

**Office of Developmental Programs
Quality Assessment & Improvement (QA&I)
Tool Changes for Cycle 3, Year 1 (C3Y1)**

KEY - **Bold** = Updated
 Strikethrough = Removed
 Italics = New

All Tools

Section	Update(s)	Reason for Update(s)
General updates	<ul style="list-style-type: none"> References to “C2Y3” were updated to reflect “C3Y1”. Question numbers were updated due to the addition of several new questions. Outdated/obsolete source documents were removed. References to Appendix K modifications were removed. 	

Administrative Entity (AE) Tool

Question	Update(s)	Reason for Update(s)
The AE completes monitoring of delegated or purchased administrative functions.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer determines if the AE completes monitoring for delegated or purchased administrative functions. Monitoring documentation should include at a minimum: <ul style="list-style-type: none"> A method to verify compliance with written Policies, Procedures, Departmental Decisions, state and federal laws and regulations and the requirements to the function purchased/delegated. The frequency of monitoring by the AE. The staff position/titles responsible for the monitoring. Exclude the review of delegated or purchased incident management functions. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
<i>New - The AE has an Incident Manager (IM) that is a Certified Investigator (CI).</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> <i>The reviewer will determine if the AE has designated a person who is fulfilling the role of the agency’s Incident Manager (IM), through verification of evidence provided, including but not limited to a current organizational chart or designation by position description. The evidence provided shall include the date of which the person</i> 	The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.

	<p><i>began fulfilling the role of the Incident Manager.</i></p> <ul style="list-style-type: none">o <i>The reviewer will determine if the IM has a current CI certificate.</i>o <i>The reviewer will compare the date the IM assumed their role as the IM with the current date the IM obtained their certificate.</i>o <i>IMs have 12 months from the date of assuming their role as IM to complete and pass the ODP CI training.</i> <p><u><i>Response Options:</i></u></p> <p><i>(Yes) There is evidence that the AE has an IM that is a CI, or the IM assumed their role less than 12 months ago.</i></p> <p><i>(No) There is no evidence that the AE has an Incident Manager.</i></p> <p><i>(No) The Incident Manager did not have a CI certificate within the required timeframe.</i></p> <p><u><i>Source Documents:</i></u></p> <p><i>IM Bulletin 00-21-02 IV.g</i></p>	
<p><i>New - The Incident Manager ensures Certified Investigator Peer Reviews (CIPRs) are conducted on a semi-annual basis.</i></p>	<p><u><i>Guidance:</i></u></p> <ul style="list-style-type: none">• <i>The reviewer will determine if the Incident Manager ensures CIPRs are conducted on a semi-annual basis.</i>• <i>All entities that complete investigations are required to conduct the standardized CIPR process which involves using the most current forms as outlined in the ODP CIPR manual.</i> <p><i>Review Period is 7/1/2024-6/30/2025</i></p> <p><u><i>Response Options:</i></u></p> <p><i>(Yes) The Incident Manager ensured Certified Investigator Peer Reviews (CIPRs) were conducted on a semi-annual basis.</i></p> <p><i>(No) There is no evidence that the Incident Manager ensured Certified Investigator Peer Reviews (CIPRs) were conducted on a semi-annual basis.</i></p> <p><i>(N/A) No new investigations conducted during the review period.</i></p> <p><u><i>Source Documents:</i></u></p> <p><i>ODP Certified Investigator Peer Review (CIPR) Manual, 2023 Version 4.0</i></p> <p><i>Bulletin 00-21-02, Incident Management</i></p>	<p>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.</p>
<p><i>New - The Incident Manager ensures adherence to expectations</i></p>	<p><u><i>Guidance:</i></u></p> <ul style="list-style-type: none">• <i>The reviewer will determine if any complaints related to the IM Process were received by the AE.</i>	<p>The new question was added to address an area of need identified in Cycle 2 as</p>

related to the Incident Management complaint process.	<ul style="list-style-type: none">• The reviewer will determine if the Incident Manager adheres to the Incident Management Complaint Process requirements that include a timely response to complaints provided to the individual/complainant in the communication method preferred by the individual/complainant. <p><u>Response Options:</u> (Yes) There is evidence that the AE's response was timely and delivered in the communication method preferred by the individual/complainant. (No) There is no evidence that the AE's response was timely and delivered in the communication method preferred by the individual/complainant. (N/A) No complaints received during the review period.</p> <p><u>Source Documents:</u> 1915(c) HCBS Waiver Bulletin 00-21-02, Incident Management</p>	well as other processes that evaluate incident and risk management.
The AE maintains a signed written documentation contract or agreement of any delegated or purchased function related to Incident Management (IM).		The question was updated to provide clarification in response to feedback and questions from Cycle 2.
The AE completes monitoring of delegated or purchased Incident Management function(s).	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will determine if the AE completes monitoring for delegated or purchased IM function(s) identified in previous question.• Monitoring documentation should include at a minimum:<ul style="list-style-type: none">◦ A method to verify compliance with ODP Regulations, written policies and procedures, departmental decisions, state and federal laws and regulations that are related to the function purchased/delegated.◦ The frequency for monitoring by the AE (at least quarterly) The monitoring of delegated functions should be completed on at least a quarterly basis and the results of the monitoring should be readily available in a written format.◦ The staff position/titles and names of those responsible for the monitoring.◦ Description of any issues detected during monitoring and their resolution. <p><u>Response Options:</u></p>	The question and guidance were updated to provide clarification in response to feedback and questions from Cycle 2.

	<p>(Yes) The AE completes monitoring of all delegated or purchased IM function(s) and has written documentation of all the listed requirements.</p> <p>(No) The AE completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.</p> <p>(No) The AE did not complete monitoring of delegated or purchased IM function(s) and/or did not have written documentation of all the listed requirements.</p> <p>(N/A) The AE does not delegate or purchase any IM functions or the delegated/purchased incident management function did not need to be utilized during the review period.</p>	
<p><i>New - AE follows up on actions taken to address concerns identified through the monitoring process of Incident Management delegated functions.</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The reviewer will determine if the AE provides evidence of follow up actions taken to address concerns identified through the monitoring process of delegated functions.</i>• <i>The AE's monitoring follow up should be readily available in a written format and should include at a minimum:</i><ul style="list-style-type: none">○ <i>Area(s) of identified concern(s)</i>○ <i>Deadline for actions to be completed on behalf of the delegated or contracted entity</i>○ <i>The staff position/titles and name(s) of those responsible to ensure identified actions are completed</i>○ <i>The manner in which the information was relayed to the delegated or contracted entity (e.g.: email, documentation of live communication between the AE and entity such as meeting minutes, or letter)</i> <p><u>Response Options:</u></p> <p><i>(Yes) The AE follows up on actions taken to address concerns identified through the monitoring process of delegated functions.</i></p> <p><i>(No) The AE did not follow up on actions taken to address concerns identified through the monitoring process of delegated functions.</i></p> <p><i>(N/A) The AE does not delegate or purchase or did not identify concerns through monitoring activities of delegated functions.</i></p> <p><u>Source Documents:</u></p> <p><i>Consolidated, CL and P/FDS Waivers</i></p> <p><i>Bulletin 00-21-02, Incident Management</i></p> <p><i>AE OA</i></p>	<p>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.</p>

<p><i>New – The AE has a protocol that describes how Multi Year Program Growth Strategy standards and measures are monitored.</i></p> <p><i>Non-Scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The reviewer determines if the AE has a written protocol that monitors the standards and measures set forth as part of ODP’s Multi Year Program Growth Strategy for their MYPGS standards and measures.</i>• <i>The AE’s protocol shall include the following:</i><ul style="list-style-type: none">○ <i>Data collection methods</i>○ <i>Monitoring activities</i>○ <i>Provider communication and Technical Assistance</i>○ <i>Documentation and reporting</i>○ <i>Review and continuous improvement</i>○ <i>Staff roles and responsibilities</i> <p><u>Response Options:</u></p> <p><i>(Yes) The AE has a protocol that describes how Multi Year Program Growth Strategy Standard and Measures are monitored.</i></p> <p><i>(No) The AE did not have a protocol that describes how Multi Year Program Growth Strategy Standard and Measures are monitored.</i></p> <p><u>Source Documents:</u></p> <p><i>Exploratory</i></p> <p><i>AE OA Section 3.4</i></p>	<p>The new question was added to address an area of need.</p>
<p><i>New – The AE has a protocol that describes how Utilization Reviews are conducted.</i></p> <p><i>Non-Scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The reviewer will determine if the AE has a written protocol that describes how utilization reviews are conducted and evidence that reflects implementation.</i>• <i>Protocol should include, but is not limited to the following:</i><ul style="list-style-type: none">○ <i>Usage of available tools such as the AE Dashboard and HCSIS reports</i>○ <i>Communication between AE program and fiscal staff</i>○ <i>Monthly reviews of authorization versus utilization</i>○ <i>Collaboration on utilization with partnering Supports Coordination Organizations</i> <p><u>Response Options:</u></p> <p><i>(Yes) The AE has a protocol that describes Utilization Review.</i></p> <p><i>(No) The AE does not have a protocol that describes Utilization Review.</i></p> <p><u>Source Documents:</u></p>	<p>The new question was added to address an area of need.</p>

	<p><i>Exploratory</i> <i>AE OA Section 3.4</i></p>	
<p><i>New – The AE has a policy/protocol that describes their process reviews for interval Individual Support Plan (ISP) reviews and service authorizations.</i></p> <p><i>Non-Scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • <i>The reviewer will determine if the AE has documentation of a policy/protocol for their interval ISP reviews and service authorizations that adheres to ODP’s requirements.</i> • <i>Policy/protocol should include, but is not limited to the following:</i> <ul style="list-style-type: none"> ◦ <i>Internal controls around ISP reviews</i> ◦ <i>Review of ISPs to ensure services are authorized in accordance with identified needs, waiver expectations, and budget impact</i> <p><u>Response Options:</u></p> <p><i>(Yes) The AE has a policy/protocol that describes their process for interval ISP reviews and service authorizations.</i></p> <p><i>(No) The AE does have a policy/protocol for interval ISP reviews and service authorizations.</i></p> <p><u>Source Documents:</u></p> <p><i>Exploratory</i> <i>AE OA Section 3.4</i></p>	<p>The new question was added to address an area of need.</p>
<p>The AE follows ODP’s record retention policy for individual closed records.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the AE followed ODP’s record retention policy for individual closed records. • The reviewer will determine if the AE has any individual closed records by reviewing the “Demographics by County” report in HCSIS. • The reviewer will review 1% of individual closed records with a maximum of five closed records. If there are less than five individuals closed for an AE, all individual closed records must be reviewed. <ul style="list-style-type: none"> ◦ While an AE may have a longer purge period, this applies to all closed records that have not been purged; no closed records should be purged before five years of being closed. • The AE must: <ul style="list-style-type: none"> ◦ Preserve the documents listed in Section 3.3.1 until the expiration of five (5) years after the ID/A Waiver Participant’s case is closed; or ◦ Record(s) that relate to litigation, audit exceptions, or the settlement of a Claim related to performance or expenditures under this Agreement must be retained by the AE until such litigation, audit exception, or Claim has reached final disposition. • The reviewer will determine if the AE’s closed record(s) reviewed adhered to ODP’s record retention policy. In Year 1, reviewers will look back 5 years; in Year 2, reviewers will look back 4 years; and in Year 3, reviewers will look back 3 	<p>The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.</p>

	years.	
<p>The AE has a process to manage vacated capacity to ensure waiting list emergent needs are addressed timely.</p> <p>Non-Scored</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">The reviewer will talk with the AE to determine how the AE:<ul style="list-style-type: none">Triage and prioritizes emergent needProvides updated information to the SCOs about emergent needs of those on the waiting listUses data to identify who will be in need of waiver services (e.g., aging out of EPSDT, aging out of a RTF, children and youth, etc.)The reviewer will review the AE's process to ensure the process includes:<ul style="list-style-type: none">How the AE triages and prioritizes emergent needHow the AE will provide updated information to SCOs about emergent needs of those on the waiting listHow the AE uses data to identify who will be in need of waiver services (e.g., aging out of EPSDT, aging out of a RTF, children and youth, etc.)The reviewer will consider that emergent needs are addressed timely according to the following criteria unless there is documentation that the circumstance was outside the AE's control.<ul style="list-style-type: none">Within 14 calendar days to be in either reserved capacity or enrolled for the Consolidated and Community Living WaiversWithin 30 calendar days in reserved capacity or enrolled for the P/FDS Waiver. <p><u>Response Options:</u></p> <p><u>(Yes)</u> The AE has a process to manage vacant capacity to ensure waiting list emergent needs are addressed timely. The AE demonstrates it is managing vacated capacity to timely address waiting list emergent needs.</p> <p><u>(No)</u> The AE does not have a process to manage vacant capacity, or required components to process are missing, to ensure waiting list emergent needs are addressed timely. The AE is unable to demonstrate verbally or through provided documentation that it is addressing emergent needs by managing vacated capacity.</p> <p><u>Source Documents:</u></p> <p>Exploratory</p> <p>AE OA, Sections 3.4 & 3.4.1</p>	<p>The question, guidance, and response options were updated to provide clarification in response to feedback and questions as well as data analysis from Cycle 2.</p>

New – The AE has a Prioritization of Urgency of Need for Services (PUNS) protocol.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will determine that the AE has a PUNS protocol that includes the following:<ul style="list-style-type: none">○ Identified AE staff responsible for PUNS related activities.○ Engagement with the SCO on a regular basis to ensure PUNS accuracy and information sharing to determine emergent individuals on the PUNS waiting list.○ Training of AE staff, SCOs and intake/registration workers○ Oversight to ensure prospective and current waiver participants are placed in the appropriate category of need.• The reviewer will look at documentation and other evidence provided by the AE to verify the AE has implemented the protocol. <p><u>Response Options:</u></p> <p>(Yes) The AE has a Prioritization of Urgency of Needs for Services protocol.</p> <p>(No) The AE does not have a Prioritization of Urgency of Need for Services protocol.</p> <p><u>Source Documents:</u></p> <p>AE OA 6.4</p>	The new question was added to address an area of need.
The AE conducts oversight of the Priority of Urgency of Need for Services (PUNS) as per ODP’s PUNS policy.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will access the PUNS data in HCSIS for the previous month and the current month.• The reviewer will compare the PUNS data from the previous month to the current month to ensure that the AE is conducting oversight as per ODP’s PUNS policy.• The reviewer will determine if through the AE’s oversight, the following areas are considered:<ul style="list-style-type: none">○ PUNS are updated within 365 days from the date of the last PUNS○ Within 30 days of an identified change in need○ Marked inactive when an individual is fully served○ Active in the Consolidated Waiver and has an emergency PUNS Enrolled in the Consolidated Waiver and marked as inactive and fully served. <p>COMMENT NEEDED – Identify instances where the AE has documentation of contact with the SCO regarding PUNS updates needed and the SCO did not take action.</p> <p><u>Source Documents:</u></p> <p>AE OA, Section 6.4</p>	The guidance and source documents were updated to provide clarification in response to the updated PUNS Manual.

