QUALITY ASSESSMENT & IMPROVEMENT: ANNUAL STATEWIDE REPORT

Pennsylvania Office of Developmental Programs

Cycle 2 Year 1 (C2Y1) ~ Fiscal Year 2022-2023

Table of Contents

Executive Summary

About the QA&I Process

The Office of Developmental Programs (ODP) Quality Assessment and Improvement (QA&I) process, launched in July 2017, is one tool that ODP uses to evaluate the current system of supports and to identify ways to improve the service system for all individuals. As part of ODP's Quality Management Strategy, the QA&I process is designed to:

- Follow an individual's experience throughout the system,
- Measure progress toward implementing *Everyday Lives: Values in Action,*
- Gather timely and useable data to manage system performance,
- Use data to manage the service delivery system with a continuous quality improvement (CQI) approach,
- Assess compliance with Centers for Medicare and Medicaid Services (CMS) performance measures and 55 Pa. Code Chapter 6100 regulations, and
- Demonstrate Administrative Entity (AE) outcomes in the AE Operating Agreement.

Through the QA&I process, a comprehensive quality management review is conducted over a 3-year cycle, of all county programs, AEs, Supports Coordination Organizations (SCOs), and providers who deliver services and supports to individuals with intellectual disabilities and autism spectrum disorders. While compliance with requirements is part of the QA&I process, ODP's goal is to foster a statewide focus on quality improvement and the experience of individuals, building collaborative partnerships toward that end, and engaging in technical assistance and shared learning.

QA&I C2Y1 marked the move away from modified processes for QA&I Interim Years 1 (FY 20/21) and 2 (FY 21/22), approved by CMS because of the COVID-19 pandemic, and a return to originally approved sampling methodologies and self-assessment requirements. The monitoring tools for AEs, SCOs and providers were enhanced for C2Y1 to move away from evaluation of policy development towards evaluation of policy implementation. ODP also enhanced the questions about quality management plans to include variation responses to be able to better evaluate the quality of the plans. Additionally, questions were added to evaluate new ODP policies such as Incident Management bulletin requirements, and HCBS settings rule for unlicensed settings. Lastly, the AE tool was revised to be more in alignment with the AE operating agreement.

For C2Y1 individual interviews, all individuals in the Core, Base, and SC Services only samples were offered an interview, conducted by the Independent Monitoring for Quality (IM4Q) local programs on behalf of ODP. Interviews were conducted from August through December either in-person, by phone or video, based on individual preference. Of the 436 individuals offered interviews, 338 chose to participate and 98 declined the opportunity. Results from individual interviews are not included in this report but are published in a separate report.

About the Findings

This report includes a summary analysis of statewide data collected during QA&I C2Y1 for ODP's Consolidated, Person/Family Directed Support (P/FDS) and Community Living waivers, which are collectively referred to as the Intellectual Disability/Autism (ID/A) waivers, and the Adult Autism Waiver (AAW).

