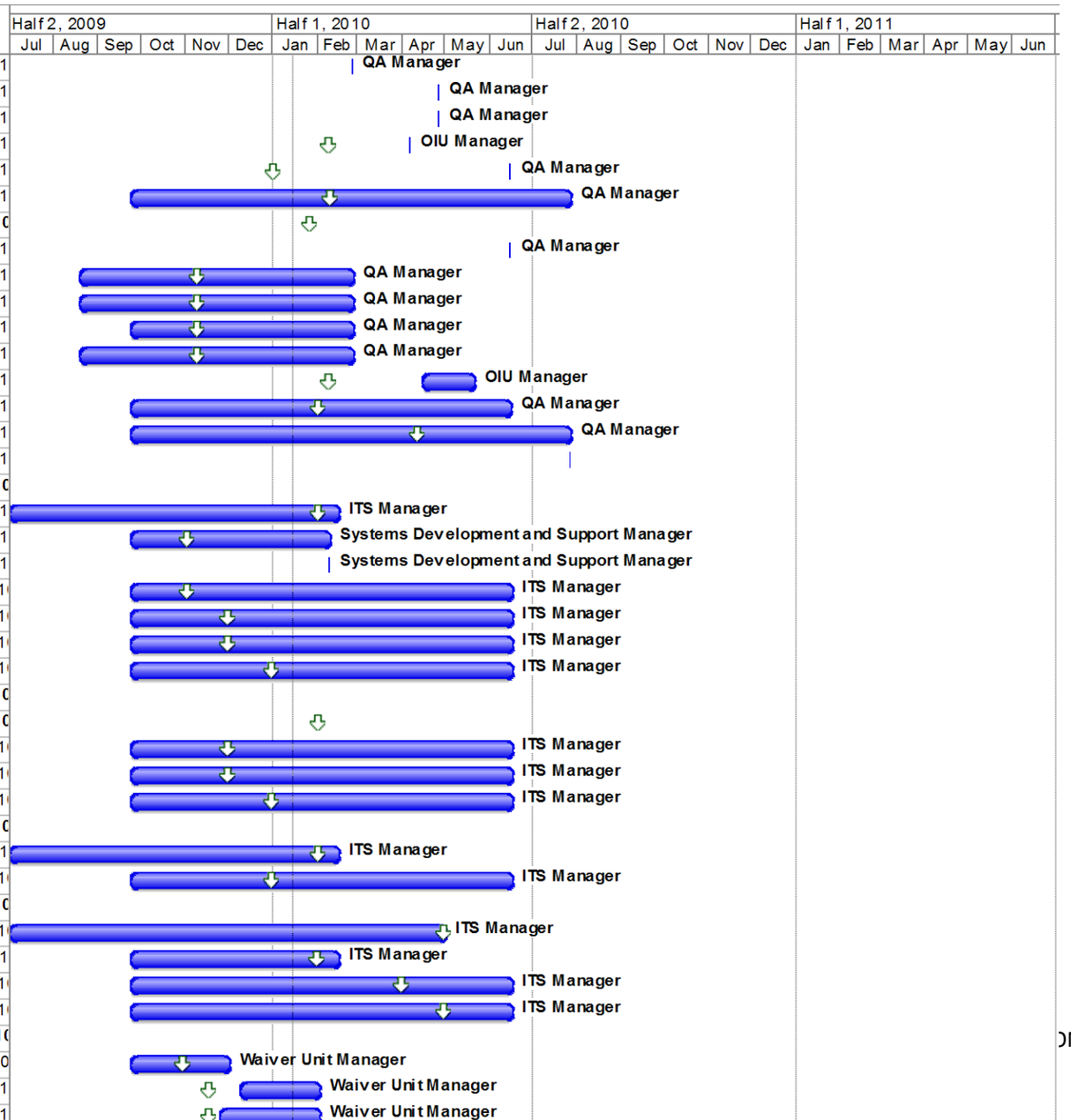
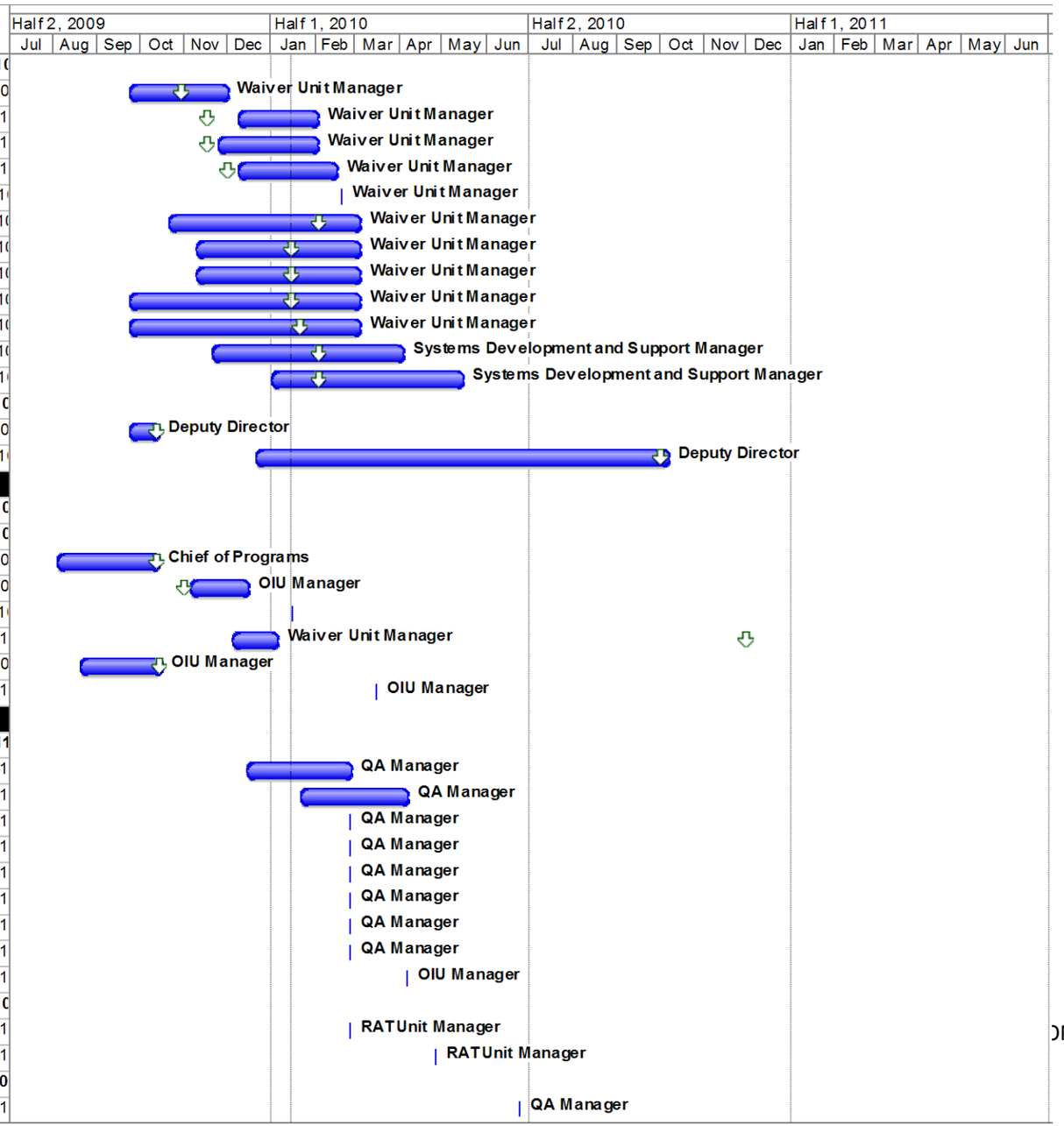
ID	Task Name	Finish
116	a. Team meets and engages NQE in assessment of survey findings	Mon 4/5/1
117	b. If new LOC determination tool is identified, tool is submitted to CMS for	Mon 5/3/1
118	**Make decision re: model for delivery of initial and annual LOC determina**	**Fri 5/28/1**
119	a. Develop an action plan for implementation of the chosen model to p	Fri 5/21/1
120	b. Submit action plan to CMS for review and feedback	Fri 5/28/1
121	c. Develop plan for DSDS to begin to perform CCMC assessments for ir	Thu 3/18/1
122	d. Submit plan for SDS to begin to perform CCMC assessments for initi	Fri 4/9/1
123	SDS staff begin to perform CCMC assessments for initial LOC determination	Thu 7/1/1
124	Submit waiver amendment if required.	Fri 5/21/1
125	**Conduct comprehensive staffing analysis including staffing efficiencies, stre**	**Sun 7/1/12**
126	Secure funding to conduct a third party staffing analysis	Mon 5/3/1
127	a. Identify SDS staff responsible to manage staffing analysis contract.	Mon 5/3/1
128	b. Define scope of project and timelines.	Mon 5/3/1
129	c. Post request for proposal/contract bids	Tue 6/1/1
130	d. Select contractor	Sun 8/1/1
131	e. Completion of contract deliverables	Tue 2/1/1
132	f. Work with NQE to develop a back-up plan in the event necessary funding	Mon 5/3/1
133	**Develop detailed work plan to implement strategies identified in compre**	**Sun 7/1/12**
134	Establish workgroup to address staffing analysis findings. Identify work	Mon 8/1/1
135	a. Group meets and reviews findings	Mon 8/1/1
136	b. Findings and analysis are reviewed with CMS	Thu 9/1/1
137	**Prioritize staffing analysis findings.**	**Thu 9/1/11**
138	a. Develop implementation plan for prioritized staffing strategies.	Thu 9/1/1
139	b. Submit implementation plan to CMS for review and feedback.	Thu 9/1/1
140	Begin to implement strategies from staffing implementation plan.	Thu 9/1/1
141	a. Prepare and submit budget reflecting staffing needs	Thu 9/1/1
142	b. As budget allows, fill identified vacancies	Sun 7/1/1
143	c. Incorporate identified efficiencies into operations	Thu 9/1/1
144	Apply monitoring methods to new staffing model and analyze effective	Sun 7/1/1
145	**Subassurance 3: Goal #2: Establish a systematic, data-driven quality impro**	**Wed 10/6/10**
146	**Define Performance Measures and implement data-driven monitoring pr**	**Mon 7/26/10**
147	SDS staff working with Waivers will attend Version 3.5 Web Based Appl	Tue 12/8/0
148	Develop performance measures related to (proposed):	Thu 2/25/1
149	**Develop monitoring process for performance measures regarding L**	**Mon 4/26/10**
150	a. Identify data source for performance measure related to LOC de	Thu 2/25/1
151	b. Identify responsible person to generate data for performance me	Thu 2/25/1
152	c. Determine monitoring frequency for performance measures relat	Thu 2/25/1
153	d. Determine monitoring frequency for PM	Thu 2/25/1
154	e. Develop case file review procedure and monitoring tool elemer	Mon 4/26/1
155	f. Monitoring tool is submitted to CMS for review and feedback.	Mon 4/26/1
156	Provide staff training to identified staff re: performance measures for pe	Mon 4/5/1

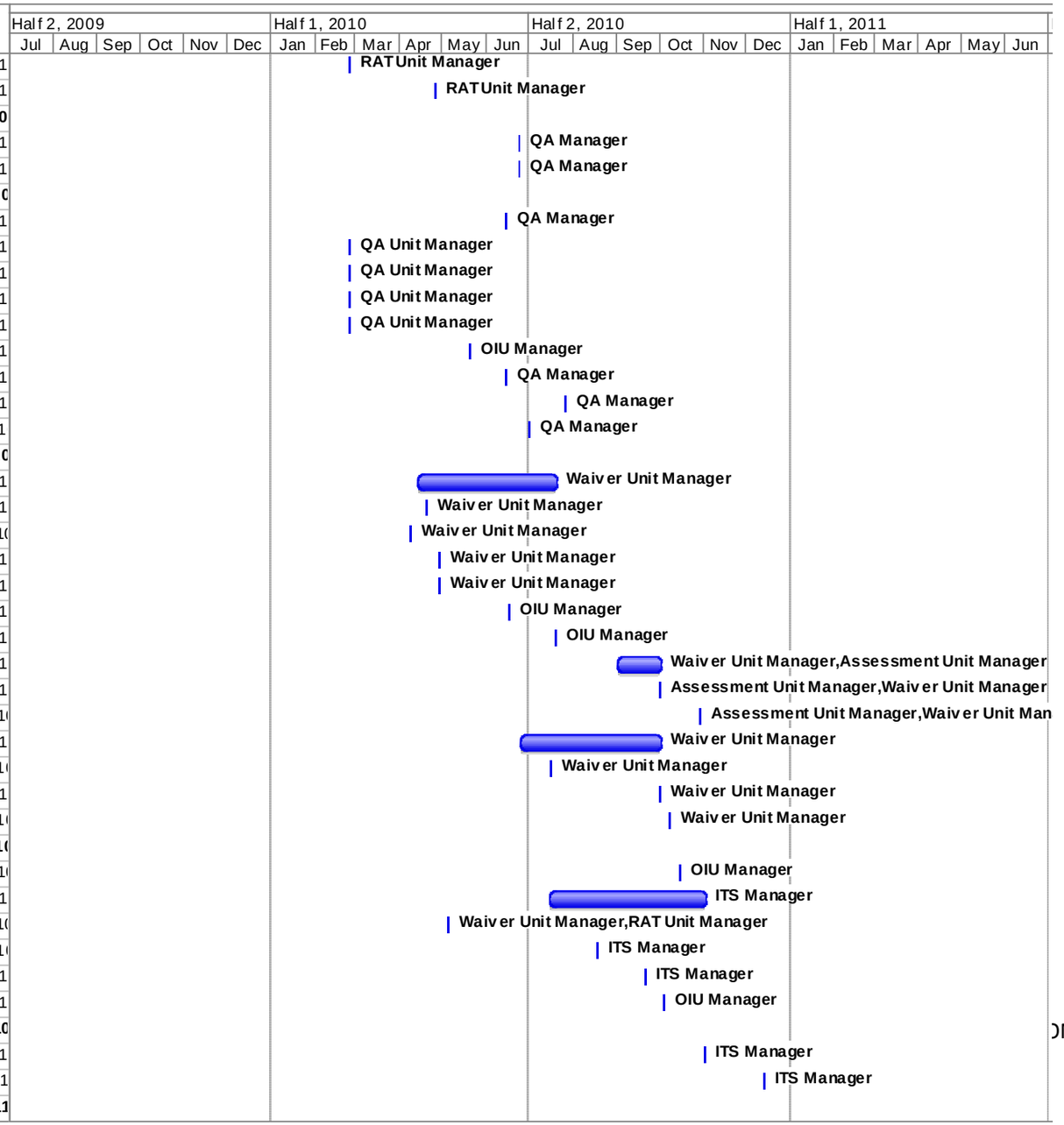
ID	Task Name	Finish
153	d. Determine monitoring frequency for PM	Thu 2/25/1
154	e. Develop case file review procedure and monitoring tool elemer	Mon 4/26/1
155	f. Monitoring tool is submitted to CMS for review and feedback.	Mon 4/26/1
156	Provide staff training to identified staff re: performance measures for pe	Mon 4/5/1
157	Begin to collect data required to monitor annual LOC evaluation perfo	Tue 6/15/1
158	Submit first monitoring report on annual LOC evaluation performance r	Mon 7/26/1