	<p>Consolidated, CL and P/FDS Waivers</p> <p>Bulletin 00-19-03, Prioritization of Urgency of Need for Services (PUNS) Manual</p> <p>Prioritization of Urgency of Need for Services (PUNS) Manual for Individuals with Intellectual Disabilities and/or Autism</p> <p>ODP Announcement 25-043, Updates to the Prioritization of Urgency of Need for Services (PUNS) Manual for Individuals with Intellectual Disabilities and/or Autism</p>	
<p>The AE has worked with community stakeholders to develop a local employment coalition if none exists or has enhanced its current coalition.</p>		<p>This question was removed as it was determined that this data is collected in another area.</p>
<p>The AE actively expands and builds capacity of the Provider network.</p> <p>Non-Scored</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer will have a conversation with the AE about its Provider network expansion efforts and review documentation of outreach and capacity building efforts to ensure the AE is actively working to expand and build the capacity of its Provider network. The reviewer will review the AE’s documentation of outreach and capacity building efforts to ensure the AE is actively working to expand and build the capacity of its Provider network. The reviewer will review evidence of expansion of service capacity. (Examples include: Providers of all ID/A services available in county, new residential service locations, new community participation supports services providers or new locations, number of individuals served, new providers rendering services) The reviewer will have a conversation with the AE about how the needs of the individuals are monitored/tracked and how willing and qualified providers are identified to address said needs. <p><u>Response Options:</u></p> <p>(Yes) The AE actively works to expand and build the capacity of its Provider network.</p> <p>(No) The information reviewed does not demonstrate sufficient activities by the AE to expand and build the capacity of the Provider network.</p> <p>(No) The AE does not have a protocol for Provider network capacity building and expansion.</p> <p><u>Source Documents:</u></p> <p>Exploratory</p>	<p>The question, guidance, and response options were updated to provide clarification in response to feedback and questions as well as data analysis from Cycle 2.</p>

	AE OA, Section 8.1	
<p>The AE identifies, develops, and implements strategies regarding the areas of need in the community and the resources available.</p> <p>Non-Scored</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer will have a conversation with the AE about how they assess community resources and review documentation such as meeting notes, SWOT analyses, environmental scans, etc. to ensure the AE has assessed the areas of need in the community and the resources available. 	<p>The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.</p>
<p>**The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • This question is about assessing the AE’s utilization of the “Plan” and “Do” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle. • To assess this, the reviewer should ask the AE about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff/stakeholders and how?) and review documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.). • The reviewer requests to see performance data used by AE to develop the QMP and its Action Plan. • The reviewer discusses with AE the data results and how priorities for quality improvement projects were identified, how target objectives were determined and what performance measures were chosen for tracking performance over time. <ul style="list-style-type: none"> ○ Person-centered performance data specifically targets people outcomes, not compliance outcomes and can include but is not limited to: <ul style="list-style-type: none"> - Results from QA&I self-assessments and full reviews (if applicable), targeting those areas where performance falls below 86% - Employment - Individual interviews (QA&I and IM4Q) - Communication needs - Community Participation - Self-direction, choice, and control - Management of incidents of abuse, neglect, exploitation, rights violations and unexplained deaths - Use of restrictive interventions, including restraints - Local level data, e.g., agency satisfaction surveys ○ Engaging agency leadership and gathering input from agency staff and other stakeholders to develop the QMP and its Action Plan (response option #1), is considered the best practice/high quality standard. Response option #2 is compliant however, the AE should be encouraged to strive to achieve the best practice/high quality 	<p>The guidance was updated to enhance the review for quality and best practice. In addition, the two “No” responses were combined in response to data analysis from Cycle 2.</p>

	<p>standard. To assess this, the reviewer should first ask the SCO about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff/stakeholders and how?) and then request documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.).</p> <p><u>Response Options:</u></p> <p>(Yes) The AE used person-centered performance data to develop the QMP and its Action Plan and engaged agency leadership and gathered input from agency staff and other stakeholders to develop the QMP and its Action Plan.</p> <p>(Yes) The AE used person-centered performance data to develop the QMP and its Action Plan.</p> <p>(No) The AE does not have a QMP and its Action Plan or did not use person-centered performance data to develop it.</p> <p>(No) The AE has a QMP and its Action Plan but did not use person-centered performance data to develop it.</p>	
<p>** The AE uses data to assess progress towards achieving identified person-centered goals and target objectives in the Quality Management Plan (QMP) goals and its Action Plan target objectives.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• This question is about assessing the AE’s utilization of the “Check” and “Act” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle. Use of data involves the following actions: collecting data, analyzing data, sharing data, and taking actions based on what the data reveals.• The reviewer determines if the AE uses data to assess progress toward achieving identified person-centered QMP goals and target objectives in the QMP and its Action Plan target objectives by ensuring all three criteria listed below have been met: <ol style="list-style-type: none">1. Requesting to see data AE collects on a routine basis (monthly data collection is desired best practice).2. Asking AE to share data analysis, including how often analysis occurs and how/where results are documented and shared with leadership and stakeholders, e.g., managers, responsible parties, staff, individuals and families, etc. (Quarterly analysis and reporting are the desired best practice.)3. Asking how AE uses routine data and analysis to track performance over time, including whether changes to the Action Plan are warranted and why. <ul style="list-style-type: none">• Response option #1, is considered the best practice/high quality standard. Response option #2 is compliant however, the AE should be encouraged to strive to achieve the best practice/high quality standard. To achieve option #1, the AE must be able to provide the reviewer with evidence that person-centered data is: collected monthly, analyzed, and shared with leadership and stakeholders at least quarterly, and that actions are taken and documented, via changes to its Action Plan, based on what the data reveals. <p><u>Response Options:</u></p>	<p>The guidance was updated to enhance the review for quality and best practice. In addition, the criteria for the first “Yes” response were broken out for clarity and four “No” responses were combined in response to data analysis from Cycle 2.</p>

	<p>(Yes) The AE collects person-centered data monthly and leadership, managers, responsible parties, and staff review it at least quarterly to assess progress toward QMP goals and updates the QMP and its Action Plan target objectives annually.</p> <p>(Yes) The AE uses person-centered data to determine if goals and objectives are on track in the QMP and its Action Plan, at least every 3 years.</p> <p>(No) The AE does not have a QMP and its Action Plan.</p> <p>(No) The AE has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives.</p> <p>(No) The AE has not updated the QMP in more than 3 years.</p> <p>(No) The AE has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives and has not updated the QMP in more than 3 years (i.e., both 4 and 5 are “No”).</p> <p>(Yes) The AE:</p> <ul style="list-style-type: none">a. Collects person-centered data monthly ANDb. Leadership, managers, responsible parties, and staff review it at least quarterly to assess progress toward QMP goals ANDc. Updates the QMP and its Action Plan target objectives annually. <p>(Yes) The AE uses person-centered data to determine if goals and objectives are on track in the QMP and its Action Plan, at least every 3 years.</p> <p>(No) AE does not have a QMP and its Action Plan OR has not updated the QMP in more than 3 years OR does not use person-centered data to assess progress towards achieving goal(s) and target objectives.</p>	
<p><i>New – The AE has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</i></p> <p><i>Non-Scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The ODP QM Certification Handbook defines a target objective as a statement that describes where you want to go (what you want to happen), in precise, quantifiable terms (by how much and by when), using S-M-A-R-T guidelines, baselines and benchmarks.</i>• <i>Before the AE can make a decision about where they want to go with a target objective, they have to first understand their current performance (baseline). The reviewer should start an assessment of this question by first identifying the AE’s baseline.</i>• <i>The reviewer then determines if the AE’s QM plan target objectives include all of the following components to be effective and increase the likelihood of being successful:</i><ul style="list-style-type: none"><i>a. What they want to happen - e.g., increase, decrease, or eliminate a specific problem (e.g., employment, incidents, community participation)</i><i>b. By how much – e.g., counts or percentages</i><i>c. By when – e.g., fiscal year end date</i>	<p>The new question was added to support entities to be successful with Quality Management planning.</p>

	<p><i>Examples:</i></p> <ul style="list-style-type: none">• Increase % of people employed by 10% by 6/30/2025• Increase # of people using CPS to 30 by 6/30/2025 <p>• The reviewer should ensure the target objective math makes sense. For example, if the AE has 4 people employed in competitive integrated employment and their TO is to increase this number by 10%, then they are saying they want to increase by a part (4/10th) of a person.</p> <p>• To be successful in quality management planning and activities, the AE should be encouraged to develop target objectives that include all necessary components. Without an effectively written target objective, the AE will be unable to determine if they are making progress or have met the outcome/goal that they wanted to achieve.</p> <p><u>Response Options:</u></p> <p>(Yes) The AE has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</p> <p>(No) The AE's QM plan does not include target objectives OR target objectives do not include all necessary components to increase the likelihood of being successful.</p> <p><u>Source Documents:</u></p> <p>ODP Quality Management Certification Handbook</p>	
The AE ensures that the individual's ISP includes all assessed needs and includes services that adequately address the assessed needs.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the most recent Critical Revision or Annual Review ISP within the timeframe of review approved and authorized by the AE was based on all formal and informal assessments based on a review of the service notes, Individual Monitoring Tools, PUNS (ID/A), the SIS assessment (ID/A), HRST (if applicable), communication assessments and any applicable assessments.<ul style="list-style-type: none">○ The ISP reflects the full range of a waiver individual's needs and therefore must include all Medicaid and non-Medicaid services, including informal, family and community supports and supports paid by other service systems to address those needs.• The reviewer determines if the AE reviewed the content of the ISP prior to approval and authorization of ODP paid supports identified to ensure the individual's assessed needs are met.• The AE has authorized services funding through an ID/A Waiver as necessary to address documented and current Assessed Needs.• Consolidated: All assessed needs must be met.	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

	<ul style="list-style-type: none"> • CLW and P/FDS: Immediate health and welfare needs must be met. <p>COMMENT NEEDED – If “No,” identify any assessed needs that were not addressed in the ISP.</p>	
The DP 251 form is complete.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the DP 251 (1/22 current version) was signed and dated within the past year at the time of the QA&I review. • The annual reevaluation must be signed and dated by the Qualified Developmental Disabilities Professional (QDDP) and AE designee for compliance. <ul style="list-style-type: none"> ○ Electronic signature and date are acceptable. ○ AE signature and date must be after (can be on same day) the QDDP signed and dated to be in compliance. ○ ICF/ID or ICF/ORC box must be checked to be in compliance. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
The DP 251 is timely.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the DP 251 (AE signature and date) is timely. • “Timely” is defined as the first reevaluation of need for an ICF/ID or ICF/ORC level of care is to be made within 365 days of the individual’s initial determination (date on the current DP 250) and subsequent reevaluations are made within 365 days of the individual’s previous reevaluation. • The reviewer will compare the AE signature and date on the current DP 251 to the prior year’s completed DP 251 to ensure compliance. • Remediation is only required for DP 251s NOT completed at the time of the QA&I review. If the DP 251 is completed but not timely, remediation is not needed. <p>COMMENT NEEDED – If not timely, document how late the DP 251 was in comments.</p>	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
<p>The AE offers choice of Supports Coordination Organizations (SCOs) to the individual/family upon initial enrollment to TSM that includes documenting the offering of choice.</p> <p>Base and SC Services Only</p>	<p><u>Response Options:</u></p> <p><u>(Yes)</u> The AE has documentation for offering choice at initial enrollment to TSM, including notes in writing of the offering.</p> <p><u>(No)</u> The AE did not have any written documentation that shows offering choice of SCOs at initial enrollment to TSM.</p> <p><u>(N/A)</u> The individual was not newly enrolled within the review period or individual is enrolled in waiver or base.</p>	The response options were updated to provide clarification in response to feedback and questions from Cycle 2.

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Provider Tool

Question	Update(s)	Reason for Update(s)
<p>**The Provider uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • This question is about assessing the Provider’s utilization of the “Plan” and “Do” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle. • To assess this, the reviewer should ask the Provider about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff and stakeholders and how?) and review documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.). • The reviewer requests to see performance data used by Provider to develop the QMP and its Action Plan. • The reviewer discusses with Provider the data results and how priorities for quality improvement projects were identified, how target objectives were determined and what performance measures were chosen for tracking performance over time. <ul style="list-style-type: none"> ○ Person-centered performance data specifically targets people outcomes, not compliance outcomes and <i>can include but is not limited to:</i> <ul style="list-style-type: none"> - Results from QA&I self-assessments and full reviews (if applicable), targeting those areas where performance falls below 86% - Employment - Individual interviews (QA&I and IM4Q) - Communication needs - Community Participation - Self-direction, choice, and control - Management of incidents of abuse, neglect, exploitation, rights violations, and unexplained deaths. - Use of restrictive interventions, including restraints - Local level data, e.g., agency satisfaction surveys ○ Engaging agency leadership and gathering input from agency staff and other stakeholders to develop the QMP and its Action Plan (response option #1), is considered the best practice/high quality standard. Response option #2 is compliant however, the Provider should be encouraged to strive to achieve the best practice/high quality standard. 	<p>The guidance was updated to enhance the review for quality and best practice. In addition, the two “No” responses were combined in response to data analysis from Cycle 2.</p>