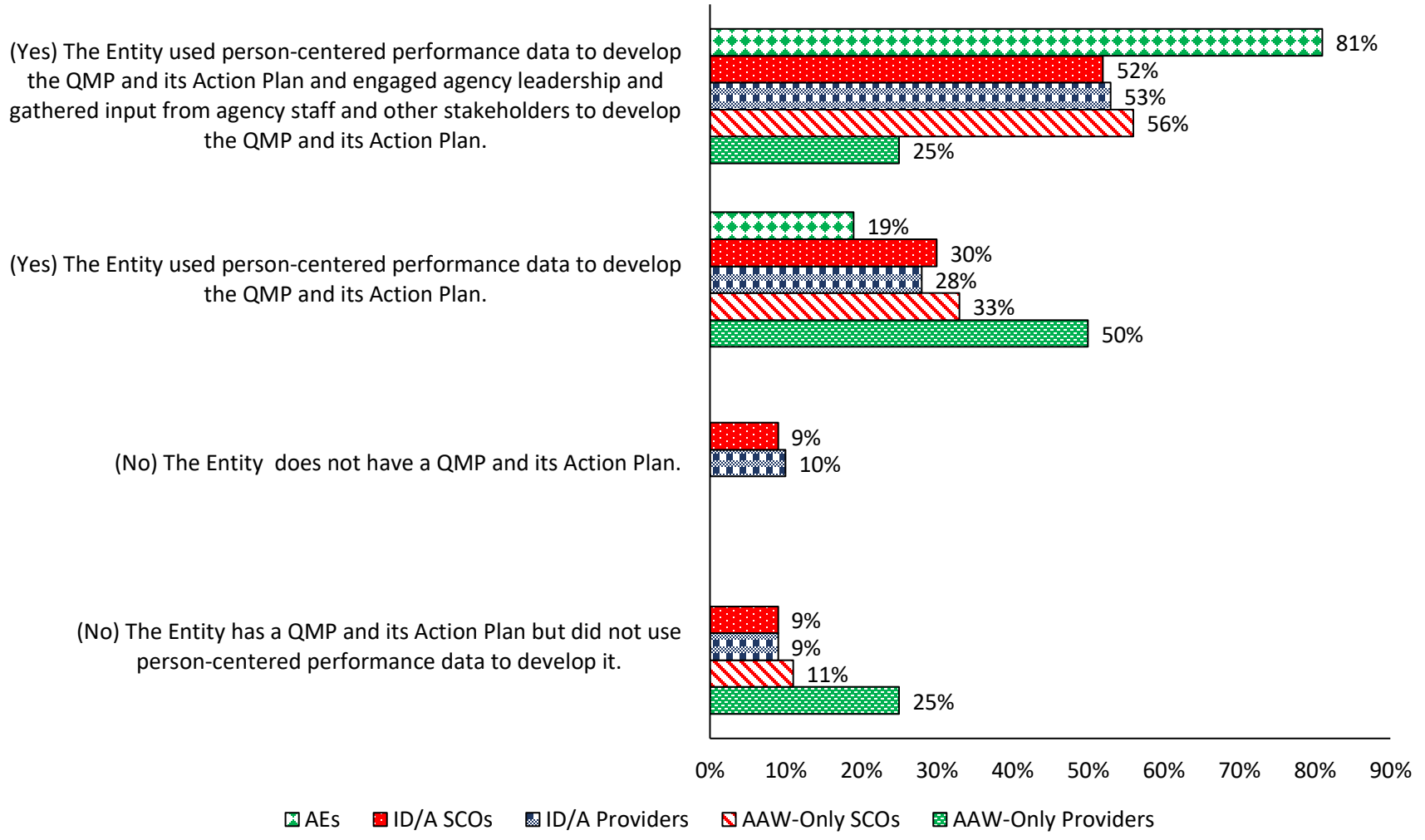
For ease of use, select findings from C2Y1 are presented in separate sections identified by entity type: AEs, SCOs and providers. Findings for the ID/A waivers and the AAW are presented separately within the SCO and provider sections. Results are underscored in subsections entitled "Reasons to Celebrate" and "Highlighting Opportunities." The intent of the latter is to encourage entities to target these low performing areas with quality improvement activities.

In addition to highlighting select findings in the body of this report, all findings from C2Y1 are provided at the end of this report, in the appendices. For comparison purposes, if there were stark differences between self-assessment data and full review data, the self-assessment results are highlighted in red font, within those questions in the appendices.