159	**Develop remediation strategies to address performance measures a**	**Mon 7/26/10**
160	a. Develop provider remediation policy	Tue 6/15/1
161	b. Identify who aggregates and analyzes performance measure dat	Thu 2/25/1
162	c. Identify frequency of performance measure data aggregation an	Thu 2/25/1
163	d. Identify person(s) responsible to address individual issues relatec	Thu 2/25/1
164	e. Identify individual/group responsible to address systemic issues r	Thu 2/25/1
165	Provide staff training to identified staff re: remediation protocol for	Thu 5/20/1
166	Begin to collect data on remediation efforts related to processes ar	Tue 6/15/1
167	Submit first report to QIW regarding remediation efforts for process	Mon 7/26/1
168	Submit implementation data to CMS	Mon 7/26/1
169	**Develop automated IT solutions to capture/track remediation actions for**	**Wed 6/16/10**
170	Develop Medicaid waiver application system to track waiver applicants	Mon 2/15/1
171	a. Implement policy defining specific requirements and processes for th	Mon 2/8/1
172	b. Submit policy to CMS for review and feedback	Mon 2/8/1
173	c. Build interfaces that collect applicant information and place the app	Wed 6/16/1
174	d. Build processing reports that queue SDS staff to take action on appli	Wed 6/16/1
175	e. Develop letter generators that are tied into key process points (denial	Wed 6/16/1
176	f. Link application process to other key processes such as the ICAP or (	Wed 6/16/1
177	**Automate CCMC monitoring functions related to application of the proces**	**Wed 6/16/10**
178	**Develop CCMC assessment system to facilitate the scheduling, con**	**Wed 6/16/10**
179	a. Develop an automated tool to monitor the status of CCMC appli	Wed 6/16/1
180	b. Develop interfaces to capture assessment details such as date, n	Wed 6/16/1
181	c. Reports identifying CCMC recipients requiring annual re-assessm	Wed 6/16/1
182	**Automate MRDD monitoring functions related to application of the proces**	**Wed 6/16/10**
183	Review of ICAP assessment system in DS3/gaps analysis.	Mon 2/15/1
184	a. Enhance scheduling tool to include ICAP reviews in order to guarant	Wed 6/16/1
185	**Automate a new system to capture LOC assessment performance meas**	**Wed 6/16/10**
186	Develop new system to capture reasons that LOC assessments are not c	Fri 4/30/1
187	a. New DS3 task order item created for continued development and sup	Mon 2/15/1
188	b. System will track specific Medicaid waiver recipients and will connec	Wed 6/16/1
189	C. LOC Variance Reports identifying no LOC and reason for to accomr	Wed 6/16/1
190	**Develop and implement new model for MRDD LOC annual determination**	**Fri 5/14/10**
191	Compile research on Best Practice/ LOC determinations and any applic	Mon 11/30/0
192	Compile a draft concept paper on possible solutions.	Mon 2/1/1
193	Present concept paper to Division Director, Chief of Programs, Deputy D	Mon 2/1/1



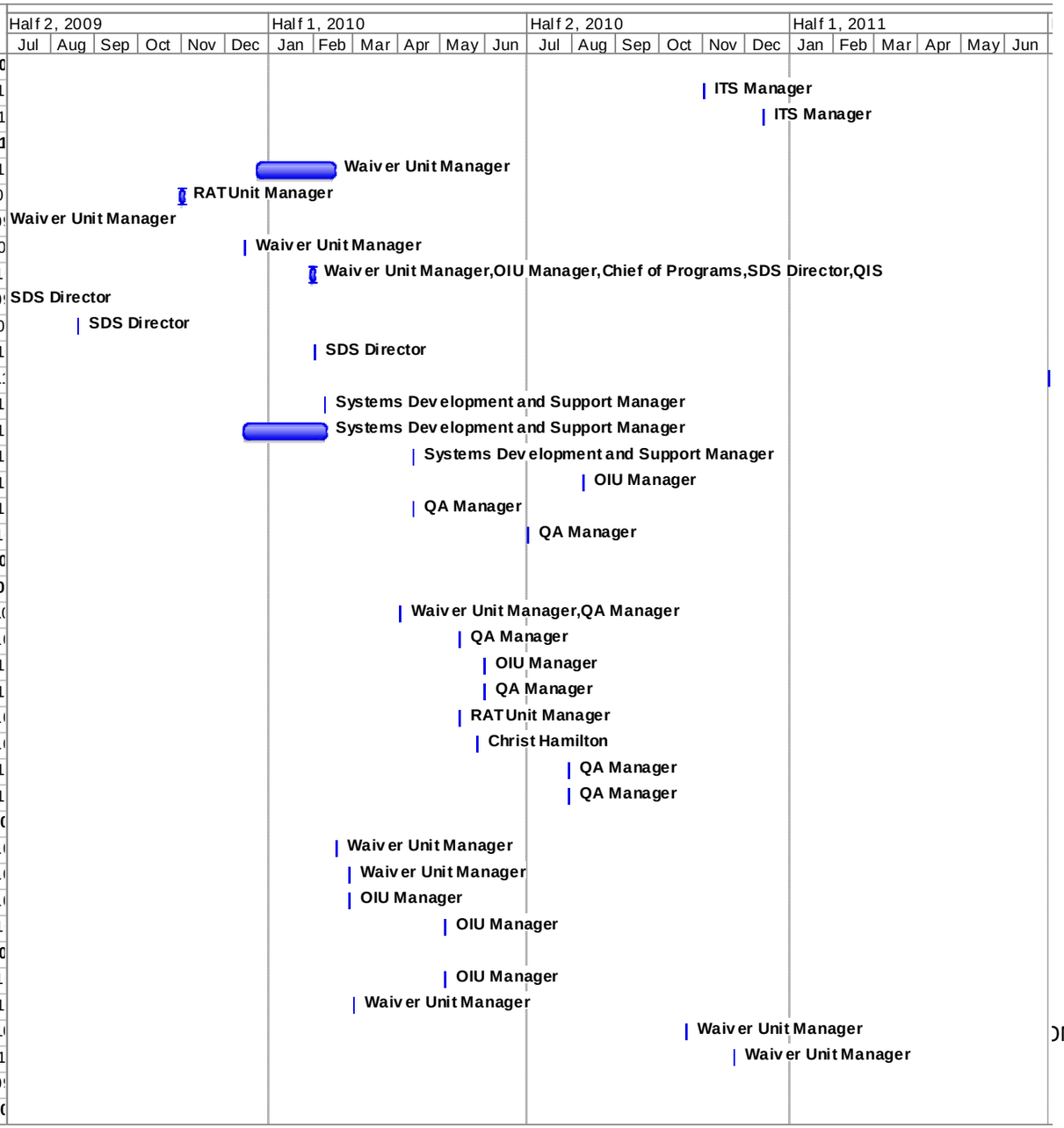
ID	Task Name	Finish
190	**Develop and implement new model for MRDD LOC annual determination**	**Fri 5/14/10**
191	Compile research on Best Practice/ LOC determinations and any applic	Mon 11/30/0
192	Compile a draft concept paper on possible solutions.	Mon 2/1/1
193	Present concept paper to Division Director, Chief of Programs, Deputy D	Mon 2/1/1
194	a. Revisions to concept paper and prepare final draft for submission to	Mon 2/15/1
195	b. Submit concept paper to CMS for review and feedback.	Fri 2/19/1
196	Deliver action plan for development and implementation of the choser	Wed 3/3/1
197	Conduct a gap analysis to explore training, policy, roll-out of alternate	Wed 3/3/1
198	Develop a curriculum for training for staff and providers on the alternate	Wed 3/3/1