	<ul style="list-style-type: none">○ To assess this the reviewer should first ask the Provider about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff/stakeholders and how?) and then request documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.). <p><u>Response Options:</u></p> <p>(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan and engaged agency leadership and gathered input from agency staff and other stakeholders to develop the QMP and its Action Plan.</p> <p>(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan.</p> <p>(No) The Provider does not have a QMP and its Action Plan or</p> <p>(No) The Provider has a QMP and its Action Plan but did not use person-centered performance data to develop it.</p> <p>(N/A) The Provider is new (defined as a Provider determined to be qualified/enrolled in the previous fiscal year) or the Provider did not work with any individuals at any point during the entire review period.</p>	
<p>**The Provider uses data to assess progress towards achieving identified person-centered goals and target objectives in the Quality Management Plan (QMP) goals and its Action Plan target objectives.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• This question is about assessing the Provider’s utilization of the “Check” and “Act” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle. <i>Use of data involves the following actions:</i> collecting data, analyzing data, sharing data, <i>and</i> taking actions based on what the data reveals.• The reviewer determines if the Provider uses data to assess progress toward achieving identified person-centered QMP goals and target objectives in the QMP and its Action Plan target objectives by <i>ensuring all three criteria listed below have been met:</i><ol style="list-style-type: none">1. Requesting to see data Provider collects on a routine basis (monthly data collection is desired best practice).2. Asking Provider to share data analysis, including how often analysis occurs and how/where results are documented and shared with leadership and stakeholders, e.g., managers, responsible parties, staff, individuals, and families, etc. (Quarterly analysis and reporting are the desired best practice.)3. Asking how Provider uses routine data and analysis to track performance over time, including whether changes to the Action Plan are warranted and why.• Response option #1, is considered the best practice/high quality standard. Response option #2 is compliant however, the Provider should be encouraged to strive to achieve the best practice/high quality standard. To achieve option #1, the Provider must be able to provide the reviewer with evidence that person-centered data is: collected monthly, analyzed, and shared with leadership and stakeholders at least quarterly, and that actions are taken and documented, via changes to its Action Plan, based on what the data reveals. <p><u>Response Options:</u></p>	<p>The guidance was updated to enhance the review for quality and best practice. In addition, the criteria for the first “Yes” response were broken out for clarity and four “No” responses were combined in response to data analysis from Cycle 2.</p>

	<p>(Yes) The Provider:</p> <ul style="list-style-type: none">a. Collects person-centered data monthly ANDb. Leadership, managers, responsible parties, and staff review it at least quarterly to assess progress toward QMP goals ANDc. Updates the QMP and its Action Plan target objectives annually. <p>(Yes) The Provider uses person-centered data to determine if goals and objectives are on track in the QMP and its Action Plan, at least every 3 years.</p> <p>(No) The Provider does not have a QMP and its Action Plan OR has not updated the QMP in more than 3 years OR</p> <p>(No) The Provider has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives.</p> <p>(No) The Provider has not updated the QMP in more than 3 years.</p> <p>(No) The Provider has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives AND has not updated the QMP in more than 3 years (i.e., both 4 and 5 are “No”).</p> <p>(N/A) The Provider is new (defined as a Provider determined to be qualified/enrolled in the previous fiscal year) or the Provider did not work with any individuals at any point during the entire review period.</p>	
<p><i>New - The Provider has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</i></p> <p><i>Non-scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The ODP QM Certification Handbook defines a target objective as a statement that describes where you want to go (what you want to happen), in precise, quantifiable terms (by how much and by when), using S-M-A-R-T guidelines, baselines and benchmarks.</i>• <i>Before the Provider can make a decision about where they want to go with a target objective, they have to first understand their current performance (baseline). The reviewer should start an assessment of this question by first identifying the Provider’s baseline.</i>• <i>The reviewer then determines if the Provider’s QM plan target objectives include all of the following components to be effective and increase the likelihood of being successful:</i><ul style="list-style-type: none">○ <i>What they want to happen - e.g., increase, decrease, or eliminate a specific problem (e.g., employment, incidents, community participation)</i>○ <i>By how much – e.g., counts or percentages</i>○ <i>By when – e.g., fiscal year end date</i> <p><u>Examples:</u></p>	<p>The new question was added to support entities to be successful with Quality Management planning.</p>

	<ul style="list-style-type: none">◦ Increase % of people employed by 10% by 6/30/2025◦ Increase # of people using CPS to 30 by 6/30/2025 <ul style="list-style-type: none">• The reviewer should ensure the target objective math makes sense. For example, if the Provider has 4 people employed in competitive integrated employment and their TO is to increase this number by 10%, then they are saying they want to increase by a part (4/10th) of a person.• To be successful in quality management planning and activities, the Provider should be encouraged to develop target objectives that include all necessary components. Without an effectively written target objective, the Provider will be unable to determine if they are making progress or have met the outcome/goal that they wanted to achieve. <p><u>Response Options:</u></p> <p>(Yes) The Provider has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</p> <p>(No) The Provider’s QM plan does not include target objectives OR target objectives do not include all necessary components to increase the likelihood of being successful.</p> <p>(N/A) The Provider is new (defined as an Provider determined to be qualified/enrolled in the previous fiscal year) or the Provider did not work with any individuals at any time during the entire review period.</p> <p><u>Source Documents:</u></p> <p>ODP Quality Management Certification Handbook</p>	
The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals.		This question was removed as it was determined that this would be evaluated for actual implementation during the Claim and Service Documentation review.
Enter the number of individuals who have transitioned from prevocational services to competitive integrated employment during the review period.		This question was removed as data could be collected by a different means than QA&I.

Non-Scored		
The Provider has a written policy regarding the individual choice when sharing a bedroom with another individual.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• This question is applicable to ID/A Providers of unlicensed Residential Habilitation and Life Sharing services only.• The reviewer determines if the Provider has a written policy which provides individual choice when sharing a bedroom with another individual.• The reviewer determines if the policy addresses the following:<ul style="list-style-type: none">○ Informs the individual of how they can request a choice of or change in whom they share a bedroom.○ Allows individuals to meet potential individuals with whom they will share a bedroom.○ Provides written notice when the Provider plans to add a person with whom they will share a bedroom. <p><u>Response Options:</u></p> <p>(Yes) The Provider has a written policy that includes all the listed criteria.</p> <p>(No) The Provider’s written policy did not include one or more of the listed criteria or the Provider does not have a written policy as required</p> <p>(No) The Provider does not have a written policy</p> <p>(N/A) The Provider did not render the applicable service(s) during the review period.</p>	One “No” response was removed in response to data analysis from Cycle 2.
The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will determine if the Provider has written procedures to receive, document, manage, and respond to oral or written complaints from any source, including an anonymous source, regarding the delivery of a service.• The procedures must contain information about how individuals and persons designated by the individual, are informed of the right to file a complaint and the procedure for filing a complaint upon initial entry into the Provider’s program and annually thereafter. <p><u>Response:</u></p> <p>(Yes) The Provider has written procedures that includes all requirements.</p> <p>(No) The Provider’s has written procedures did not include one or more of the listed however, it does not include all requirements, or the Provider does not have written procedures as required.</p> <p>(No) The Provider does not have written procedures.</p>	One “No” response was removed in response to data analysis from Cycle 2.

<p>*The Provider’s staff completed annual training core courses as required in the training year.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• This question is <u>NOT</u> applicable to AAW only Providers.<ul style="list-style-type: none">○ All AAW Providers are evaluated during AAW Provider Qualifications.• This question is <u>NOT</u> applicable to Providers that are not providing services to any individuals.<ul style="list-style-type: none">• For self-assessment, the Provider will complete the “Training Tracker” tab of the self-assessment spreadsheet as described in the "How to use Spreadsheet” tab.• For full reviews, the AE will use the Staff Training Record and complete the “Training Tracker” tab of the full review spreadsheet as described in the "How to use Spreadsheet” tab.• The reviewer will review 25% of DSPs and DSP Supervisors (ID/A provider) who have been working with the Provider for at least one complete training year, with a minimum of five staff and a maximum of 25 staff. If there are less than five staff, all staff records must be reviewed.• The reviewer will review 25% of SSPs (AWC Providers) who have been working with the Provider for at least one complete training year, with a minimum of five staff and a maximum of 25 staff. If there are less than five staff, all staff records must be reviewed.• Staff that are no longer employed with the Provider are excluded from the review.• The reviewer determines if the identified staff completed each required annual training core courses based on Provider training records including, but not limited to: a description of the course, sign-in sheets, transcripts or certificates of completion from the training.<ul style="list-style-type: none">○ A training year is defined by the Provider and is a 12-month time frame.○ Providers can choose to use the same training year to cover all staff or different training years for each staff.○ The reviewer should review records from the most recently completed 12-month training year.• 55 Pa. Code Chapter 6100.143 core courses are:<ul style="list-style-type: none">○ The application of person-centered practices, community integration, individual choice and assisting individuals to develop and maintain relationships.○ The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.○ Individual rights.○ Recognizing and reporting incidents.○ The safe and appropriate use of behavior supports if the person works directly with an individual.▪ *This training does not apply to SSPs.<ul style="list-style-type: none">○ Implementation of the individual plan if the person provides an HCBS or base-funding service.	<p>The guidance was updated to add clarifying language to included applicable entity.</p> <p>The response options were updated to reflect when an entity has no employees during the training year.</p> <p>A new source document released in 2025 was added.</p>
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	<ul style="list-style-type: none">• The final response is based off the information entered into training tracker and will auto-populate into the “Questions” tab of the QA&I Provider spreadsheet.• For each core course, the percentage, number of staff reviewed and number of staff where training courses can be verified must be entered into QuestionPro. <p>For full reviews:</p> <ul style="list-style-type: none">• When the overall percentage falls below 86.0%, the issue must be referred to the regional ODP office for review of further actions to be taken.• The AE <u>must</u> document the date they referred the issue to the Regional Coordinator on the spreadsheet and in QuestionPro.• ODP will review referred issues with the AE to determine the seriousness, continued or repeated nature, and combination of issues identified to determine appropriate actions through DCAP or sanctions, which may include adjusting of claims. <p><u>Responses:</u> (Yes) All staff reviewed completed all required annual training core courses in the training year. (No) One or more staff reviewed did not complete all of the required annual training core courses in the training year. (N/A) The Provider is only enrolled in the AAW, or the Provider is not serving any individuals, or there are no employees who have been working with the Provider for at least one complete training year.</p> <p><u>Source Documents:</u> 55 Pa Code Chapter 6100.143 ODP Announcement 21-034, ODP Regulation Update: Orientation and Annual Training Question and Answer Document and Annual Training Clarifications ODP Announcement 25-030: Reminder of 6100 Annual Training Requirements</p>	
Provider staff completed the required number of training hours in the training year.	<p><u>Responses:</u> (Yes) All staff reviewed completed all required annual training core courses in the training year. (No) One or more staff reviewed did not complete all of the required annual training core courses in the training year. (N/A) The Provider is only enrolled in the AAW, or the Provider is not serving any individuals, or there are no employees who have been working with the Provider for at least one complete training year.</p> <p><u>Source Documents:</u> 55 Pa Code Chapter 6100.143 ODP Announcement 21-034, ODP Regulation Update: Orientation and Annual Training Question and Answer Document and Annual Training Clarifications ODP Announcement 25-030: Reminder of 6100 Annual Training Requirements</p>	The response options were updated to reflect when an entity has no employees during the training year. A new source document released in 2025 was added.

The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	<p><u>Response:</u></p> <p>(Yes) The Provider has a policy that addresses sexual health, personal relationships, and sexuality consistent with the guidelines.</p> <p>(No) The Provider’s has a policy; however, it is inconsistent with the guidelines identified in ODP Bulletin 00-18-01 or the Provider does not have a policy as required.</p> <p>(No) The Provider does not have a policy.</p> <p>(N/A) The Provider is a transportation only Provider.</p>	One “No” response was removed in response to data analysis from Cycle 2.
<i>New - The Community Participation Support (CPS) or Day Habilitation Provider has a QMP and corresponding Action Plan that includes all required components.</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>This question is only applicable to Providers of CPS (ID/A) and Day Habilitation (AAW) where more than 10% of the individuals’ receiving services spent less than 25% of their time in a community setting on average from 7/1/24-12/31/24 and/or 1/1/25-6/30/25.</i>• <i>For self-assessments, applicable Providers will determine if they’re required to include the applicable services in the QMP and Action Plan by reviewing their CPS/Day Habilitation data collection tool (e.g. QM Data Collection Tool for CPS Community and Day Habilitation) for the designated timeframes.</i>• <i>For full reviews, the reviewer will determine if the Provider is required to include the applicable services in the QMP and Action Plan by reviewing the CPS and Day Habilitation data provided by ODP.</i>• <i>If required, the reviewer will determine if the Provider has a QMP and corresponding Action Plan that include the following requirements:</i><ul style="list-style-type: none">o <i>Action steps for increasing time in the community for individuals who want to increase the amount of time they spend in the community including timeframes for achieving each action step.</i>o <i>Barriers to supporting individuals with engaging in community activities, including action steps to address the barriers & timeframes for achieving each action step.</i>o <i>The methods used by the Provider to offer options to receive services in integrated community settings in-line with each individual’s preferences, choices, & interests for community activities & the frequency such options will be offered.</i>o <i>Successful community experiences, such as building relationships, employment opportunities and natural supports for individuals served.</i> <p><u>Response Options:</u></p> <p>(Yes) The Provider has a QMP and Action Plan that includes all requirements</p>	The new question was added to address an area of need identified in Cycle 2

	<p><i>(No) The Provider does not have a QMP and/or Action Plan that includes all requirements.</i></p> <p><i>(N/A) The Provider did not render the applicable service(s) OR is not required to include the applicable services in the QMP and Action Plan.</i></p> <p><u>Source Documents:</u></p> <p><i>Consolidated, P/FDS, CL, and Adult Autism Waivers</i></p> <p><i>ODP Announcement 24-067, Updated Guidance for the Community Participation Support (CPS) Service in the Intellectual Disability/Autism (ID/A) Waivers and Day Habilitation in the Adult Autism Waiver (AAW)</i></p>	
<p>If the staff administers medication, the Provider has a policy that addresses providing support to individuals with medication administration needs.</p> <p>Non-Scored</p>	<p><u>Response options:</u></p> <p>(Yes) The Provider has a policy that addresses providing supports to individuals with medication administration.</p> <p>(No) The Provider does not have a policy, or the Provider has a policy and one or more of the identified requirements were not met.</p> <p>(N/A) The Provider did not render the applicable service(s) during the review period.</p> <p>(No) The Provider has a policy, however, one or more of the identified requirements were not met.</p> <p>(N/A) The Provider does not have a policy.</p>	<p>One “No” response was removed in response to data analysis from Cycle 2.</p>
<p>The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).</p>	<ul style="list-style-type: none"> This question is <u>NOT</u> applicable to AAW only Providers. <ul style="list-style-type: none"> All AAW Providers are evaluated during AAW Provider Qualifications. The reviewer will determine that the Provider has designated a person who is fulfilling the role of the agency’s IM Representative through verification of evidence provided, included but not limited to a current organizational chart or designation by position description. The evidence provided shall include the date of which the person began fulfilling the role of the IM Representative. The reviewer will determine if the IM Representative has a current CI certificate. The reviewer will compare the date the IM Representative assumed their role as the IM Representative with the current date the IM Representative obtained their certificate. IM Representatives have 12 months from the date of assuming their role as IM Representative to complete and pass the ODP CI training. 	<p>The guidance was updated to add clarifying language to include date of role fulfillment.</p>
<p><i>New - The Incident Management (IM) Representative ensures point person(s) maintains</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> <i>The Reviewer will determine if Point Person ensures investigation assignment to the CI within 24 hours of discovery date/time of the incident.</i> 	<p>The new question was added to address an area of need identified in Cycle 2 as</p>