NEW This Year—Variation Responses

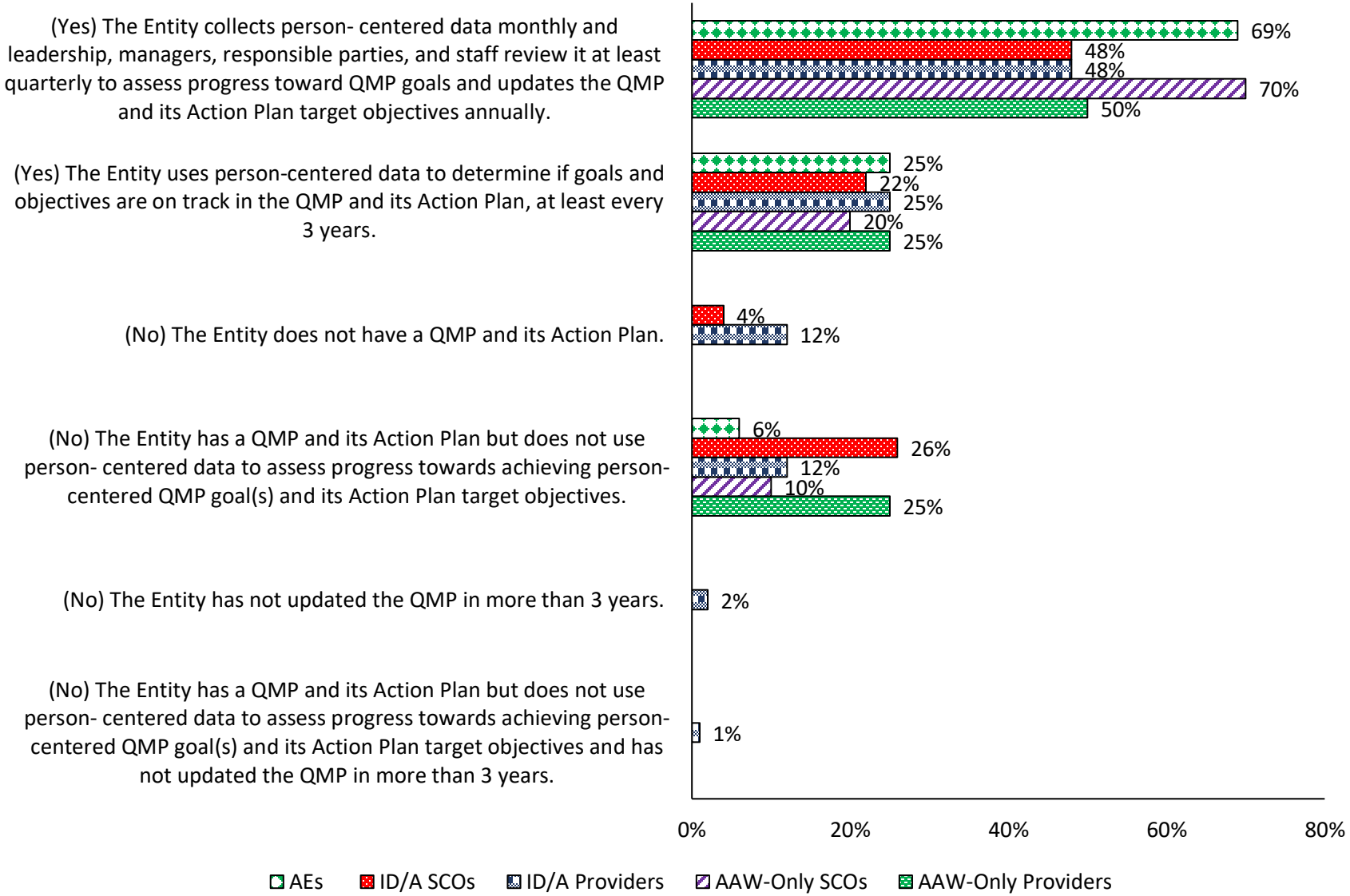
For QA&I C2Y1, the use of variation responses was introduced for the first time and included updated QA&I data collection tools for AEs, SCOs and providers. Variation responses are more than a "Yes/No" option when determining adherence to an expectation or requirement and they help to focus ODP and entities on *what* to improve on, if needed. Additionally, if an entity is found to be minimally compliant (meet basic requirements) but is not meeting best practice standards that improve the likelihood of success, then responses help them to identify what they need to improve upon to increase the likelihood of success. The following charts display a couple of examples of questions that included variation responses in QA&I C2Y1. See Appendix F for the full list of C2Y1 questions with variation responses.

The Entity Uses Person-Centered Performance Data in Developing the Quality Management Plan (QMP) and its Action Plan



** Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.*

The Entity Uses Data to Assess Progress Towards Achieving Identified Person-Centered QMP Goals and its Action Plan Target Objectives



** Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.*

About the Full Reviews

A QA&I full review is the process during which all AEs, SCOs and providers in the sample receive a comprehensive quality management review, which includes a self-assessment, individual interviews, Managing Employer (ME) interviews and full reviews. A QA&I full review is the process during which AE, SCO and provider documentation is reviewed by ODP or the AE to evaluate performance related to data/policy and record review questions, which are linked to key performance metrics and quality outcomes for individuals. It is important to note that many SCOs and providers are enrolled to serve participants in both the ID/A waivers and the AAW. When this is the case, they are referred to as shared providers, and full reviews are completed by ODP or the AE. For SCOs and providers who are only enrolled to serve AAW participants, AAW program completes the full reviews.