199	Draft policies to reflect new method of LOC determinations for MRDD V	Wed 3/3/1
200	Present proposed method of training, policy changes, and plan for roll-	Wed 3/3/1
201	Finalize policy for implementation of new method of LOC determinatic	Fri 4/2/1
202	If needed, submit waiver plan amendment to reflect modifications to a	Fri 5/14/1
203	**Communicate and codify required timelines for completion of initial and**	**Wed 10/6/1**
204	Meet with stakeholders (providers, special interest groups, consumers) to	Mon 10/12/0
205	Submit regulatory language for approval regarding the initial and annu	Wed 10/6/1
206	**FAIR HEARING**	
207	**Fair Hearing: Goal #1: Fair Hearing data will be collated and evaluated as**	**Mon 3/15/1**
208	**Establish a policy and procedure for the collection, distribution and anal**	**Mon 3/15/1**
209	Identify individual within DSDS responsible for overseeing fair hearing	Mon 10/12/0
210	a. Publish policy re: the fair hearing process that includes quality assura	Tue 12/15/0
211	b. Submit developed policy to CMS for review and feedback.	Fri 1/15/1
212	Provide staff training to identified staff re: fair hearing process policy.	Mon 1/4/1
213	Develop fair hearing report and submit to QIW for review and analysis.	Thu 10/15/0
214	Establish defined Fair Hearings performance standards	Mon 3/15/1
215	**SERVICE PLAN**	
216	**Service Plan Sub # 1, 2, 3, 4, 5 Goal #1: Establish QI program to monitor Se**	**Fri 7/1/11**
217	Develop PM r/t Service Plans	Thu 2/25/1
218	Develop monitoring process to track PM re: Service Plans	Mon 4/5/1
219	a. ID source for PM r/t Service Plans	Thu 2/25/1
220	b. Identify responsible person/unit to generate data for PM r/t Service Plans	Thu 2/25/1
221	c. Determine sampling method for PM r/t Service Plans	Thu 2/25/1
222	d. Determine monitoring frequency for PM r/t Service Plans	Thu 2/25/1
223	e. Develop monitoring tools to generate data for PM re: service plans	Thu 2/25/1
224	f. Submit monitoring tool to CMS for review and feedback	Thu 2/25/1
225	Provide QA, OIU and Waiver Unit Supervisors education re: Service Plan Pl	Mon 4/5/1
226	**Begin to collect data required to track Service Plan PM.**	**Mon 4/26/10**
227	a. Data points are defined and documented to ensure data is valid and	Thu 2/25/1
228	b. Data is tracked and trended and presented in monthly, quarterly and	Mon 4/26/1
229	**Submit first monthly SDS QM Report on Service Plan**	**Thu 6/24/10**
230	a. QIW critically analyzes data	Thu 6/24/1



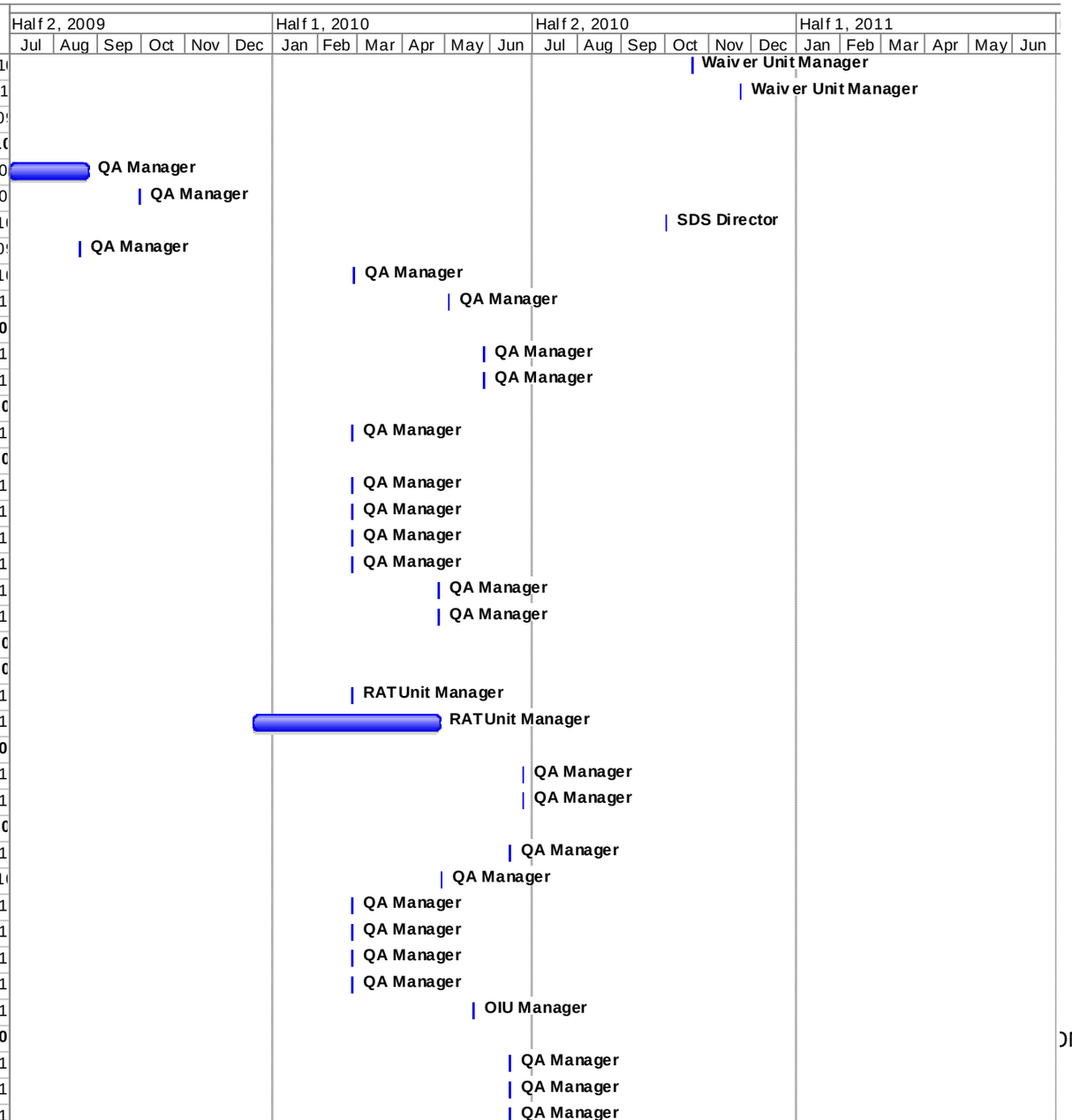
ID	Task Name	Finish
227	a. Data points are defined and documented to ensure data is valid and	Thu 2/25/1
228	b. Data is tracked and trended and presented in monthly, quarterly and	Mon 4/26/1
229	**Submit first monthly SDS QM Report on Service Plan**	**Thu 6/24/10**
230	a. QIW criticaly analyzes data	Thu 6/24/1
231	b. QIW implements remediation/system improvement	Thu 6/24/1
232	**Develop remediation protocol to address problems discovered during or**	**Mon 7/26/10**
233	a. Develop remediation policy	Tue 6/15/1
234	b. Identify who tracks and trends the aggregated remediation data and	Thu 2/25/1
235	c. Identify frequency of Service Plans PM remediation data aggregatio	Thu 2/25/1
236	d. Identify person responsible to address individual remediation r/t Ser	Thu 2/25/1
237	e. Identify individual/group resopnsible to address system improvemen	Thu 2/25/1
238	Provide supervisor training to identified staff re: remediation protocol fo	Thu 5/20/1
239	Begin to collect data on remediation efforts r/t Service Plan PM failures	Tue 6/15/1
240	Submit first SDS Monthly QM Report to QIW	Mon 7/26/1
241	Submit implementation data to CMS	Thu 7/1/1
242	**Service Plan Sub # 1, 2 :Goal #1: Assessments are sufficient to identify**	**Mon 11/1/10**