<i>compliance with initiation of investigation activities.</i>	<ul style="list-style-type: none"><i>The Reviewer will need to limit the review to closed incidents requiring investigations from the Incident and Complaint Custom Report for the review period.</i> <p><i>PATH: EIM>Reports>Incident and Complaint Custom Report</i></p> <ul style="list-style-type: none"><i>o Program Office: Select the applicable program office</i><i>o View Incidents or Complaints: Incident</i><i>o Subject Areas: Incident Details-Final and "Investigation Details</i><i>o Occurrence Dates: 7/1/2024-6/30/2025</i><i>o Type: Select All</i><i>o Status: Closed</i><i>o Primary Category: Select All</i><i>o Secondary Category: Select All</i> <p><i>Search Providers: Enter the name of the entity being reviewed</i></p> <p><u><i>Response Options:</i></u></p> <p><i>(Yes) The IM Representative ensured the Point Person(s) maintained compliance with initiation of investigation activities.</i></p> <p><i>(No) The IM Representative did not ensure the Point Person(s) maintained compliance with initiation of investigation activities.</i></p> <p><i>(N/A) There were no investigations during the review period.</i></p> <p><u><i>Source Documents:</i></u></p> <p><i>Bulletin 00-21-02, Incident Management</i></p> <p><i>Administrative Review Process Manual, 2023 – Version 3.1</i></p>	well as other processes that evaluate incident and risk management.
<i>New - The Incident Management (IM) Representative maintains a list of active Certified Investigators including recertification dates.</i>	<p><u><i>Guidance:</i></u></p> <ul style="list-style-type: none"><i>The Reviewer will review the IM Representative’s existing tracking mechanism to ensure all Department Certified Investigators (CI) certifications are current. A Department Certified Investigator (CI) certification is valid for three (3) years.</i><i>If a reviewer identifies the expiration of a certificate, the reviewer shall confirm that no investigation assignments were made until the investigator attained certification.</i>	The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.

	<ul style="list-style-type: none">• Utilizing the Incident and Complaint Custom Report from Q17, the Reviewer will review the names of all CIs assigned to incidents during the review period. The names contained within the tracking tool should match the names reflected in the Incident and Complaint Custom Report. <p><u>Response Options:</u></p> <p>(Yes) There is evidence that the IM Representative maintains a list of active CIs (including certificates and recertification dates); and no investigation assignments were made to those whose certificate was expired or there were no investigations during the review period.</p> <p>(No) There is no evidence that the IM Representative maintains a list of active CIs (including certificates, recertification dates); or the IM Representative maintains a list of CIs, but assignments were made to investigator(s) whose certificate was expired.</p> <p><u>Source Documents:</u></p> <p>Bulletin 00-21-02, Incident Management</p> <p>ODP Certified Investigator Peer Review (CIPR) Manual, 2023 Version 4.0</p> <p>Certified Investigator’s Manual 2024</p> <p>55 Pa Code Chapter 6100.402</p>	
New - The Incident Management (IM) Representative ensured Certified Investigator Peer Reviews (CIPRs) were conducted on a quarterly basis.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will determine if the IM Representative ensured CIPRs were conducted on a quarterly basis.• All entities that complete investigations are required to conduct the standardized CIPR process which involves using the most current forms as outlined in the ODP CIPR Manual (Review Period is 7/1/2024-6/30/2025). <p><u>Response Options:</u></p> <p>(Yes) The IM Representative ensured CIPRs were conducted on a quarterly basis.</p> <p>(No) There is no evidence that the IM Representative ensured CIPRs were conducted on a quarterly basis.</p> <p>(N/A) No investigations were conducted during the review period.</p> <p><u>Source Documents:</u></p> <p>ODP Certified Investigator Peer Review (CIPR) Manual, 2023 Version 4.0</p> <p>Bulletin 00-21-02, Incident Management</p>	The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.

The Provider maintains a signed written contract or agreement documentation of any delegated or purchased function related to incident management.		The question was updated to provide clarification in response to feedback and questions from Cycle 2.
The Provider completes monitoring of delegated or purchased incident management function(s).	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer will determine if the Provider completes monitoring for delegated or purchased IM function(s) identified in previous question. Monitoring documentation should include at a minimum: <ul style="list-style-type: none"> A method to verify compliance with ODP regulations, written policies and procedures, departmental decisions, state and federal laws and regulations that are related to the function purchased/delegated. The frequency for monitoring by the Provider (at least quarterly) The monitoring of delegated functions should be completed on at least a quarterly basis and the results of the monitoring should be readily available in a written format. The staff position/titles and names responsible for the monitoring Description of any issues detected during monitoring and their resolution. <p><u>Response options:</u></p> <p>(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.</p> <p>(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.</p> <p>(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and <u>/or</u> did not have written documentation of one or more all the listed requirements.</p> <p>(N/A) The Provider does not delegate or purchase any incident management functions or the delegated/purchased incident management function did not need to be utilized during the review period.</p>	The guidance and responses were updated to provide clarification in response to feedback and questions from Cycle 2.
<i>New - The Provider follows up on actions taken to address concerns identified through the monitoring process of Incident management delegated functions</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> <i>The reviewer will determine if the Provider provides evidence of follow up actions taken to address concerns identified through the monitoring process of delegated functions.</i> <i>The Provider's monitoring follow up should be readily available in a written format and should include at a minimum:</i> <ul style="list-style-type: none"> <i>Area(s) of identified concern(s)</i> <i>Deadline for actions to be completed on behalf of the delegated or contracted entity</i> 	The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.

	<ul style="list-style-type: none">○ The staff position/titles and name(s) of those responsible to ensure identified actions are completed○ The manner in which the information was relayed to the delegated or contracted entity (e.g.: email, documentation of live communication between the AE and entity such as meeting minutes, or letter) <p><u>Response Options:</u></p> <p>(Yes) The Provider follows up on actions taken to address concerns identified through the monitoring process of delegated functions.</p> <p>(No) The Provider did not follow up on actions taken to address concerns identified through the monitoring process of delegated functions and/or did not have the documentation to validate the follow up.</p> <p>(N/A) The Provider does not delegate or purchase or did not identify concerns through monitoring activities of delegated functions.</p> <p><u>Source Documents:</u></p> <p>Bulletin 00-21-02, Incident Management</p>	
The Provider completes monthly individual incident data monitoring.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer will determine if the Provider monitored incident data to take action(s) to mitigate risk, prevent recurring incidents, and implement corrective action as appropriate.• The reviewer will review documentation of the activity from the last three months.• Documentation of this monthly activity must include at a minimum:<ul style="list-style-type: none">○ Review of incident data to detect incidents that have been initiated but have not had the First Section submittedEvaluation of the effectiveness of incident corrective actions for all incident categories.○ Evaluation of the circumstances and frequency of restraints○ Evaluation of the circumstances and frequency of medication errors○ Identification and implementation of preventative measures to reduce:<ul style="list-style-type: none">- The number of incidents- The severity of the risks associated with the incident- The likelihood of an incident recurring—The monitoring of the effectiveness of any noted corrective actions in incident reports- Actions taken by the Provider to address ineffective corrective actions○ Documentation of:<ul style="list-style-type: none">- The need to revise the ISP with the ISP team to include new and/or revised information, risk mitigation plans, or a change in services or supports.	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

	<ul style="list-style-type: none"> - The need to consult with a County ID Program/AE/BSASP Risk Manager for assistance related to monthly data monitoring. - The actions and outcomes of any activities that occurred related to the monthly data monitoring. <p>Review Period is 7/1/2024-6/30/2025</p>	
The Provider conducts and documents a trend analysis of all incident categories at least every 3 months.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer will determine if the Provider conducted a trend analysis by reviewing the most recent analysis of the incidents the Provider entered. <ul style="list-style-type: none"> ○ The trend analysis will include the development, the methodology used, data source, implementation plan, and documentation of both individual and agency-wide risk mitigation activities based on the results of the analysis. • The three-month analysis shall include, but is not limited to (as applicable): <ul style="list-style-type: none"> ○ Adherence to timeframes in accordance with policy as it relates to reporting, investigation, and finalization of incidents as stated in 55 Pa. Code §§6100.401-§6100.404 ○ Evaluation of effectiveness of corrective actions for all incident categories ○ Evaluation of the effectiveness of education to the individual, staff, and others based on the circumstances of an incident ○ A review and trend analysis of comments from the County ID Program/AE and ODP initial management review and disapproval reasons from the final management review ○ Identification and implementation of preventative measure to reduce: ○ Any measures that have been implemented or will be implemented to reduce: <ul style="list-style-type: none"> - The number of incidents - The severity of the risks associated with the incident - The likelihood of an incident recurring ○ Documentation of the actions and outcomes of any activities that occurred related to trend analysis <p>COMMENT NEEDED – If “Yes,” provide details on how the Provider is completing their trend analysis.</p> <p>Review Period is 7/1/2024-6/30/2025</p>	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
**Staff are trained on the individual’s communication profile and/or formal communication system.	<p><u>Guidance:</u></p>	The guidance and responses were updated to provide clarification in response to feedback and questions from Cycle 2.

	<ul style="list-style-type: none">• The reviewer determines if the individual has a functional communication impairment significant communication needs, and a corresponding communication profile and/or formal communication system based on a review of the individual’s ISP.• An individual with significant communication needs a functional communication impairment is someone who cannot effectively communicate basic wants and needs such as “I want that” or “I am in pain.”• A communication profile is a term used to describe how the individual communicates and how communication partners communicate effectively with the individual through strategies and systems utilized, across environments. This may be included in the communication section of the ISP.• A communication system includes all strategies and aids used to effectively communicate.• If the individual has a communication profile and/or formal communication system identified in the ISP, the Provider will give a list of all Provider staff who worked and rendered authorized supports and services to the individual during the review period.• The reviewer will review 25% of Provider staff working with the individual, with a minimum of five Provider staff and a maximum of 25 Provider staff. If there are less than five Provider staff working with the individual, all Provider staff records must be reviewed.• Staff that are no longer employed with the Provider are excluded from the review.• The reviewer determines if the Provider staff completed training on the individual’s communication profile and/or formal communication system based on Provider training records including, but not limited to: a description of the course/training/meeting, sign-in sheets, transcripts or certificates of completion from the training. <p>On the QA&I Spreadsheet, the reviewer must complete the Communication Tracker as described in the “How to Use Spreadsheet” tab.</p> <p><u>Response options:</u></p> <p>The appropriate response will be determined by the information entered into the Communication Tracker.</p> <p>(Yes) The individual has significant communication needs a functional communication impairment and all staff reviewed completed training on the individual’s communication profile and/or formal communication system.</p> <p>(No) The individual has significate communication needs a functional communication impairment and one or more staff reviewed did not complete training on the individual’s communication profile and/or formal communication system.</p> <p>(N/A) The individual does not have significant communication needs a functional communication impairment.</p>	
The Provider maintains a signed statement acknowledging that the individual has received information on individual rights.	<p><u>Guidance:</u></p> <p>This question is only applicable to the following: all unlicensed direct service Providers and Older Adult Daily Living Centers licensed under 6 Pa. Code Chapter 11 that render Community Participation Support services.</p>	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

	<ul style="list-style-type: none"> ○ Unlicensed direct service Providers ○ Older Adult Daily Living Centers licensed under 6 Pa. Code Chapter 11 that render Community Participation Support services. <ul style="list-style-type: none"> • The reviewer determines if the Provider has a signed statement on file that acknowledges the individual has received information on individual rights. • The statement must document that the provider informed and explained individual rights outlined in 6100.182. For unlicensed Residential Habilitation and Life Sharing service locations the statement must also document that the provider informed and explained individual rights outlined in 6100.183. • The statement must be signed by the individual or the legal guardian. • The statement must be written in a language understood by the individual. • If the individual does not understand written language and does not have a court-appointed legal guardian, the provider must document how individual rights were communicated in a means of communication understood by the individual. 	
The individual has a current signed Department-approved room and board residency agreement on file.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • This question is only applicable to individuals receiving the following services from the Provider: <ul style="list-style-type: none"> ○ ID/A: Residential Habilitation and Life Sharing ○ AAW: Residential Habilitation (Community Home and Life Sharing) • The reviewer determines if the ISP indicates that the applicable services are received from the Provider. • The reviewer will look at the department-approved room and board residency agreement (DP 1077 or DP 1077 LS) for the current year to verify that a document is on file and signed by the appropriate person. • The Department-approved room and board residency agreement (DP 1077) can be signed by the following people: <ul style="list-style-type: none"> ○ The individual ○ The individual's court-appointed legal guardian if an individual is adjudicated incompetent to handle finances; or ○ The designated person if the individual is 18 years of age or older and has a designated person for the individual's benefits. <ul style="list-style-type: none"> ▪ Reviewers should look at the ISP to determine if the individual has a court-appointed legal guardian or designated person identified. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
The Department-approved room and board residency agreement is completed at least annually.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • This question is only applicable to individuals receiving the following services from the Provider: <ul style="list-style-type: none"> ○ ID/A: Residential Habilitation and Life Sharing ○ AAW: Residential Habilitation (Community Home and Life Sharing) 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