A full review also includes an in-person conference with entity leadership and ODP or the AE, to discuss findings from the review. After the review, each entity receives a comprehensive report and may be required to complete remediation, a plan to prevent recurrence, and quality improvement activities. The tables below provide count details for full reviews conducted in C2Y1.

ID/A: Number of Entities Engaged in QA&I, C2Y1, Full Review Process					
	Central	**Northeast**	**Southeast**	**Western**	**Statewide**
AEs	4	3	2	7	16
SCOs	4	2	6	11	23
Providers	66	48	131	98	343
TOTAL	**74**	**53**	**139**	**116**	**382**

AAW: Number of Entities Engaged in QA&I, C2Y1, Full Review Process					
	Central	**Northeast**	**Southeast**	**Western**	**Statewide**
SCOs	2	3	3	2	10
Providers	3	1	3	1	8
TOTAL	**5**	**4**	**6**	**3**	**18**

How ODP Uses This Data

In 2016, following the publication of *Everyday Lives: Values in Action*, the Information Sharing and Advisory Committee (ISAC) became ODP's Stakeholder Quality Council and went on to create a detailed series of recommendations, strategies, and performance measures used to guide ODP and to evaluate progress in achieving goals put forth in *Everyday Lives*. Data and findings from the QA&I process are used to measure and inform progress toward achieving the desired outcomes stated in multiple ISAC recommendation areas, including but not limited to assuring effective communication, increasing employment, and improving quality.

Additionally, some QA&I findings are used to report to the Centers for Medicare and Medicaid Services (CMS) on ODP's compliance with approved waiver performance measures. CMS established a threshold of 86% compliance with these performance measures to determine when a state must conduct further analysis related to the causes of performance problems. Based on that analysis, a quality improvement plan may be developed and implemented to address systemic issues. In this report, ODP has highlighted the findings related to CMS performance measures by identifying them with an asterisk (*) in the tables. ODP also currently uses the 86% threshold to identify compliance issues with ODP rules and regulations and the implementation of best practices in the field.

It should also be noted that ODP asks "exploratory" questions to assess what is happening in the field related to new requirements and/or best or promising practices. Exploratory questions may be scored or non-scored and the findings help ODP develop or update guidance if a need for improvement is indicated. Non-scored questions do not result in the non-compliance counting towards the entity's overall performance.

How Entities Can Use This Data

All entities should engage in a process of reviewing statewide results followed by a review of their regional, entity-specific data and performance. After studying these results, ODP encourages the use of the information to inform and track quality improvement activities at all levels within the organization. In instances where results are below 86%, staff at all levels should evaluate the need for systemic improvement and include these areas in their Quality Management (QM) plans and supporting action plans. When appropriate, ODP staff, AEs, SCOs, and providers should collaborate to develop and implement QM plans.

ODP continues to use information discovered during the QA&I process to:

- Update question guidance in the QA&I process,
- Update policies and procedures, and provide clarification as needed,
- Identify and respond to needs for training and technical assistance, and
- Develop and implement QM plans where performance improvement is needed statewide and/or specific to a region.

Entities are expected to use their self-assessment results to engage in improvement activities and to request technical assistance from either ODP or AEs, if needed. QA&I teams also use self-assessment results as evidence of current performance and to inform provision of technical assistance to entities. The use of self-assessment results to inform quality improvement and technical assistance activities is the reason why it is so important that self-assessments are completed accurately. Not completing a self-assessment accurately misinforms these other activities and robs entities and the system of opportunities to identify issues and make improvements. See some examples of a few significant differences between C2Y1 self-assessment results versus full review results below. As a reminder, for comparison purposes, if there were stark differences between self-assessment data and full review data, the self-assessment results are highlighted in red font within those questions in the appendices.