243	Revise service plan standards, investigate best practices	Mon 7/19/1
244	a. Conduct research on best practices in other states	Tue 4/20/1
245	b. Collaborate with NQE on identifying and implementing best practic	Fri 4/9/1(
246	c. Develop service plan standards	Thu 4/29/1
247	d. Develop process for implementation.	Thu 4/29/1
248	e. Train providers and staff.	Thu 6/17/1
249	f. Educate participants and families on revisions to service planning pr	Mon 7/19/1
250	Analyze and refine current assessment and reassessment tools and proc	Thu 9/30/1
251	a. Develop a process for implementation	Thu 9/30/1
252	b. Implement and train to the identified tool	Fri 10/29/1(
253	Analyze and refine current tools and processes to ensure person-centere	Thu 9/30/1
254	a. Research tools that can be used to facilitate person-centered planni	Fri 7/16/1(
255	b. Develop a process for implementation, including testing phase to er	Thu 9/30/1
256	c. Implement and train to the identified tool	Fri 10/8/1(
257	**Develop and begin deliivering provider training regarding person-ce**	**Fri 10/15/1(**
258	a. Develop provider curriculum and submit to CMS for review.	Fri 10/15/1(
259	Develop and implement automated service plan	Mon 11/1/1
260	a. Develop work tem to research options for automating service plan.	Wed 5/5/1(
261	b. Automate the new service plan modl.	Wed 8/18/1(
262	c. Pilot test the model to identify any technical issues and make chang	Mon 9/20/1
263	d. Introduce the product to providers and lay out plan for delivery of tra	Mon 10/4/1
264	**Service Plan Goal #2: Develop automated serice plan monitoring tool.**	**Mon 12/13/10**
265	Develop automated monitoring tool for service plan standards to monti	Mon 11/1/1
266	Provide CMS with demonstration of automated service plan monitoring	Mon 12/13/1
267	**Service Plan Sub #3: Service Plans are updated/revised at least annual**	**Fri 7/1/11**



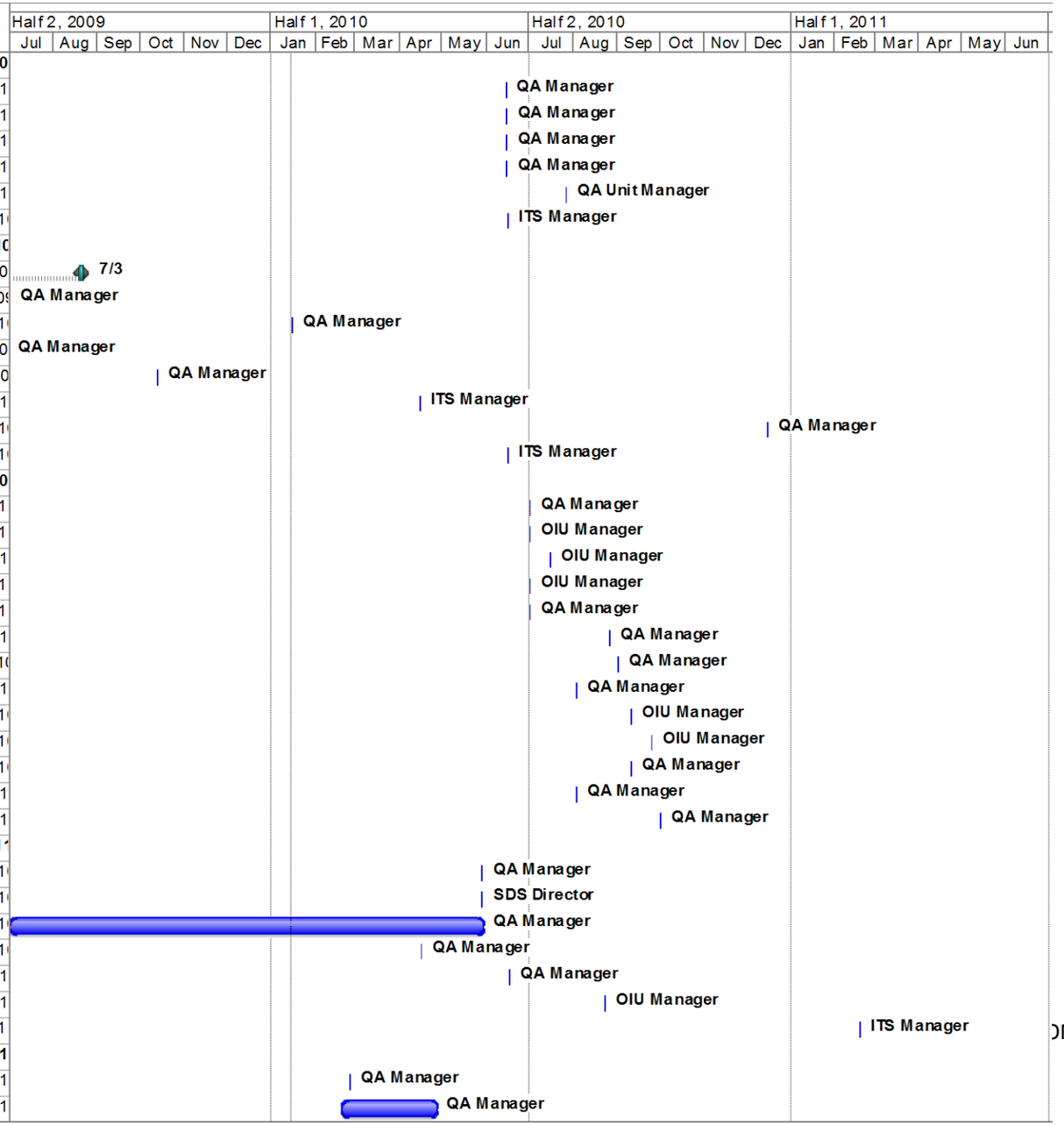
ID	Task Name	Finish
264	**Service Plan Goal #2: Develop automated serice plan monitoring tool.**	**Mon 12/13/10**
265	Develop automated monitoring tool for service plan standards to monti	Mon 11/1/1
266	Provide CMS with demonstration of automated service plan monitoring	Mon 12/13/1
267	**Service Plan Sub #3: Service Plans are updated/revised at least annual**	**Fri 7/1/11**
268	Eliminate existing backlog of annual service plan reviews for all Waiver	Mon 2/15/1
269	a. Develop weekly Service Plan Review Status Report	Sun 11/1/0
270	b. Create a projected timeline for completion of Service Plan Reviews	Fri 6/26/0
271	c. Analyze weekly service plan review status report	Tue 12/15/0
272	i. respond to report findings	Sun 1/31/1
273	Conduct Interim Staffing Analysis staffing needs based on current mode	Fri 6/26/0
274	Begin to implement staffing measues to conduct annual service plans	Thu 8/20/0
275	Develop and implement a process to continuously monitor staffing nee	Mon 2/1/1
276	Begin to implement staffing measures to meet identified staffing needs	Fri 7/1/1
277	Develop SDS policy defining "due date" for annual service planning ar	Mon 2/8/1
278	Publish policy defining "due date" and provide education to staff and k	Mon 2/8/1
279	a. Define criteria, develop and implement waiver service plan amendn	Mon 4/12/1
280	b. Begin training of providers on waiver service plan amendment P&P	Mon 8/9/1
281	Develop long term staffing plan for quality assurance unit that includes	Mon 4/12/1
282	Identified staffing plan is implemented if budget approved	Thu 7/1/1
283	**Service Plans Sub 4: Services are delivered in accordance with service pla**	**Mon 11/22/10**
284	**Analyze and refine current assessment and reassessment tools and pro**	**Thu 7/29/10**
285	a. Research how other states monitor service delivery	Fri 4/2/1