	<ul style="list-style-type: none">• The reviewer determines if the ISP indicates that the applicable services are received from the Provider.• The reviewer will look at the current Department-approved room and board residency agreement (DP 1077 or DP 1077 LS) by looking at the prior year’s agreement and ensuring that the effective date on the current agreement is within 12 months from the effective date on the previous agreement to determine if it was completed annually (note the date of the signatures on the form).	
<i>NEW - The amount documented on the individual’s Room and Board Agreement meets the ODP Regulations and requirements.</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>This question is only applicable to individuals receiving the following services from the Provider:</i><ul style="list-style-type: none">◦ <i>ID/A: Residential Habilitation and Life Sharing</i>◦ <i>AAW: Residential Habilitation (Community Home and Life Sharing)</i>• <i>The reviewer determines if the ISP indicates that the applicable services are received from the Provider.</i>• <i>The reviewer will look at the department-approved room and board residency agreement (DP 1077 or DP1077 LS) for the current year to determine the total amount the individual agrees to pay for room and/or board.</i>• <i>The reviewer will look at the Provider’s reported amount of the following: 1.) Actual Monthly Cost Per Individual and 2.) Individual’s income.</i><ul style="list-style-type: none">◦ <i>Examples of the reporting mechanism include, but are not limited to, the following: email, written documentation, and a printout of the ODP Room and Board Calculator.</i>◦ <i>This information will then be entered into the QA&I Room and Board Tool by the reviewer.</i>• <i>The reviewer will compare the total amount the individual agrees to pay for room and/or board with the information in the QA&I Room and Board Tool to ensure the following:</i><ul style="list-style-type: none">◦ <i>The amount of room and/or board is not over the maximum amount allowed (note: If the individual’s available income is less than the SSI maximum rate plus Pennsylvania State Supplementary Payment (PA SSP), the Provider may only charge 72% of individual’s available monthly income).</i>◦ <i>The amount of room and/or board is not more than the provider’s actual monthly cost per individual.</i>◦ <i>The amount of room and/or board is zero if they have less than the personal needs allowance (\$30).</i> <p><u>Response Options:</u></p> <p><i>(Yes) The amount documented on the individual’s Room and Board Agreement meets the ODP Regulations and requirements.</i></p> <p><i>(No) The amount documented on the individual’s Room and Board Agreement does not meet the ODP Regulations and requirements.</i></p> <p><i>(N/A) The individual did not receive the applicable service(s) during the review period, or the individual has not received the applicable service(s) from the Provider for more than one year.</i></p>	<p>The new question was added to address an area of need identified in Cycle 2.</p>

	<u>Source Documents:</u> <ul style="list-style-type: none"> • 55 Pa Code Chapter 6100.681-6100.694 • Bulletin 00-25-01, Room and Board Requirements for Individuals Enrolled with the Office of Developmental Programs 	
The Provider ensures the individual has the right to control his/her own schedule and activities and has the right to update those activities as desired.	<u>Guidance:</u> <ul style="list-style-type: none"> • This question is applicable to all direct services from the Provider <u>EXCEPT</u> the following: Licensed Residential Habilitation, Life Sharing, and Community Participation Support, Day Habilitation, Transportation, ASL Interpreter, Benefits Counseling, Music Therapy, Art Therapy, Equine Assisted Therapy, Communication Specialist, Consultative Nutritional, and Nutritional Consultation. • The reviewer determines if the Provider ensured that the individual was given opportunities to update their activities as desired by reviewing service notes, progress notes and the ISP for an indication of preferred activities and if those activities were attended by the individual, or if there is indication of ongoing progress to participate in a preferred activity. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.
The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome.	<u>Source Documents:</u> 55 Pa Code Chapter 6100.227 Bulletin 00-20-04, <i>Participant-Directed Services: Agency with Choice Financial Management Services Model</i> (ID/A Waivers) Bulletin 00-22-03, Technical Guidance for Claim and Service Documentation Bulletin 00-18-04 Interim Technical Guidance for Claim and Service Documentation (ID/A)	Obsolete source document was removed.
The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP.	<u>Guidance:</u> <ul style="list-style-type: none"> • The reviewer identifies the services, amount, frequency, and duration of service delivery by reviewing the ISP. • The reviewer determines if the progress notes for the review period show that the Provider delivered services as specified in accordance with the individual's ISP. If the Provider did not deliver the services as specified, the progress notes should reflect this as well. • Examples of acceptable justification can include (but not limited to): individual out of town, extended illness, hospitalization/ rehabilitation, disruptions experienced due to the COVID-19 pandemic, etc. • ODP Announcement 21-083 clarifies when an event involving Provider staff constitutes alleged neglect and states the following, "The scope, duration and/or frequency of support needed as specified in the ISP was not provided such that the individual was at imminent risk of harm or there was an impact to the individual's health or safety". <u>Source Documents:</u>	The guidance was updated to reflect the ending of the pandemic and obsolete source document was removed. Source documents updated to reflect current bulletins

	<p>Bulletin 00-22-03, Technical Guidance for Claim and Service Documentation</p> <p>Bulletin 00-18-04 Interim Technical Guidance for Claim and Service Documentation (ID/A)</p> <p>Bulletin 00-20-02 00-22-05, Individual Support Plans (ISPs) (ID/A Waivers)</p>	
<p>**The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the individual's ISP has an outcome or goal that focuses on communication during the review period identifies communication supports and services needed to ensure effective communication. • The reviewer determines if progress notes reflect that the communication supports and services identified in the individual's ISP are being provided to the individual. <p><u>Response Options:</u></p> <p>(Yes) The Provider implemented the communication supports and services that were specified in the individual's ISP outcome/goal.</p> <p>(No) The Provider did not implement communication supports and services as specified in the individual's ISP.</p> <p>(No) There is no documentation which shows communication supports and services were implemented as specified in the individual's ISP.</p> <p>(N/A) The individual does not have a need for communication supports and services to ensure effective communication.</p> <p>(N/A) the individual does not have an outcome or goal for communication or the Provider being reviewed is not responsible for that outcome/goal.</p> <p><u>Source Documentation:</u></p> <p>Bulletin 00-22-03 Technical Guidance for Claim and Service Documentation (ID/A)</p>	<p>The guidance, response options, and source documentation were updated to provide clarification in response to feedback and questions from Cycle 2.</p>
<p>The individual's ISP includes a competitive integrated employment outcome/objective(s) goals.</p>	<p><u>Source Documentation:</u></p> <p>Consolidated, P/FDS, Community Living, and Adult Autism Waivers</p> <p>Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p>	<p>The source document was updated.</p>
<p>The individual is supported in exploring competitive integrated employment opportunities.</p>	<p><u>Source Documentation:</u></p> <p>Consolidated, P/FDS, Community Living, and Adult Autism Waivers</p> <p>Everyday Lives Values in Action 2021</p>	<p>The source document was updated.</p>

	<p>Executive Order 2016-03 – Employment First</p> <p>Executive Order 2016-03 Recommendations</p> <p>2018 Act 36 – Employment First Act</p> <p>Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p> <p>Bulletin 00-22-03, Technical Guidance for Claim and Service Documentation</p> <p>Bulletin 00-18-04 Interim Technical Guidance for Claim and Service Documentation (ID/A Waiver)</p> <p>AAW Provider Manual (AAW)</p>	
<p>The Provider supports the individual in obtaining competitive integrated employment.</p> <p>Non-Scored</p>	<p><u>Source Documentation:</u></p> <p>Exploratory</p> <p>Consolidated, P/FDS, Community Living, and Adult Autism Waivers</p> <p>Everyday Lives Values in Action 2021</p> <p>Executive Order 2016-03</p> <p>Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p>	<p>The source document was updated.</p>
<p>The Provider supports the individual in maintaining employment.</p>	<p><u>Source Documentation:</u></p> <p>Consolidated, P/FDS, Community Living, and Adult Autism Waivers</p> <p>Everyday Lives Values in Action 2021</p> <p>Executive Order 2016-03 – Employment First</p> <p>Executive Order 2016-03 Recommendations</p> <p>2018 Act 36 – Employment First Act</p> <p>Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p> <p>Bulletin 00-22-03, Technical Guidance for Claim and Service Documentation</p> <p>Bulletin 00-18-04 Interim Technical Guidance for Claim and Service Documentation (ID/A Waiver)</p>	<p>The source document was updated.</p>
<p>The Provider supports the individual to maintain competitive integrated employment by facilitating transportation</p>		<p>This question was removed as it was determined that this would be evaluated as part of Performance Based Contracting.</p>

<p>If an individual receiving Supported Employment requires Career Assessment activities in excess of 6 consecutive months, there is documentation of an explanation of the reason why the activities are needed for an extended period of time.</p> <p>Non-Scored</p>	<p><u>Source Documentation:</u> Consolidated, P/FDS, and Community Living Waivers ID/A Waiver Employment Services Q&A Document Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p>	<p>The question was changed from “Non-Scored” to “Scored” to include remediation options and the source document was updated.</p>
<p>There is documentation of a fading plan or fading schedule for the individual’s ongoing use as part of Supported Employment.</p> <p>Non-Scored</p>	<p><u>Source Documentation:</u> Consolidated, P/FDS, and Community Living Waivers Everyday Lives Values in Action 2021 ID/A Waiver Employment Service Definition Q&A Document (ID/A Waivers) Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers) BSASP Administrative Notice BAW16-31, “Request for an Exception to Established Service Limits” (AAW)</p>	<p>The question was changed from “Non-Scored” to “Scored” to include remediation options and the source document was updated.</p>
<p>The Provider ensures the individual completes all health care appointments, screenings, and follow-up as prescribed.</p>	<p><u>Source Documentation:</u> 55 Pa Code Chapters 6100.182, 6100.183, 6100.224 ODP Announcement 20-054, Guidance for Modifications to Medical Examinations for Residential Staff and Individuals to Service Delivery During the COVID-19 Pandemic. ODP Announcement 20-072, Home and Community Based Services (HCBS) At a Glance Reopening Guide by Phase, issued 6/10/20</p>	<p>The source documentation was updated to reflect the ending of the pandemic and obsolete source document was removed.</p>
<p>The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • This question is applicable to all direct services from the Provider <u>EXCEPT</u> Transportation. • The reviewer determines if the individual’s preference for wellness activities as specified in the ISP have been able to be pursued by the individual by review of the Provider’s documentation, including but not limited to service notes and progress notes. 	<p>The question was changed from “Non-Scored” to “Scored” to include remediation options. The guidance was updated to provide clarification.</p>

Non-Scored	<ul style="list-style-type: none"> Areas in which the individual may wish to pursue wellness may include activities from any of the domains of wellness. The domains of wellness are: Emotional, physical, intellectual, spiritual, environmental, social, occupational, and financial. <p><u>Source Documentation:</u> Exploratory 55 Pa Code 6100.223 and 6100.224 Everyday Lives Values in Action 2021</p>	
If a restrictive intervention was used, the Provider followed the approved Behavior Support Component of the Individual Support Plan (ISP) for each instance to ensure that the individual is free from coercion and restraint.	<p><u>Source Documentation:</u> 55 Pa Code Chapters 6100.344, 6100.345, 6100.346 and 6100.349 Bulletin 00-21-01, Guidance for Human Rights Teams and Human Rights Committees Bulletin 00-20-02 00-22-05 Individual Support Plans (ISPs)/Attachment #1 ISP Manual (ID/A Waivers)</p>	The source document was updated.
<p>The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM.</p> <p>Non-Scored</p>	<p><u>Response Options:</u> (Yes) There is evidence that the individual was offered and educated about the circumstances of all incidents reported in the EIM system by the Provider. (Yes) There is evidence that the individual was offered and educated about the circumstances of all incidents reported in the EIM system by the Provider but refused by the individual. (No) There is no evidence that the individual was educated about the circumstances of incidents reported in the EIM system by the Provider. (N/A) The individual did not have any incidents for which the Provider is required to file in EIM during the review period.</p>	The question was changed from “Non-Scored” to “Scored” to include remediation options. One “Yes” response was removed in response to data analysis from Cycle 2
<i>New - The AWC Provider has a process or procedure that ensure service utilization reports are provided to the Managing Employer (ME) within seven (7) days of the last day of the pay period.</i>	<p><u>Guidance:</u> <i>The reviewer will examine the AWC Provider’s process or procedure to ensure it demonstrates steps/actions taken to provide utilization reports to the ME within the required timeframe.</i></p> <p><u>Response Options:</u> (Yes) <i>The AWC Provider has a process or procedure that ensures that utilization reports were provided to the ME within seven (7) days of the last day of the pay period.</i></p>	The new question was added to address an area of need identified in Cycle 2.

	<p><i>(No) The AWC Provider does not have a process or procedure that ensures utilization reports were provided to the ME within seven (7) days of the last day or the pay period</i></p> <p><u>Source Documentation:</u> <i>Bulletin 00-20-04, Participant Directed Services: Agency with Choice Financial Management Services Model</i></p>	
<p>The AWC Provider takes action and document when the maximum allowable hours of care provided by a relative are exceeded.</p>		<p>This question was removed in response to data analysis from Cycle 2</p>
<p><i>NEW - Does the AWC have a process/policy for determining if an SSP is a relative of the participant</i></p>	<p><u>Guidance:</u> <i>The reviewer will determine if AWC Provider has a process/policy that determines the relationship of the SSPs to the participant that aligns with the Waiver definition as defined in the waiver: which is A relative is any of the following by blood, marriage or adoption who have not been assigned as legal guardian for the participant: a spouse, a parent of an adult, a stepparent of an adult child, grandparent, brother, sister, aunt, uncle, niece, nephew, adult child or stepchild of a participant or adult grandchild of a participant.</i></p> <p><u>Response Options:</u> <i>(Yes) The AWC has a process/policy for determining if a SSP meets the definition of a relative as defined by the wavier. (No) the AWC does not have a policy/process for determining if the SSP meets the definition of a relative as defined by the waiver.</i></p> <p><u>Source Documentation:</u> <i>Bulletin 00-20-04, Participant Directed Services: Agency with Choice Financial Management Services Model</i></p>	<p>The new question was added to address an area of need identified in Cycle 2.</p>
<p>The AWC Provider has and implements a process for ensuring the MEs comply with the ME agreement, and the actions taken</p>		<p>This question was removed in response to data analysis from Cycle 2</p>

when the MEs do not follow the agreement requirements.		
The AWC Provider takes action to fulfill unmet responsibilities of the ME.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer will talk with the AWC Provider and look at documentation demonstrating action taken when the AWC Provider was required to fulfill the unmet responsibilities of the ME. • The reviewer will review the ME Agreement to ensure the provider's policy addresses those responsibilities outlined within the ME agreement • The reviewer will ask the AWC Provider to explain its process/policy to fulfill unmet ME responsibilities. • The reviewer will examine the AWC Provider's policy and procedures for fulfilling unmet needs. The policy and procedures must address, at a minimum, all of the ME responsibilities indicated in Bulletin 00-20-04. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2
The AWC Provider ensures that they do not limit the MEs able to schedule ability to schedule an SSP to work up to 40 hours per week as needed and allowed within the participant's waiver budget limits.		The question was updated to provider better clarification based of feedback from Cycle 2.
AWC Managing Employer Interview Questions	<p><u>Completion Tips and Successful Interview Strategies:</u></p> <ol style="list-style-type: none"> 1. All questions should be answered by the individual (if they are their own ME) or by the person who serves as the ME that receives AWC Financial Management Services (FMS). 2. The ME interview can occur in person at a location determined by the ME, by phone, or by video. 3. Interviews should focus on the ME's overall experience in the past 12 months. 4. Interviews should be conversational and as relaxed as possible – questions do not need to be scripted. There are no right or wrong answers. 5. It is acceptable for there to be a person designated to answer questions on behalf of the ME. This proxy respondent should be listed in the appropriate space of the first section of the interview tool. The ME may designate the proxy respondent at the start of the interview. The interviewer may make assumptions about the identification of the proxy respondent if the individual is not able to communicate and there is an obvious trusted person to provide support during the interview. 6. The ME's response should be prioritized over that of a proxy, guardian, family member, team member, etc. If someone other than the ME answers the question, use the comment boxes in this tool to indicate who answered the question. 	The Completion Tips and Successful Interview Strategies was updated based on feedback from Cycle 2.