AE SELF-ASSESSMENT (SA) DATA VS. FULL REVIEW (FR) RESULTS	SA	FR
Q7. The AE follows ODP's record retention policy for individual closed records.	100%	75%
Q15. The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis.	77%	56%

SCO SELF-ASSESSMENT (SA) DATA VS. FULL REVIEW (FR) RESULTS	ID/A SA	IDA FR	AAW SA	AAW FR
Q10. The SCO has a written policy that supports the release of the incident information upon request.	86%	78%	83%	40%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months.	81%	50%	80%	63%

PROVIDER SELF-ASSESSMENT (SA) DATA VS. FULL REVIEW (FR) RESULTS	ID/A SA	IDA FR	AAW SA	AAW FR
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan.	98%	80%	99%	75%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	99%	80%	97%	75%

Metrics to Watch

The table below highlights findings from C2Y1 that are hovering around the 86% threshold (1% above or below), have slipped below that threshold for satisfactory performance and/or have declined significantly from IY2, putting them in danger of slipping below that threshold. ODP will be paying special attention to these areas to determine whether quality improvement projects should be implemented and strongly encourages entities to be doing the same. Questions highlighted with an asterisk (*) are used to answer a CMS performance measure.

METRICS TO WATCH: ADMINISTRATIVE ENTITIES	IY2	C2Y1	% Change
Q63. Certification of Need for ICF/ID or ICF/ORC LOC DP 250 completed (signed and dated).	84%	49%	-35%
Q64. The AE ensures that the program diagnosis corresponds with the correct criteria of LOC.	74%	43%	-31%
Q67. *The psychological evaluation meets ODP standards.	89%	81%	-8%
Q68. *A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning.	86%	82%	-4%

	METRICS TO WATCH: SCOs	IY2	C2Y1	% Change
ID/A	Q6. SCO staff completed the required number of training hours in the training year.	99%	87%	-12%
ID/A	Q43. 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.	100%	85%	-15%
AAW	Q19. *The individual's ISP was updated when a change in need was identified.	86%	83%	-3%
AAW	Q24. *The SC developed a person-centered ISP to address all assessed needs.	92%	85%	-7%
AAW	Q29. *The individual received services in type, scope, amount, duration & frequency as defined in the ISP.	95%	85%	-10%
AAW	Q42. *The individual's identified physical and mental health care needs are addressed.	92%	85%	-7%

	METRICS TO WATCH: PROVIDERS	IY2	C2Y1	% Change
ID/A	Q1. The Provider uses person-centered performance data in developing the QMP and its Action Plan.	91%	81%	-11%
ID/A	Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider.	68%	83%	+15%
ID/A	Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service.	NA	87%	NA

METRICS TO WATCH: PROVIDERS *(continued)*		IY2	C2Y1	% Change
ID/A	Q10. The Provider has a policy which ensures that all individuals receiving service(s) have access to food at any time and has the flexibility about where and when individuals eat within the home or in the community during the provision of services consistent with non-Medicaid recipients in the same and/or similar settings.	NA	87%	NA
ID/A	Q15. Provider staff completed the required number of training hours in the training year.	84%	85%	+1%
ID/A	Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	NA	85%	NA
ID/A	Q39. The individual's ISP includes a competitive integrated employment outcome/objective(s).	NA	85%	NA
ID/A	Q49. 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.	100%	84%	-16%
AAW	Q16. The Provider has a policy on sexual health, personal relationships & sexuality consistent with the guidelines.	94%	63%	-31%
AAW	Q21. If there were identified issues, the SC followed up on the issues.	NA	87%	NA
AAW	Q24. *The SC developed a person-centered ISP to address all assessed needs.	NA	85%	NA
AAW	Q29. *The individual received services in type, scope, amount, duration & frequency as defined in the ISP.	NA	85%	NA
AAW	Q42. *The individual's identified physical and mental health care needs are addressed.	NA	85%	NA

Section 1: Administrative Entities (AEs)

Reasons to Celebrate

Statewide, there are many areas where AEs are maintaining very positive scores in the areas monitored by ODP via QA&I. As seen in the table below, 30 of the 71 questions scored 100% during C2Y1. When compared against IY2, 9 questions listed below either maintained scores of 100% (6) or improved to 100% (3) for C2Y1. The remaining 21 questions were new for C2Y1, so comparison data from IY2 was not available. An additional 26 questions in C2Y1 scored between 88% and 99%.