286	b. Monitoring process is developed to track the information in the asses	Fri 5/14/1
287	c. Provide QA, OIU, and Waiver Unit supervisors education re: assessm	Mon 5/31/1
288	d. Begin to collect data required to track that assessment driven service	Mon 5/31/1
289	e. Data points are defined and documented	Fri 5/14/1
290	f. Data is tracked and trended and presented in monthly, quartelry and	Wed 5/26/1
291	g. QIW critically analyzes aggregated data	Thu 7/29/1
292	h. QIW implements remediation/system improvement	Thu 7/29/1
293	**Review section IX of the Plan of Care and revise the language to include**	**Fri 2/26/10**
294	a. Revise client choice form	Wed 2/17/1
295	b. Share revised POC re: choice requirements w/Governor's Council for	Fri 2/26/1
296	Submit training curriculum on Choice requirements to CMS for review and f	Fri 2/26/1
297	Begin training of providers on Choice requirements	Tue 5/4/1
298	**Develop safeguards to address the potential issue of conflict of interest**	**Mon 11/22/10**
299	a. Outline process of review of Choice Form by POC Review	Tue 5/4/1
300	b. Develop a brochure describing available services and a plan for dist	Mon 3/1/1
301	c. Develop a process/expectation for the care coordinators to utilize an	Wed 10/20/1
302	d. Submit safeguards to assure freedom from conflict of interest to CMS	Mon 11/22/1
303	HEALTH & WELFARE	Fri 6/26/0
304	**H&W Sub 1: Goal 1: Establish Mortality Review Process**	**Fri 10/1/10**



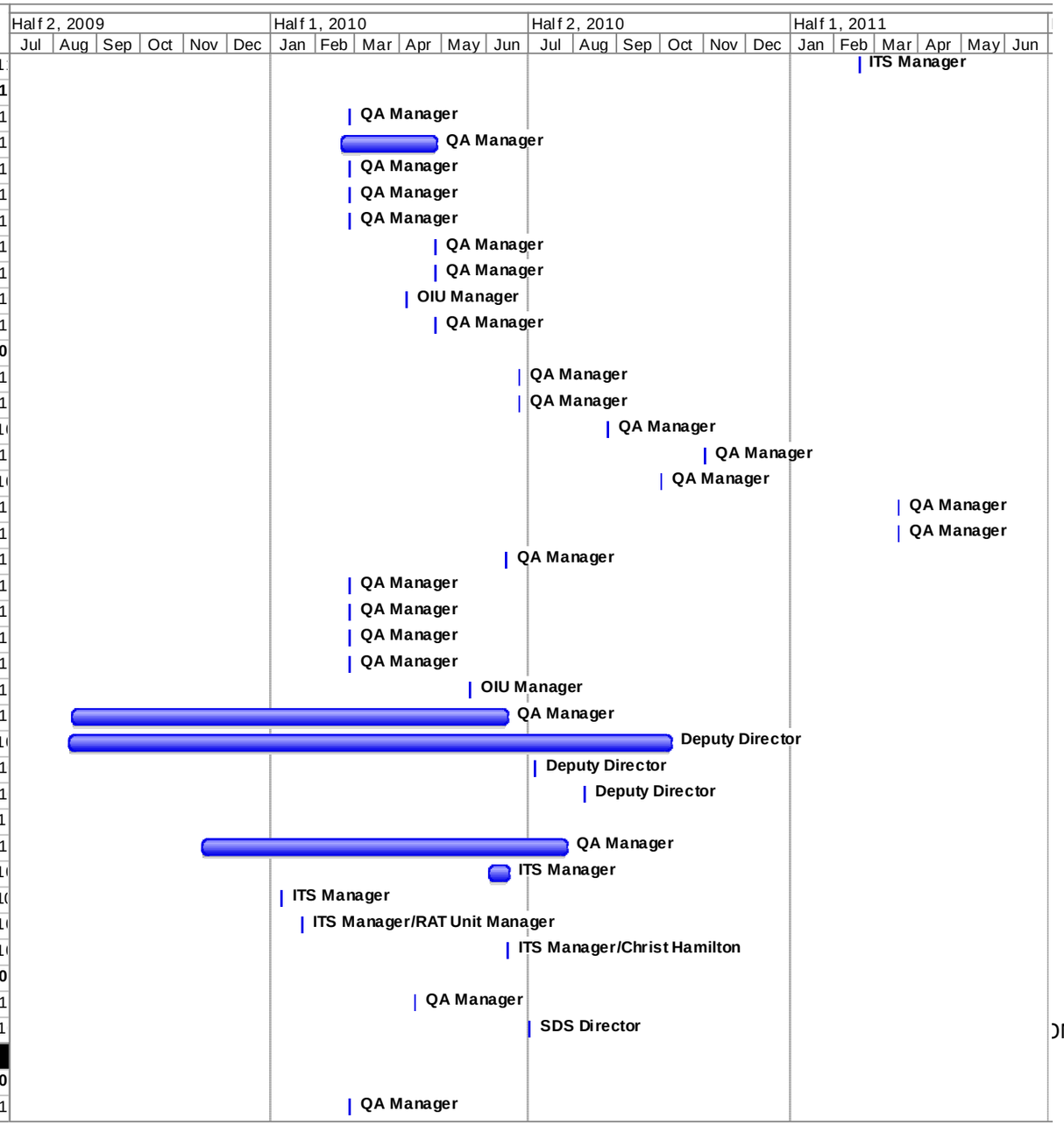
ID	Task Name	Finish
301	c. Develop a process/expectation for the care coordinators to utilize an	Wed 10/20/1
302	d. Submit safeguards to assure freedom from conflict of interest to CMS	Mon 11/22/1
303	**HEALTH & WELFARE**	Fri 6/26/0
304	**H&W Sub 1: Goal 1: Establish Mortality Review Process**	**Fri 10/1/1**
305	Establish mortality review committee and conduct weekly meetings.	Mon 8/24/0
306	a. Identify Mortality Review Committee members	Tue 9/29/0
307	i. SDS will continue to look for opportunities to refine its process and will co	Fri 10/1/1
308	b. Work with NQE to ID best practices in other states	Wed 8/19/0
309	c. Draft Mortality Review policy that incorporates guidance for MRC re: role	Fri 2/26/1
310	d. Develop reporting format to submit aggregated data and analysis quarte	Mon 5/3/1
311	**Incorporate Mortality Review Report into Monthly QIW meetings**	**Thu 5/27/10**
312	a. QIW criticially analyzes data	Thu 5/27/1
313	b. QIW implements remediation/system improvement if problems found	Thu 5/27/1
314	**H&W Sub 1: Goal 2: Establish quality improvement program to monitor PMs r**	**Mon 7/26/1**
315	Develop Performance Measure r/t H&W	Thu 2/25/1
316	**Develop monitoring process for PM regarding H&W**	**Mon 4/26/1**
317	a. ID data source for PM r/t H&W	Thu 2/25/1
318	b. Identify responsible person to generate data for PM r/t H&W	Thu 2/25/1
319	c. Determine sampling method for PM r/t H&W	Thu 2/25/1
320	d. Determine monitoring frequency for PM r/ot H&W	Thu 2/25/1
321	e. Develop review tool for PM r/t H&W	Mon 4/26/1
322	f. Submit monitoring tool to CMS for review and feedback	Mon 4/26/1
323	**Provide training to identified staff re: PM r/t H&W**	**Mon 7/26/1**
324	**Begin to collect data required to monitor H&W PM**	**Mon 4/26/1**
325	a. Data points are defined and documented to ensure data is valid	Thu 2/25/1
326	b. Data is tracked and trended and presented for analysis	Mon 4/26/1
327	**Submit SDS monthly QM report on H&W PM to QIW for review and ar**	**Thu 6/24/10**
328	a. QIW critically analyzes data	Thu 6/24/1
329	b. If QIW implements remediation/system improvement	Thu 6/24/1
330	**Develop and implement remediation strategies to address PM and p**	**Mon 7/26/1**
331	a. Develop provider remediation policy inclusive of remediation pr	Tue 6/15/1