	<p>7. The individual may choose to cancel or reschedule the interview because their preferred communication method is not available, and they do not wish to identify a proxy respondent.</p> <p>8. The majority of the questions include a scale of response options from Always to Never. Interviewers should use the following guidance when selecting the appropriate response option:</p> <ul style="list-style-type: none">a. Select ‘Always’ when the circumstance occurs at all times or occasions. There is no variability, and it is 100% of the time.b. Select ‘Almost Every Time’ when the circumstance occurs nearly every time, but no less than 80% of the timec. Select ‘Sometimes’ when the circumstance occurs occasionally or from time to time. There is a moderate degree of variability and can occur anywhere from 20% to 80% of the time.d. Select ‘Almost Never’ when the circumstance hardly ever occurs. There is a high degree of variability and occurs less than 20% of the time.e. Select ‘Never’ when the circumstance does not occur at all.f. Answers using the response option “Don’t know, no response, or unclear response. Describe” should include specification of which one occurred (e.g., ME did not know, there was no response, etc.) “N/A”, a comment must be entered.	
AWC Managing Employer Interview Questions	<p><u>Completion Tips and Successful Interview Strategies:</u></p> <p>The following individual was identified as the proxy respondent (the proxy selected cannot be the SSP):</p>	The Completion Tips and Successful Interview Strategies was updated based on feedback from Cycle 2.
I know how to contact my Agency with Choice (AWC).	<p><u>Response and Comments:</u></p> <p>Pick the one answer that most closely represents the given response:</p> <ul style="list-style-type: none"><input type="checkbox"/> Always<input type="checkbox"/> Almost all the time<input type="checkbox"/> Sometimes<input type="checkbox"/> Almost never<input type="checkbox"/> Never<input type="checkbox"/> Don’t know, no response, or unclear. Describe: N/A	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
If I have a question, I am pleased with the response time of my AWC.	<p><u>Response and Comments:</u></p> <p>Pick the one answer that most closely represents the given response:</p> <ul style="list-style-type: none"><input type="checkbox"/> Always<input type="checkbox"/> Almost all the time	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.

	<input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> Never <input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A	
When I've had a complaint, the AWC resolved the issue to my satisfaction.	<u>Response and Comments:</u> Pick the one answer that most closely represents the given response: <input type="checkbox"/> Always <input type="checkbox"/> Almost all the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> Never <input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
My AWC gives me information to help me self-direct my services.		The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
My AWC provides me with the information about Supports Broker Services.		The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
My AWC offers training opportunities (beyond required training) that are useful to me as a ME.	<u>Guidance to Assist the Interviewer:</u> The intent of the question is to determine to what degree the AWC offers additional training opportunities that assist the ME in self-directing services. These are training opportunities that are beyond the foundational training expectations to serve as a ME. Examples of training, include but are not limited to: trauma-informed care, support for individuals with complex needs, first aid, and infection control practices. Medication administration, incident management, service note completion , and other trainings. <u>Response and Comments:</u> Pick the one answer that most closely represents the given response: <input type="checkbox"/> Always	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.

	<div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	
My AWC will work with me at times that best suit my schedule.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div> <div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
I get support from my AWC to find support service professionals (SSP) when requested.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div> <div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
New Support Service Professionals (SSP) are able to start work quickly after they are hired.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div> <div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
I get support from my AWC to develop SSPs' schedules.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div>	The Managing Employer Interview Questions, Guidance and Responses was

	<div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	updated based on feedback from Cycle 2.
My AWC supports me when I need to dismiss an SSP from employment.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div> <div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.
Overall, I am satisfied with my AWC.	<div><u>Response and Comments:</u></div> <div>Pick the one answer that most closely represents the given response:</div> <div><input type="checkbox"/> Always</div> <div><input type="checkbox"/> Almost all the time</div> <div><input type="checkbox"/> Sometimes</div> <div><input type="checkbox"/> Almost never</div> <div><input type="checkbox"/> Never</div> <div><input type="checkbox"/> Don't know, no response, or unclear. Describe: N/A</div>	The Managing Employer Interview Questions, Guidance and Responses was updated based on feedback from Cycle 2.

Supports Coordination Organization (SCO) Tool

Question	Update(s)	Reason for Update(s)
**The SCO uses person-centered performance data in developing	<u>Guidance:</u>	The guidance was updated to enhance the review for quality and best practice.

<p>the Quality Management Plan (QMP) and its Action Plan.</p>	<ul style="list-style-type: none">• This question is about assessing the SCO’s utilization of the “Plan” and “Do” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle.• To assess this, the reviewer should ask the SCO about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff and stakeholders and how?) and review documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.).• The reviewer requests to see performance data used by SCO to develop the QMP and its Action Plan.• The reviewer discusses with SCO the data results and how priorities for quality improvement projects were identified, how target objectives were determined and what performance measures were chosen for tracking performance over time.<ul style="list-style-type: none">◦ Person-centered performance data specifically targets people outcomes, not compliance outcomes and <i>can include but is not limited to:</i><ul style="list-style-type: none">- Results from QA&I self-assessments and full reviews (if applicable), targeting those areas where performance falls below 86%- Employment- Individual interviews (QA&I and IM4Q)- Communication needs- Community Participation- Self-direction, choice, and control- Management of incidents of abuse, neglect, exploitation, rights violations, and unexplained deaths.- Use of restrictive interventions, including restraints- Local level data, e.g., agency satisfaction surveys◦ Engaging agency leadership and gathering input from agency staff and other stakeholders to develop the QMP and its Action Plan (response option #1), is considered the best practice/high quality standard. Response option #2 is compliant however, the SCO should be encouraged to strive to achieve the best practice/high quality standard.◦ To assess this the reviewer should first ask the SCO about their practice (is agency leadership engaged in the process and how; is input gathered from agency staff/stakeholders and how?) and then request documentation as evidence to support leadership engagement and stakeholder input (e.g., meeting minutes/agendas, etc.). <p><u>Response Options:</u></p> <p>(Yes) The SCO used person-centered performance data to develop the QMP and its Action Plan and engaged agency leadership and gathered input from agency staff and other stakeholders to develop the QMP and its Action Plan.</p> <p>(Yes) The SCO used person-centered performance data to develop the QMP and its Action Plan.</p> <p>(No) The SCO does not have a QMP and its Action Plan or</p>	<p>In addition, the two “No” responses were combined in response to data analysis from Cycle 2.</p>
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	<p>(No) The SCO has a QMP and its Action Plan but did not use person-centered performance data to develop it.</p> <p>(N/A) The SCO is new (defined as an SCO determined to be qualified/enrolled in the previous fiscal year) or the SCO did not work with any individuals at any point during the entire review period.</p>	
<p>**The SCO uses data to assess progress towards achieving identified person-centered goals and target objectives in the Quality Management Plan (QMP) goals and its Action Plan target objectives.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• This question is about assessing the SCO’s utilization of the “Check” and “Act” steps in the Plan-Do-Check-Act (PDCA) quality improvement cycle. <i>Use of data involves the following actions:</i> collecting data, analyzing data, sharing data, <i>and</i> taking actions based on what the data reveals.• The reviewer determines if the SCO uses data to assess progress toward achieving identified person-centered QMP goals and target objectives in the QMP and its Action Plan target objectives by <i>ensuring all three criteria listed below have been met:</i><ol style="list-style-type: none">4. Requesting to see data SCO collects on a routine basis (monthly data collection is desired best practice).5. Asking SCO to share data analysis, including how often analysis occurs and how/where results are documented and shared with leadership and stakeholders, e.g., managers, responsible parties, staff, individuals, and families, etc. (Quarterly analysis and reporting are the desired best practice.)6. Asking how SCO uses routine data and analysis to track performance over time, including whether changes to the Action Plan are warranted and why.• Response option #1, is considered the best practice/high quality standard. Response option #2 is compliant however, the SCO should be encouraged to strive to achieve the best practice/high quality standard. To achieve option #1, the SCO must be able to provide the reviewer with evidence that person-centered data is: collected monthly, analyzed, and shared with leadership and stakeholders at least quarterly, and that actions are taken and documented, via changes to its Action Plan, based on what the data reveals. <p><u>Response Options:</u></p> <p>(Yes) The SCO:</p> <ol style="list-style-type: none">a. Collects person-centered data monthly ANDb. Leadership, managers, responsible parties, and staff review it at least quarterly to assess progress toward QMP goals ANDc. Updates the QMP and its Action Plan target objectives annually. <p>(Yes) The SCO uses person-centered data to determine if goals and objectives are on track in the QMP and its Action Plan, at least every 3 years.</p> <p>(No) The SCO does not have a QMP and its Action Plan OR has not updated the QMP in more than 3 years OR</p>	<p>The guidance was updated to enhance the review for quality and best practice. In addition, the criteria for the first “Yes” response were broken out for clarity and four “No” responses were combined in response to data analysis from Cycle 2.</p>

	<p>(No) The SCO has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives.</p> <p>(No) The SCO has not updated the QMP in more than 3 years.</p> <p>(No) The SCO has a QMP and its Action Plan but does not use person-centered data to assess progress towards achieving person-centered QMP goal(s) and its Action Plan target objectives AND has not updated the QMP in more than 3 years (i.e., both 4 and 5 are “No”).</p> <p>(N/A) The SCO is new (defined as an SCO determined to be qualified/enrolled in the previous fiscal year) or the SCO did not work with any individuals at any point during the entire review period.</p>	
<p><i>New - The SCO has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</i></p> <p><i>Non-scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The ODP QM Certification Handbook defines a target objective as a statement that describes where you want to go (what you want to happen), in precise, quantifiable terms (by how much and by when), using S-M-A-R-T guidelines, baselines and benchmarks.</i>• <i>Before the SCO can make a decision about where they want to go with a target objective, they have to first understand their current performance (baseline). The reviewer should start an assessment of this question by first identifying the SCO’s baseline.</i>• <i>The reviewer then determines if the SCO’s QM plan target objectives include all of the following components to be effective and increase the likelihood of being successful:</i><ul style="list-style-type: none">◦ <i>What they want to happen - e.g., increase, decrease, or eliminate a specific problem (e.g., employment, incidents, community participation)</i>◦ <i>By how much – e.g., counts or percentages</i>◦ <i>By when – e.g., fiscal year end date</i> <p><u>Examples:</u></p> <ul style="list-style-type: none">◦ <i>Increase % of people employed by 10% by 6/30/2025</i>◦ <i>Increase # of people using CPS to 30 by 6/30/2025</i> <ul style="list-style-type: none">• <i>The reviewer should ensure the target objective math makes sense. For example, if the SCO has 4 people employed in competitive integrated employment and their TO is to increase this number by 10%, then they are saying they want to increase by a part (4/10th) of a person.</i>	<p>The new question was added to support entities to be successful with Quality Management planning.</p>

	<ul style="list-style-type: none"> To be successful in quality management planning and activities, the SCO should be encouraged to develop target objectives that include all necessary components. Without an effectively written target objective, the SCO will be unable to determine if they are making progress or have met the outcome/goal that they wanted to achieve. <p><u>Response Options:</u></p> <p>(Yes) The SCO has developed effective target objectives that include all necessary components to increase the likelihood of being successful.</p> <p>(No) The SCO's QM plan does not include target objectives OR target objectives do not include all necessary components to increase the likelihood of being successful.</p> <p>(N/A) The SCO is new (defined as an SCO determined to be qualified/enrolled in the previous fiscal year) or the SCO did not work with any individuals at any time during the entire review period.</p> <p><u>Source Documents:</u></p> <p>ODP Quality Management Certification Handbook</p>	
*The SCO's staff completed annual training core courses as required in the training year.	<p><u>Source Documents:</u></p> <p>ODP Announcement 25-030: Reminder of 6100 Annual Training Requirements</p>	A new source document released in 2025 was added.
New - The Incident Management (IM) Representative ensures point person(s) maintains compliance with initiation of investigation activities.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The Reviewer will determine if Point Person ensures investigation assignment to the CI within 24 hours of discovery date/time of the incident. The Reviewer will need to limit the review to closed incidents requiring investigations from the Incident and Complaint Custom Report for the review period (note: it may take 24 hours to obtain the report). PATH: EIM>Reports>Incident and Complaint Custom Report <ul style="list-style-type: none"> Program Office: Select the applicable program office View Incidents or Complaints: Incident Subject Areas: Incident Details-Final and "Investigation Details" Occurrence Dates: 7/1/2024-6/30/2025 Type: Select All Status: Closed Primary Category: Select All 	The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.