AE Reasons to Celebrate: QA&I C2Y1 Questions	%
Q2. The AE ensures that any delegated or purchased administrative functions are established in writing pursuant to a subcontract or agreement.	100%
Q4. The AE maintains written documentation of any delegated or purchased function related to incident management (IM).	100%
Q6. The AE's designated point person for claims resolution uses ODP's claims resolution support process to assist Providers when claims are denied.	100%
Q9. The AE has a process to manage vacated capacity to ensure waiting list emergent needs are addressed timely. (*NS*)	100%
Q11. The AE implements its established protocols for management of unanticipated emergencies.	100%
Q12. The AE implements the ODP Provider risk screening process.	100%
Q16. The AE has a policy to develop mitigation plans to address medical, behavioral, and socioeconomic crisis situations.	100%
Q18. The AE engages with the Health Care Quality Unit (HCQU).	100%
Q20. The AE conducts oversight of the Priority of Urgency of Need for Services (PUNS) as per ODP's PUNS policy.	100%
Q21. The AE provides information and resources to individuals and families.	100%
Q24. The AE has a protocol for supporting individuals and families to resolve issues with SCOs and/or Providers. (*NS*)	100%
Q27. The AE promotes competitive integrated employment as a priority. (*NS*)	100%
Q28. **The AE has assigned a point person as a Subject Matter Expert (SME) in employment.	100%
Q30. The AE ensures that fair hearing and appeal activities are conducted in compliance with all ODP requirements.	100%
Q31. The AE actively expands and builds capacity of the Provider network. (*NS*)	100%

AE Reasons to Celebrate: QA&I C2Y1 Questions *(continued)*	%
Q33. *The AE qualifies AWC FMS Provider utilizing ODP standardized procedures.	100%
Q34. *The AE qualifies PROVIDER 1 utilizing ODP standardized procedures.	100%
Q35. *The AE qualifies PROVIDER 2 utilizing ODP standardized procedures.	100%
Q36. *The AE qualifies a COMMUNITY PARTICIPATION SUPPORT PROVIDER utilizing ODP standardized procedures.	100%
Q37. **The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	100%
Q41. The AE provides the SCOs and Providers with assistance to support individuals with complex physical and behavioral needs.	100%
Q48. The AE provides the SCOs and Providers with assistance to support people with complex physical and behavioral needs.	100%
Q49. The AE authorizes services consistent with the service definitions.	100%
Q52. A referral is made and the eligibility determination or case closure letter from OVR is in the individual's record for those individuals who are under age 25, authorized for the prevocational component of CPS, and are paid subminimum wage.	100%
Q53. If Q52 is yes, the service is eligible for waiver funding.	100%
Q54. The DP 251 form is complete.	100%
Q55. The DP 251 is timely.	100%
Q56. *The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.	100%
Q57. The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251.	100%
Q58. The AE used the Waiver reevaluation tool to complete the reevaluation process.	100%

Highlighting Opportunities

For C2Y1, 5 of the 14 questions included in the opportunities table below are related to the Level of Care (LOC) eligibility process and showed data results dropping by varying degrees from IY2. C2Y1 results for all 5 LOC-related questions were below the 86% threshold, with performance for 2 of the 5 questions dropping by more than 30%. AEs should consider inclusion of these areas in quality improvement (QI) activities going forward. Lower performance for these LOC-related questions is mainly attributed to new AE staff misunderstanding LOC eligibility requirements, especially those regarding medical and psychological evaluations. ODP has already taken steps to improve performance in this area by providing training in March and June 2022 for AEs/Qualified Developmental Disability Professionals (QDDPs).

AE Opportunities: QA&I Questions *(Q#s are for C2Y1)*	**IY2**	**C2Y1**	**% Change**
Q1. **The AE engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	NA	81%	NA
Q5. The AE completes monitoring of delegated or purchased IM function(s).	NA	79%	NA
Q7. The AE follows ODP's record retention policy for individual closed records. (*NS*)	NA	75%	NA
Q13. The AE has a written policy that supports the release of the incident report information upon request. (*NS*)	NA	81%	NA
Q14. The AE has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	NA	56%	NA
Q15. The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis.	NA	56%	NA
Q26. The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis. (*NS*)	NA	69%	NA
Q39. The AE actively uses a process to share IM4Q information with stakeholders.	NA	81%	NA
Q63. Certification of Need for ICF/ID or ICF/ORC LOC DP 250 completed (signed and dated).	84%	49%	-35%
Q64. The AE ensures that the program diagnosis corresponds with the correct criteria of LOC.	74%	43%	-31%
Q65. *The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.	NA	78%	NA
Q67. *The psychological evaluation meets ODP standards.	89%	81%	-8%
Q68. *A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning.	86%	82%	-4%
Q71. Waiver services are initiated within forty-five (45) calendar days.	68%	72%	4%