332	b. Submit draft provider remediation policy to CMS	Wed 4/28/1
333	c. Identify who tracks and trends the aggregated data and analyze	Thu 2/25/1
334	d. Identify frequency of Health & Welfare performance measure re	Thu 2/25/1
335	e. Identify person responsible to address individual issues r/t H&W	Thu 2/25/1
336	f. Identify individual/group responsible to address systemic issues.	Thu 2/25/1
337	Provide staff training to unit managers and supervisors re: remedial	Thu 5/20/1
338	**Begin to collect data on remediation efforts r/t H&W PM and proc**	**Tue 6/15/10**
339	a. Collect and aggregate data to measure trends in performar	Tue 6/15/1
340	b. Identify negative trends and develop system improvement s	Tue 6/15/1
341	c. Collect and code types of reasons why remediation did not	Tue 6/15/1



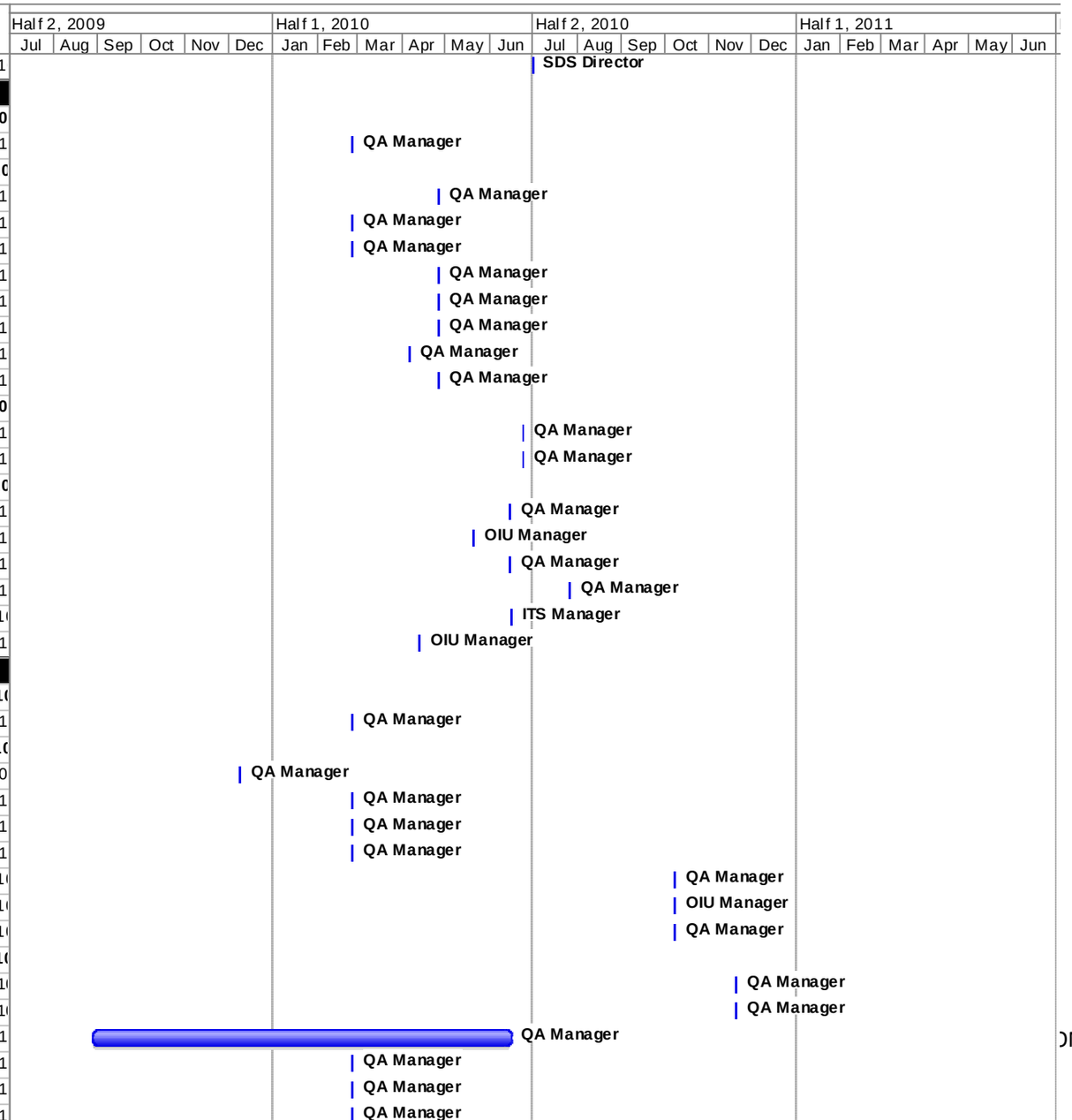
ID	Task Name	Finish
338	**Begin to collect data on remediation efforts r/t H&W PM and proc**	**Tue 6/15/10**
339	a. Collect and aggregate data to measure trends in performar	Tue 6/15/1
340	b. Identify negative trends and develop system improvement	Tue 6/15/1
341	c. Collect and code types of reasons why remediation did not	Tue 6/15/1
342	d. Collect and code types of actions taken to remediate the id	Tue 6/15/1
343	Submit first SDS Monthly QM report to QIW re: remediation efforts	Mon 7/26/1
344	a. Develop IT solution to capture/track remediation actions r/t to H	Wed 6/16/1
345	**H&W Sub 1: Goal 3: Refine Critical Incident Reporting Process and Provider**	**Wed 12/15/10**
346	Draft and submit routine periodic reports of provider training on Critical Inci	Thu 8/20/0
347	a. Implement Criticial Incident Policy.	Wed 7/1/09
348	b. Submit Critical Incident Polity to CMS	Fri 1/15/1
349	c. Train providers on new policy	Mon 6/29/0
350	Review policy and refine as needed quarterly	Mon 10/12/0
351	Develop critical incident database	Thu 4/15/1
352	Refine process for analyzing criticial incident reporting data to identify gaps	Wed 12/15/1
353	a. Develop IT solution to submit critical incident reports from providers and	Wed 6/16/1
354	**Draft and implement restraint use and reporting policy.**	**Thu 8/26/10**
355	a. Draft restraint use and reporting policy, submit for publication and a	Thu 7/1/1
356	b. Educate Unit Managers on restraint use and reporting policy	Thu 7/1/1
357	c. Begin to educate providers on restraint use and reporting policy	Thu 7/15/1
358	d. Develop a data collection monitoring tool to collect data on policy	Thu 7/1/1
359	e. Implement remediation when problems are discovered re: restraint a	Thu 7/1/1
360	f. Begin monthly report of restraints and restrictive intervention	Thu 8/26/1
361	Draft and implement medication management and administration policy	Wed 9/1/1
362	a. Draft policy re: medication management and administration	Mon 8/2/1
363	b. Educate SDS Unit Managers on medication management and administr	Fri 9/10/1
364	c. Educate providers on medication management and administration polic	Fri 9/24/1
365	d. Develop a data collection monitoring tool to collect data on medication	Fri 9/10/1
366	e. Implement remediation when problems are discovered	Mon 8/2/1
367	f. Begin monthly report of medication management and administration dis	Thu 9/30/1
368	**H&W Sub 1: Goal 4: Establish QA referral process according to policy.**	**Fri 2/18/1**
369	Develop QA Referral Policy and process	Fri 5/28/1
370	Division Director signs policy	Fri 5/28/1
371	Implement QA Referral Policy	Fri 5/28/1
372	a. Submit draft QA Referral policy to CMS for review	Fri 4/16/1
373	b. Educate staff on QA referral policy for communicating compliants or prog	Thu 6/17/1
374	c. Begin to educate providers on QA referral policy	Mon 8/23/1
375	d. Develop an automated QA referral reporting system and tracking tool	Fri 2/18/1