	<ul style="list-style-type: none">○ <i>Secondary Category: Select All</i>○ <i>Search Providers: Enter the name of the entity being reviewed</i> <p><u>Response Options:</u> (Yes) <i>The IM Representative ensured the Point Person(s) maintained compliance with initiation of investigation activities.</i> (No) <i>The IM Representative did not ensure the Point Person(s) maintained compliance with initiation of investigation activities.</i> (N/A) <i>There were no investigations during the review period.</i></p> <p><u>Source Documents:</u> <i>Bulletin 00-21-02, Incident Management</i> <i>Administrative Review Process Manual, 2023 – Version 3.1</i></p>	
<i>New - The Incident Management (IM) Representative maintains a list of active Certified Investigators including recertification dates.</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• <i>The Reviewer will review the IM Representative’s existing tracking mechanism to ensure all Department Certified Investigators (CI) certifications are current. A Department Certified Investigator (CI) certification is valid for three (3) years.</i>• <i>If a reviewer identifies the expiration of a certificate, the reviewer shall confirm that no investigation assignments were made until the investigator attained certification.</i>• <i>Utilizing the Incident and Complaint Custom Report from Q9, the Reviewer will review the names of all CIs assigned to incidents during the review period. The names contained within the tracking tool should match the names reflected in the Incident and Complaint Custom Report.</i> <p><u>Response Options:</u> (Yes) <i>There is evidence that the IM Representative maintains a list of active CIs (including certificates and recertification dates); and no investigation assignments were made to those whose certificate was expired or there were no investigations during the review period.</i> (No) <i>There is no evidence that the IM Representative maintains a list of active CIs (including certificates, recertification dates); or the IM Representative maintains a list of CIs, but assignments were made to investigator(s) whose certificate was expired (Review Period is 7/1/2024-6/30/2025).</i></p> <p><u>Source Documents:</u> <i>Bulletin 00-21-02, Incident Management</i> <i>ODP Certified Investigator Peer Review (CIPR) Manual, 2023 Version 4.0</i></p>	<i>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.</i>

	<p><i>Certified Investigator’s Manual 2024</i> <i>55 Pa Code Chapter 6100.402</i></p>	
<p><i>New - The Incident Management (IM) Representative ensured Certified Investigator Peer Reviews (CIPRs) were conducted on a quarterly basis.</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • <i>The reviewer will determine if the IM Representative ensured CIPRs were conducted on a quarterly basis.</i> • <i>All entities that complete investigations are required to conduct the standardized CIPR process which involves using the most current forms as outlined in the ODP CIPR Manual (Review Period is 7/1/2024-6/30/2025).</i> <p><u>Response Options:</u></p> <p><i>(Yes) The IM Representative ensured CIPRs were conducted on a quarterly basis.</i></p> <p><i>(No) There is no evidence that the IM Representative ensured CIPRs were conducted on a quarterly basis.</i></p> <p><i>(N/A) No investigations were conducted during the review period.</i></p> <p><u>Source Documents:</u></p> <p><i>ODP Certified Investigator Peer Review (CIPR) Manual, 2023 Version 4.0</i></p> <p><i>Bulletin 00-21-02, Incident Management</i></p>	<p>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.</p>
<p>The SCO maintains a signed written contract or agreement documentation of any delegated or purchased function related to incident management.</p>		<p>The question was updated to provide clarification in response to feedback and questions from Cycle 2.</p>
<p>The SCO completes monitoring of delegated or purchased incident management function(s).</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer will determine if the SCO completes monitoring for delegated or purchased IM function(s) identified in previous question. • Monitoring documentation should include at a minimum: <ul style="list-style-type: none"> ○ A method to verify compliance with ODP regulations, written policies and procedures, departmental decisions, state and federal laws and regulations that are related to the function purchased/delegated. 	<p>The guidance and responses were updated to provide clarification in response to feedback and questions from Cycle 2.</p>

	<ul style="list-style-type: none">○ The frequency for monitoring by the SCO (at least quarterly) The monitoring of delegated functions should be completed on at least a quarterly basis and the results of the monitoring should be readily available in a written format.○ The staff position/titles and names responsible for the monitoring○ Description of any issues detected during monitoring and their resolution. <p>Response:</p> <p>(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.</p> <p>(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.</p> <p>(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and <u>/or</u> did not have written documentation of one or more all the listed requirements.</p> <p>(N/A) The Provider does not delegate or purchase any incident management functions or the delegated/purchased incident management function did not need to be utilized during the review period.</p>	
<i>New - The SCO follows up on actions taken to address concerns identified through the monitoring process of Incident management delegated functions.</i>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">● <i>The reviewer will determine if the SCO provides evidence of follow up actions taken to address concerns identified through the monitoring process of delegated functions.</i>● <i>The SCO's monitoring follow up should be readily available in a written format and should include at a minimum:</i><ul style="list-style-type: none">○ <i>Area(s) of identified concern(s)</i>○ <i>Deadline for actions to be completed on behalf of the delegated or contracted entity</i>○ <i>The staff position/titles and name(s) of those responsible to ensure identified actions are completed</i>○ <i>The manner in which the information was relayed to the delegated or contracted entity (e.g.: email, documentation of live communication between the AE and entity such as meeting minutes, or letter)</i> <p><u>Response Options:</u></p> <p><i>(Yes) The SCO follows up on actions taken to address concerns identified through the monitoring process of delegated functions.</i></p> <p><i>(No) The SCO did not follow up on actions taken to address concerns identified through the monitoring process of delegated functions and/or did not have the documentation to validate the follow up.</i></p> <p><i>(N/A) The SCO does not delegate or purchase or did not identify concerns through monitoring activities of delegated functions.</i></p>	<p>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate incident and risk management.</p>

	<p><u>Source Documents:</u> <i>Bulletin 00-21-02, Incident Management</i></p>	
<p>The SCO has a policy to monitor EIM incidents reports, including but not limited to, restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.</p> <p>The SCO has a policy to ensure a timely response to restraint and medication error reports.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer will determine if the SCO has a written policy to ensure a timely response to alerts and email notifications for restraint and medication error reports. The policy at a minimum should contain processes that outline: <ul style="list-style-type: none"> The review of all EIM incident reports, including but not limited to restraint and medication error reports on an ongoing basis. This process is to include the review of reports that have been initiated but not submitted. The ongoing review of Enterprise Incident Management (EIM) auto generated email notifications that indicate when a restraint or medication error report is in need of follow-up. If it is determined that a critical incident (abuse, neglect, exploitation, and rights violations) is to be filed, the SCO must verify in EIM or follow up with the reporting entity to ensure the filing of a critical incident. Methods to recognize unreported critical incidents and ensure reporting, investigation, and implementation of corrective actions. Methods to recognize patterns or trends of medication errors to detect potential exploitation and/or neglect. Collaboration and communication with the individual's team to ensure health and safety. Collaboration and communication with the individual's team to revise ISP, behavior support plan, and risk mitigation plan. 	<p>The question and guidance were updated to provide clarification in response to feedback and questions from Cycle 2.</p>
<p>The SCO completes monthly individual incident data monitoring.</p> <p>The SCO completes and documents the monitoring of Individual incident data (filed by the SCO) on a monthly basis.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer will determine if the SCO monitored incident data to take action(s) to mitigate risk, prevent recurring incidents, and implement corrective action as appropriate. The reviewer will review documentation of the activity from the last three months. SCOs are responsible for monitoring monthly incidents that are reported by the SCO. Documentation of this monthly activity must include at a minimum: <ul style="list-style-type: none"> Review of incident data to detect incidents that have been initiated but have not had the First Section submitted Evaluation of the effectiveness of incident corrective actions for all incident categories. Identification and implementation of preventative measures to reduce: <ul style="list-style-type: none"> - The number of incidents - The severity of the risks associated with the incident 	<p>The question and guidance were updated to provide clarification in response to feedback and questions from Cycle 2.</p>

	<ul style="list-style-type: none">- The likelihood of an incident recurring— The monitoring of the effectiveness of any noted corrective actions in incident reports— Actions taken by the SCO to address ineffective corrective actionso Documentation of:<ul style="list-style-type: none">- The need to revise the ISP with the ISP team to include new and/or revised information, risk mitigation plans, or a change in services or supports.- The need to consult with a County ID Program/AE/BSASP Risk Manager for assistance related to monthly data monitoring.- The actions and outcomes of any activities that occurred related to the monthly data monitoring. <p>Review Period is 7/1/2024-6/30/2025</p>	
The SCO conducts and documents a trend analysis of all incident categories (filed by the SCO) at least every 3 months.	<p>Guidance:</p> <ul style="list-style-type: none">• The reviewer will determine if the SCO conducted a trend analysis by reviewing the most recent analysis of the incidents the SCO entered.<ul style="list-style-type: none">o The trend analysis will include the development, the methodology used, data source, implementation plan, and documentation of both individual and agency-wide risk mitigation activities based on the results of the analysis.• The three-month analysis shall include, but is not limited to (as applicable):<ul style="list-style-type: none">– Adherence to timeframes in accordance with policy as it relates to reporting, investigation, and finalization of incidents as stated in 55 Pa. Code §§6100.401-\$6100.404.– Evaluation of effectiveness of corrective actions for all incident categories.– Evaluation of the effectiveness of education to the individual, staff, and others based on the circumstances of an incident.– A review and trend analysis of comments from the County ID Program/AE and ODP initial management review and disapproval reasons from the final management review.— Identification and implementation of preventative measures to reduce:– Any measures that have been implemented or will be implemented to reduce:<ul style="list-style-type: none">– The number of incidents.– The severity of the risks associated with the incident.– The likelihood of an incident recurring.o Documentation of the actions and outcomes of any activities that occurred related to trend analysis. <p>Review Period is 7/1/2024-6/30/2025</p>	The question and guidance were updated to provide clarification in response to feedback and questions from Cycle 2.

*The individual’s ISP was updated when a change in need was identified.	<p><u>Response Options:</u></p> <p>(Yes) The ISP was updated when change(s) in need were identified or the SC documented justification if the ISP was not updated.</p> <p>(Yes) The SC documented justification if the ISP was not updated when change(s) in need were identified.</p> <p>(No) The ISP was not updated to reflect an ODP funded service change, and the SC did not document justification for the ISP not being updated when change(s) in need were identified.</p> <p>(N/A) There was no change(s) in need identified.</p>	The two “Yes” responses were combined in response to data analysis from Cycle 2.
If there were identified issues, the SC followed up on the issues.	<p><u>Response Options:</u></p> <p>(Yes) The SC followed up on identified issues, including notification of the Provider.</p> <p>(No) The SC did follow up on identified issues but did not notify the Provider.</p> <p>(No) The SC did not follow up on identified issues or did not notify the provider.</p> <p>(N/A) There were no issues.</p>	One “No” response was removed in response to data analysis from Cycle 2.
*The SC incorporated risk mitigation strategies into the ISP.	<p><u>Guidance:</u></p> <p>The reviewer determines if the SC incorporated risk mitigation strategies based on a review of the entire ISP.</p> <p>Risks can be found in the following:</p> <ul style="list-style-type: none"> ○ HRST (must be reviewed for all individuals in a residential setting) ○ Service notes ○ Individual Monitoring Tools ○ ISP ○ Incident Reports ○ SIS assessment (ID/A waivers) ○ PRE (AAW) ○ Scales of Independent Behavior Revised (SIB-R) assessment BSASP Assessment Protocol Bundle (AAW) ○ Any applicable planning assessments. 	The sources for identifying risks were broken out in the guidance in response to feedback and questions from Cycle 2.
*The SC developed a person-centered ISP to address all assessed needs and personal goals.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the SC developed a person- centered ISP that incorporates all formal and informal assessed needs and personal goals based on a review of service notes, the ISP, Individual Monitoring Tools, PUNS (ID/A), the SIS 	The question, guidance, and response options were updated with “and personal goals” to align with ODP performance measures. In addition, the

	<p>assessment (ID/A), the PRE (AAW), BSASP Assessment Protocol Bundle SIB-R (AAW), HRST (if applicable), communication assessments and any applicable assessments.</p> <ul style="list-style-type: none">• The reviewer determines if the SC incorporated all services and support through waiver funded services or other funding sources or natural supports to mitigate identified risks into the ISP. <p>COMMENT NEEDED – If “No,” identify the assessed needs and/or personal goals that have not been documented addressed in the ISP.</p> <p><u>Response Options:</u></p> <p>(Yes) The ISP was person-centered and included evidence that addressed all assessed needs and personal goals were reviewed and addressed.</p> <p>(No) The ISP was not person-centered, and/or the identified did not address all assessed needs and personal goals were not included.</p>	SIB-r assessment was removed and replaced in the guidance to align with forthcoming changes in the AAW.
*An ISP was developed that supports the outcomes/ objectives goals throughout the entire plan.	Changed “objectives to “goals” throughout the question.	All areas of the question were updated to provide clarification in response to feedback and questions from Cycle 2.
The SC conducted all monitorings at the required frequency.	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the SC conducted monitorings at the required frequency based on a review of the Individual Monitoring Tools.• PATH: HCSIS > SC > Indiv Monitoring.• For the ID/A waivers, ISP should be reviewed to determine if a non-statutory frequency has been established and approved. If the individual has an approved non-statutory frequency, identify them in the comments section by MCI#, name(s), or initials.• Consolidated and Community Living is minimum of a monitoring once every two months during a six (6) calendar month timeframe.• P/FDS is a minimum of a monitoring once in every three (3) calendar months.• TSM and Base is a minimum once a year and the monitoring cannot take place on the same day as the annual ISP meeting.• AAW is a minimum of a monitoring once per quarter over a 12-month period based on the individual’s Plan Effective Date.	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

<p>The SC provided due process rights information at the annual ISP meeting.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the SC provided the due process rights at the annual ISP meeting (or initial ISP meeting if newly enrolled) based on a review of the ISP Signature Page Form or service notes.• For the ID/A waivers, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual/surrogate prior to the SC indicating the appropriate answer in the check box.<ul style="list-style-type: none">○ The individual was informed of their fair hearing and appeal rights and the department’s fair hearing and appeals process.○ The individual was informed of their fair hearing and appeal rights and their right to appeal with their county program.• Prior to February of 2025, ID/A used the “4/18” version of the ISP Signature Form. An updated version was announced in late January of 2025. SCs should be reminded to utilize the correct version of the form.• For the AAW, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual and/or representative prior to the individual and/or representative placing their initials in the initials box.• Individual’s signature must be documented on the ISP Signature Page effective 5/11/23 (written or electronic signatures are permitted). <p><u>Source Documents:</u></p> <p>55 Pa Code Chapter 6100.181</p> <p>PA 1135 Approval Letter (Section 1135 of the Social Security Act)</p> <p>Consolidated, P/FDS, CL and Adult Autism Waivers</p> <p>ODP Announcement 23-023, Federal COVID-19 Public Health Emergency Ending on May 11, 2023</p> <p>Bulletin 00-10-06, Supports Coordination Services (ID/A Waivers)</p> <p>Bulletin 00-08-05, Due Process and Fair Hearing Procedures for Individuals with Mental Retardation (ID/A Waivers)</p> <p>ISP Manual Section 4 (ID/A Waivers)</p> <p>ODPANN 25-012: Updates to the Individual Support Plan (ISP) Bulletin Attachments (ID/A Waivers)</p> <p>ODPANN 25-029: Adult Autism Waiver (AAW) Updated Individual Support Plan (ISP) Signature Form (AAW)</p>	<p>The guidance was updated to reflect changes/updates with the ISP Signature Form. In addition, new sources documents released in 2025 were added.</p>
<p>*Choice of Providers was offered to the individual/family.</p> <p>*Choice of services was offered to the individual/family.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the SC offered [choice of providers], [choice of services], [information about PDS options] to the individual/family at the annual ISP meeting (or initial ISP meeting if newly enrolled) based on a review of the ISP Signature Page Form or service notes.	<p>The guidance was updated in all three questions to reflect changes/updates with the ISP Signature Form. In addition, new sources documents released in 2025 were added.</p>