376	**QP Sub 1: Goal 1: Establish PM r/t providers initially and continually meeting**	**Thu 9/1/11**
377	Develop PM r/t providers initially and continually meeting licensure and im	Thu 2/25/1
378	Develop monitoring process to track PM	Mon 4/26/1



ID	Task Name	Finish
375	d. Develop an automated QA referral reporting system and tracking tool	Fri 2/18/1
376	**QP Sub 1: Goal 1: Establish PM r/t providers initially and continually meeting**	**Thu 9/1/11**
377	Develop PM r/t providers initially and continually meeting licensure and imp	Thu 2/25/1
378	Develop monitoring process to track PM	Mon 4/26/1
379	a. Identify data source for PM r/t providers initially and continually meeting	Thu 2/25/1
380	b. Identify responsible person/unit to generate data for PM r/t providers initi	Thu 2/25/1
381	c. Determine monitoring frequency for PM r/t providers initially and continu	Thu 2/25/1
382	d. Develop monitoring tools to generate data for PM r/t providers initially a	Mon 4/26/1
383	e. Submit monitoring tool to CMS for reqview/feedback	Mon 4/26/1
384	Educate QA unit staff who will be collecting data r/t providers initially and c	Mon 4/5/1
385	Begin to collect data required to track PM r/t providers initially and continua	Mon 4/26/1
386	**Submit first monthly SDS QM report r/t providers initially and continually**	**Thu 6/24/10**
387	a. QIW analyzes data	Thu 6/24/1
388	b. QIW identifies opportunities for improvement	Thu 6/24/1
389	Refine provider standards by provider type	Wed 8/25/1
390	Refine criteria and system for provider site visits and establish visit schedule	Mon 11/1/1
391	Analyze and refine tools and processes used to monitor performance	Fri 10/1/1
392	Integrate the refined performance standards into provider agreements	Thu 3/17/1
393	Communicate refined performance standards and changes to provider agre	Thu 3/17/1
394	a. Develop remediation policy	Tue 6/15/1
395	b. Identify who tracks and trends the aggregated remediation data and ana	Thu 2/25/1
396	c. Identify frequency of QA PM remediation	Thu 2/25/1
397	d. Identify person responsible to address individual remediation r/t QA PMs	Thu 2/25/1
398	e. Identify individual/group responsible to address system improvement	Thu 2/25/1
399	Provide staff training to QA staff re: remediation protocol for PM r/t QP	Thu 5/20/1
400	Begin to collect data on remediation efforts r/t QA PM failures	Tue 6/15/1
401	Explore feasibility of performance based contracting with providers includin	Fri 10/8/1
402	a. Develop tax committee to define scope of work and deliverables	Mon 7/5/1
403	b. Outline development plan/timeline	Mon 8/9/1
404	c. Implement action plan if performance based contracting is adopted	Thu 9/1/1
405	Submit first SDS Monthly QM report to QIW	Mon 7/26/1
406	Develop IT solution to capture/track remediation actions	Wed 6/16/1
407	a. Develop task committee to define scope of work and deliverables	Fri 1/8/1
408	b. Outline development plan/timeline	Fri 1/22/1
409	c. Deploy electronic tool	Wed 6/16/1
410	**Develop viable staffing plan to meet waiver oversight requirements re:**	**Thu 7/1/10**
411	Begin to analyze staffing needs to implement QA measures	Mon 4/12/1
412	Implement strategy for increasing staffing required to conduct reviews, e	Thu 7/1/1
413	**QUALIFIED PROVIDERS**	
414	**QP Sub 3: State implements P&P for verifying that training is provided in ac**	**Thu 6/24/10**
415	Develop Performance Measures regarding implementation of policies and p	Thu 2/25/1



ID	Task Name	Finish
412	Implement strategy for increasing staffing required to conduct reviews, e	Thu 7/1/1
413	**QUALIFIED PROVIDERS**	
414	**QP Sub 3: State implements P&P for verifying that training is provided in ac**	**Thu 6/24/10**
415	Develop Performance Measures regarding implementation of policies and p	Thu 2/25/1
416	**Develop monitoring process**	**Mon 4/26/10**
417	a. ID data source for PM	Mon 4/26/1
418	b. ID responsible person/unit to generate data	Thu 2/25/1
419	c. Determine monitoring frequency	Thu 2/25/1
420	d. Develop review tool for assessing implementation of policies	Mon 4/26/1
421	e. Develop provide monitoring review tool designed to discover proble	Mon 4/26/1
422	f. Submit monitoring tool to CMS	Mon 4/26/1
423	Educate QA Unit staff	Mon 4/5/1
424	Begin data collection on performance	Mon 4/26/1
425	**Submit first monthly SDS Quality Monitoring Report r/to implementation o**	**Thu 6/24/10**
426	a. QIW critically analyzes data	Thu 6/24/1
427	b. QIW implements remediation/system improvement	Thu 6/24/1
428	**Develop and implement remediation strategies to address problems discove**	**Mon 7/26/10**
429	Develop remediation policy	Tue 6/15/1
430	Educate staff and key stakeholders on remediation protocol	Thu 5/20/1
431	Begin to collect data on the remediation efforts for implementation	Tue 6/15/1
432	Produce first report to QIW	Mon 7/26/1
433	Develop IT solution to capture/track remediation	Wed 6/16/1
434	Refine process for identifying provider training needs	Tue 4/13/1
435	**FINANCIAL ACCOUNTABILITY**	
436	**FA Sub #1 Goal #1 Establish a systematic, data-driven quality improvem**	**Fri 11/19/1**
437	Develop PM r/t claim submission consistent with services provided	Thu 2/25/1
438	**Develop process to compare claims against services provided to m**	**Fri 10/8/1**
439	a. Identify data source for PM r/t FA	Tue 12/8/0
440	b. ID responsible party/unit to generate data for PM	Thu 2/25/1
441	c. Determine sampling method for PM r/t FA	Thu 2/25/1
442	d. Determine monitoring frequency for performance measures rela	Thu 2/25/1
443	e. Develop data collection tool r/t claim submission c/w services pr	Fri 10/8/1
444	Provide QA Unit Supervisor staff education re: FA PM and monitoring	Fri 10/8/1
445	Begin collecting data on claims consistent with services provided	Fri 10/8/1
446	**Submit first report of monitoring data r/t claim submission c/w servi**	**Fri 11/19/1**
447	a. QIW critical analyzes data	Fri 11/19/1
448	b. QIW implements remediation/system improvement if problems f	Fri 11/19/1
449	Develop remediation policy to address problems identified in monitorin	Tue 6/15/1
450	a. Identify who tracks/trends aggregated remediation data r/t FA	Thu 2/25/1
451	b. Identify frequency of FA PM remediation data aggregation and anal	Thu 2/25/1
452	c. Identify person responsible to address individual remediation r/t FA	Thu 2/25/1



ID	Task Name	Finish
449	Develop remediation policy to address problems identified in monitorin	Tue 6/15/1
450	a. Identify who tracks/trends aggregated remediation data r/t FA	Thu 2/25/1
451	b. Identify frequency of FA PM remediation data aggregation and anal	Thu 2/25/1
452	c. Identify person responsible to address individual remediation r/t FA	Thu 2/25/1
453	d. Identify person/group responsible to address system improvement.	Thu 2/25/1
454	Provide staff training to identified staff re: remediation protocol for PM	Thu 5/20/1
455	Begin to collect remediation data r/t PM in claim submission c/w servic	Tue 6/15/1
456	Submit first report of remediation data collected r/t PM in claim submis	Mon 7/26/1
457	**FA Sub #1 Goal #2 Establish uniform rate methodology**	**Thu 7/1/10**
458	Begin to implement new rate methodology	Thu 7/1/1
459	Submit new rate methodology to CMS	Thu 7/1/1
460	If necessary, implement programming changes in DS3	Thu 7/1/1
461	**FA Sub #1 Goal #3 Claims processing continue when ICD-10 requiremer**	**Thu 10/1/09**
462	Verify implementation plan is in place for ICD-10 with target date of 20	Thu 10/1/0