<p>*The SC provided the individual information on participant directed service (PDS) options annually.</p>	<ul style="list-style-type: none">• For the ID/A waivers, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual/surrogate prior to the SC indicating the appropriate answer in the check box.• Prior to February of 2025, ID/A used the “4/18” version of the ISP Signature Form. An updated version was announced in late January of 2025. SCs should be reminded to utilize the correct version of the form.• For the AAW, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual and/or representative prior to the individual and/or representative placing their initials in the initials box.• Individual’s signature must be documented on the ISP Signature Page effective 5/11/23 (written or electronic signatures are permitted). <p><u>Source Documents:</u> 55 Pa Code Ch 6100.225 and 6100.182 PA 1135 Approval Letter (Section 1135 of the Social Security Act) ODP Announcement 23-023, Federal COVID-19 Public Health Emergency Ending on May 11, 2023 ISP Manual (ID/A Waivers) ODPANN 25-012: Updates to the Individual Support Plan (ISP) Bulletin Attachments (ID/A Waivers) Adult Autism Waiver (AAW) ODPANN 25-029: Adult Autism Waiver (AAW) Updated Individual Support Plan (ISP) Signature Form (AAW)</p>	
<p>The individual attended the Annual Review Update ISP meeting or ARP ISP meeting or if the individual did not attend the meeting, the SC reviewed the results with the individual.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the SC offered choice of providers to the individual/family at the annual ISP meeting (or initial ISP meeting if newly enrolled) based on a review of the ISP Signature Page Form or service notes.• If the individual is under 18 or has a surrogate/legal representative, they are not required to attend.• For the ID/A waivers, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual/surrogate prior to the SC indicating the appropriate answer in the check box.• Prior to February of 2025, ID/A used the “4/18” version of the ISP Signature Form. An updated version was announced in late January of 2025. SCs should be reminded to utilize the correct version of the form.• For the AAW, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual and/or representative prior to the individual and/or representative placing their initials in the initials box.• Individual’s signature must be documented on the ISP Signature Page effective 5/11/23 (written or electronic signatures are permitted). <p><u>Source Documents:</u></p>	<p>The guidance was updated to reflect changes/updates with the ISP Signature Form. In addition, new sources documents released in 2025 were added.</p>

	<p>55 Pa Code Ch 6100.225 and 6100.182</p> <p>PA 1135 Approval Letter (Section 1135 of the Social Security Act)</p> <p>ODP Announcement 23-023, Federal COVID-19 Public Health Emergency Ending on May 11, 2023</p> <p>ISP Manual (ID/A Waivers)</p> <p>ODPANN 25-012: Updates to the Individual Support Plan (ISP) Bulletin Attachments (ID/A Waivers)</p> <p>Adult Autism Waiver (AAW)</p> <p>ODPANN 25-029: Adult Autism Waiver (AAW) Updated Individual Support Plan (ISP) Signature Form (AAW)</p>	
The SC follows ODP’s PUNS policy based on the individual’s current need(s).	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • ODP’s PUNS policy includes: <ul style="list-style-type: none"> ○ Active PUNS must be updated at least annually. ○ A PUNS must be created or updated within 30 days of the identified change in need if it cannot be met immediately or ○ A PUNS must be made inactive when all needs have been met and the individual is fully served. <p><u>Source Documents:</u></p> <p>ODP Announcement 25-043, Updates to the Prioritization of Urgency of Need for Services (PUNS) Manual for Individuals with intellectual Disabilities and/or Autism</p>	The guidance and source documents were updated to reflect new guidance released in 2025.
The Service Notes (SNs) met quality standards.	The question was moved in the sequence of questions.	The question was moved to improve the flow of questions and information being reviewed.
If the individual has Limited English Proficiency, the SCO has staff or contractors/language services who are trained to communicate with the individual an interpreter was offered to the individual for their most recent Individual Support Plan meeting.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> Limited English Proficiency is defined as “a person who does not speak English as their primary language and who has a limited ability to read, write, speak or understand English”. Please note that signed language users, such as ASL users, may also be limited English proficient. The reviewer determines if the individual has Limited English Proficiency based on a review of assessments, service notes, Individual Monitoring Tools, and the ISP. If the individual has Limited English Proficiency, the reviewer determines if the SCO has staff or available contractors/language services to communicate with the individual with Limited English Proficiency an interpreter was offered to the individual for their most recent ISP meeting based on a review of service notes. 	The question, guidance, and response options were updated to provide clarification in response to feedback and questions as well as data analysis from Cycle 2. In addition, an updated bulletin and new communication released in 2025 were added.

	<ul style="list-style-type: none">• If an interpreter was offered to the individual, the reviewer should document how it was offered, such as in English in an email or a letter, in their native language in an email or a letter, over the phone with an interpreter, etc. <p><u>Response Options:</u></p> <p>(Yes) The SCO has staff or contractors/language services who are trained to communicate with the individual with Limited English Proficiency The individual has Limited English Proficiency and an interpreter was offered to the individual.</p> <p>(No) The SCO does not have staff or contractors/language services who are trained to communicate with the individual with Limited English Proficiency The individual has Limited English Proficiency and an interpreter was not offered to the individual.</p> <p>(N/A) The individual does not have Limited English Proficiency.</p> <p><u>Source Documents:</u></p> <p>55 Pa Code Chapter 6100.4550 Bulletin 00-04-13, Limited English Proficiency (ID/A waivers) Bulletin 00-22-05, Individual Support Plans (ID/A waivers) ODPANN 25-012: Updates to the Individual Support Plan (ISP) Bulletin Attachments (ID/A waivers) Adult Autism Waiver (AAW)</p>	
<p>**The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the ISP includes information related to the following: about how the individual communicates and, if necessary, communication supports and services to assure effective communication based on a review of the Supports Intensity Scale (SIS), SIB-r, service notes and Individual Monitoring Tools (IMTs).<ul style="list-style-type: none">○ How the individual understands others (receptive communication).○ How the individual expresses or communicates with others.○ Strategies to support communication.○ Barriers to communication, how the team is addressing them.○ If people who the individual knows and relates to (at home, work, school and the community) understand how the individual communicates. <p><u>Response Options:</u></p>	<p>The guidance and response options were updated to provide clarification in response to feedback and questions as well as data analysis from Cycle 2.</p>

	<p>(Yes) The ISP includes information about how the individual communicates and, if necessary, communication supports and services to assure effective communication.</p> <p>(No) The ISP includes how the individual communicates but does not include information on communication supports and services, that based on the ISP the individual needs to assure effective communication.</p> <p>(No) The ISP does not include information about how the individual communicates and, if necessary, or the communication supports and services needed to assure effective communication.</p>	
<p><i>New - If the individual does not use speech, a communication assessment been completed.</i></p> <p><i>Non-Scored</i></p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • <i>The reviewer determines if the individual has “verbal” listed as their “mode of communication” under the “communication” section of the ISP.</i> • <i>If the individual has something other than “verbal” listed, the reviewer determines if the ISP includes a communication assessment. This may be identified within the “Other Non-Medical Evaluation” section of the ISP.</i> • <i>A communication assessment may include but are not limited to any communication assessment or AAC evaluation by a Speech and Language Pathologist, a communication assessment or evaluation through Temple, etc.</i> <p><u>Response Options:</u></p> <p><i>(Yes) The individual had a communication assessment completed</i></p> <p><i>(No) A communication assessment was not completed</i></p> <p><i>(N/A) The individual has “verbal” listed as their primary mode of communication.</i></p> <p><u>Source Documents:</u></p> <p><i>Bulletin 00-08-18, Communication Supports & Services</i></p>	<p>The new question was added to address an area of need identified in Cycle 2 as well as other processes that evaluate communication needs.</p>
<p>**At the annual ISP meeting, the SC provided education and information to the individual about employment services (i.e., competitive, integrated employment, OVR services, or benefits counseling or the “Guidance for Conversations about Employment”).</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if the SC offered individual information about employment services at the annual ISP meeting (or initial ISP meeting if newly enrolled) based on a review of the ISP Signature Page Form or service notes. • For the ID/A waivers, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual/surrogate prior to the SC indicating the appropriate answer in the check box. • Prior to February of 2025, ID/A used the “4/18” version of the ISP Signature Form. An updated version was announced in late January of 2025. SCs should be reminded to utilize the correct version of the form. • For the AAW, the ISP Signature Form includes questions/statements the SC must thoroughly explain to the individual and/or representative prior to the individual and/or representative placing their initials in the initials box. 	<p>The guidance was updated to reflect changes/updates with the ISP Signature Form.</p>

	<ul style="list-style-type: none"> Individual's signature must be documented on the ISP Signature Page effective 5/11/23 (written or electronic signatures are permitted). 	
The ISP includes all identified medical personnel seen during the review period.	<p>The question was moved in the sequence of questions.</p> <p><u>Guidance:</u></p> <ul style="list-style-type: none"> The reviewer determines all identified medical personnel such as doctors, dentists, psychiatrists, therapists/counselors, allied health professionals, specialists, etc. seen in the review period based on a review of service notes and Individual Monitoring Tools. The reviewer determines if the ISP was updated with all identified medical personnel. ISP PATH: HCSIS > Plan > Medical > Medical Contacts. 	The question was moved to improve the flow of questions and information being reviewed. In addition, a pathway in HCSIS was added to the guidance to clarify where the needed information is located.
*The individual's identified physical and mental health care needs are addressed.	<p><u>Remediation Options:</u></p> <p>a. SCO ensures SCO staff complete Supports Coordinator Monitoring of Residential Services 2025 training.</p>	The new remediation option was added to include a training released in 2025.
The SCO maintains records that they notified the AE and Regional Program Manager (RPM) or the AAW Regional Office if there was imminent risk to the health & welfare of the individual.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> If there is an imminent risk, there is a need to act immediately to protect the individual from the undesired event and when necessary, taking action to first enlist the support of emergency services. Imminent Risk is the likelihood that something adverse (serious injury or harm) is going to happen and soon. This type of risk requires immediate action before documentation of the risk. Imminent risk usually means there is a need to enlist the immediate support of others. <p>These can include:</p> <ul style="list-style-type: none"> ○ Appropriate law enforcement authorities ○ Emergency medical care providers ○ APS/OAPSA (using parameters provided by APS and OAPSA) The reviewer determines if the SCO notified the AE and RPM (ID/A waivers) or the AAW Regional Office (AAW) of the imminent risk based on a review of service notes and, Individual Monitoring Tools, and incident reports. The reviewer should request proof of notification during the review if it is not in the record. If the imminent risk to the health and welfare of the individual is determined a reportable incident according to the policy established in ODP Bulletin #00-21-02, the appropriate program offices should be contacted. 	The guidance was updated to provide clarification in response to feedback and questions from Cycle 2.

<p>The individual's preferences for wellness activities are documented in the ISP. There is evidence that the individual participates in preferred wellness activities documented in the ISP.</p>	<p><u>Guidance:</u></p> <ul style="list-style-type: none">• The reviewer determines if the individual participates in preferred wellness activities preferences or lack of preference for wellness activities have been identified based on a review of service notes, and Individual Monitoring Tools and documented in the ISP.• Areas in which the individual may wish to pursue wellness may include activities from any of the domains of wellness. The domains of wellness are: Emotional, physical, intellectual, spiritual, environmental, social, occupational, and financial. <p><u>Response Options:</u></p> <p>(Yes) The individual's preferences or lack of preference for wellness activities have been documented There is evidence that the individual participates in preferred wellness activities.</p> <p>(No) The individual's preferences for wellness activities have not been documented There is no evidence that the individual participates in preferred wellness activities.</p> <p>(N/A) The individual's lack of preference for wellness activities has been documented.</p>	<p>The question, guidance, and response options were updated to provide clarification in response to feedback and questions as well as data analysis from Cycle 2</p>
<p>**If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.</p>	<p><u>Guidance:</u></p> <p>For individuals in an ID/A waiver:</p> <ul style="list-style-type: none">• The reviewer determines if the individual has complex needs based on a review of service notes, Individual Monitoring Tools, SIS, and ISP.• Complex needs are multiple (2 or more) needs across personal, physical, mental, social, and financial well-being that require significant attention or resources. This can include 2 or more needs in one area and should be individualized.<ul style="list-style-type: none">• Examples:<ul style="list-style-type: none">○ Medical complexity○ Socioeconomic factors○ Mental illness○ Behaviors and traits <p>For individuals in the AAW:</p> <ul style="list-style-type: none">• The reviewer determines if the individual has complex needs based on a review of the most current PRE.• Complex needs are needs in any of the following domains:<ul style="list-style-type: none">• Law Enforcement contact and accused of or being charged with a crime• Risk of Harm to Self/Others	<p>The Support Intensity Scale (SIS) assessment was added to the guidance as a source for identifying complex needs in the ID/A waivers.</p>

	<ul style="list-style-type: none"> • Unstable Living Environment • Dysfunctional or absence of Natural Supports • Substance Use • Chronic Medical Conditions • Stressful Life Events • Co-occurring Mental Health Diagnosis <ul style="list-style-type: none"> • The reviewer determines if strategies for supports are in place to address identified complex needs based on a review of service notes, Individual Monitoring Tools, ISP, and the most current PRE (AAW). 	
The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	<p><u>Guidance:</u></p> <ul style="list-style-type: none"> • The reviewer determines if there were reportable incidents based on a review of service notes, Individual Monitoring Tools, PulseLight (available to ODP staff only), and other available documentation. The reviewer will determine if each reportable incident was documented in EIM. • The reviewer will need to determine if the SCO recognized and/or was made aware of the need to document the incident(s) in EIM by an examination of all available documentation. The record must reflect the steps taken in order to ensure the incident report is entered in a timely manner by the entity responsible for reporting the incident in EIM. • If the SCO notified a Provider of the need to enter an incident and the Provider failed to do so, the SCO is required to elevate this issue to the County ID Program/AE/BSASP Regional Office. 	PulseLight was added to the guidance as a source for identifying reportable incidents.
<p>The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM.</p> <p>Non-Scored</p>	<p><u>Response Options:</u></p> <p>(Yes) There is evidence that the individual was offered and educated about the circumstances of all incidents reported in the EIM system by the SCO.</p> <p>(Yes) There is evidence that the individual was offered education about the circumstances of all incidents reported in the EIM system by the SCO but refused the information.</p> <p>(No) There is no evidence that the individual was offered and/or educated about the circumstances of all incidents reported in the EIM system by the SCO.</p> <p>(N/A) The individual did not have incidents for which the SCO is required to file in EIM during the review period.</p>	The question was changed from “Non-Scored” to “Scored” to include remediation options. In addition, the second “Yes” response was removed in response to data analysis from Cycle 2.