Section 2: Supports Coordination Organizations (SCOs)

Reasons to Celebrate

Statewide, there are many areas where ID/A SCOs are maintaining positive scores in the areas monitored by ODP via QA&I. In the table below, 25 of the 50 questions scored 95% or above during C2Y1. When compared against IY2, 7 questions listed below either maintained the same score or slightly improved. Six questions showed a slight drop in score from IY2 to C2Y1. Twelve of the questions in this table were not included in IY2, so there is no comparison data. An additional 6 questions in C2Y1 scored between 87% and 94%.

ID/A SCO Reasons to Celebrate: QA&I C2Y1 Questions	%
Q4. *The SCO's staff completed annual training core courses as required in the training year. (# of staff reviewed)	95%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	96%
Q8. The SCO maintains written documentation of any delegated or purchased function related to incident management.	100%
Q16. The SC documents the individual was provided with information about on-going opportunities and support necessary to participate in community activities of the individual's choice.	100%
Q19. *The individual's ISP was updated when a change in need was identified.	100%
Q22. *The SC documented a risk assessment.	97%
Q25. An ISP was developed that supports the outcomes/objectives throughout the entire plan.	100%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	96%
Q30. The SC provided due process rights information at the annual ISP meeting.	98%
Q31. *Choice of Providers was offered to the individual/family.	99%
Q32. *Choice of services was offered to the individual/family.	99%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	99%
Q34. 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.	99%
Q35. The SC follows ODP's PUNS policy based on the individual's current need(s).	99%
Q36. If the individual has Limited English Proficiency, the SCO has staff or contractors/language services who are trained to communicate with the individual.	100%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.	100%

ID/A SCO Reasons to Celebrate: QA&I C2Y1 Questions *(continued)*	%
Q38. If there is documentation in the individual's record of interest in employment or a goal of employment, the ISP supports how this interest or goal will be pursued.	99%
Q39. **At the annual ISP meeting, the SC provided education and information to the individual about employment services (i.e., competitive, integrated employment, OVR services, benefits counseling or the "Guidance for Conversations about Employment").	99%
Q40. A referral is made and the eligibility determination or case closure letter from OVR is in the individual's record for those individuals who are under age 25, authorized for the prevocational component of CPS, and are paid subminimum wage.	100%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	98%
Q44. The ISP includes all identified medical personnel seen during the review period.	99%
Q45. The individual's preferences for wellness activities are documented in the ISP.	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	99%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	98%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (*NS*)	97%

For the AAW, SCOs also scored positively in areas monitored by ODP during C2Y1. The 11 questions in the table below scored 95% or above during C2Y1. When compared against IY2, 4 questions listed below maintained the same scores. Question 49 results, regarding taking action on initial incident reports, increased from IY2 by 27%. Question 23 results showed a slight drop from IY2 to C2Y1. Five questions were not included in IY2, so there is no comparison data. An additional 16 AAW questions scored between 86% and 94%.

AAW SCO Reasons to Celebrate: QA&I C2Y1 Questions	%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	100%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	95%
Q34. 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.	98%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.	100%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	95%
Q43. 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.	100%

AAW SCO Reasons to Celebrate: QA&I C2Y1 Questions *(continued)*	%
Q45. The individual's preferences for wellness activities are documented in the ISP.	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	98%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (*NS*)	96%
Q49. The SCO identified and took action for issues identified upon review of initial incident reports in EIM.	100%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	100%

Highlighting Opportunities

For C2Y1, 12 ID/A SCO questions made it into the opportunities table. Seven of these 12 questions were not included in IY2, so a comparison with C2Y1 results cannot be made. One question (Q1) showed a slight positive gain over IY2 results and 4 questions showed decreased scores of 5% or more from IY2 to C2Y1. Of notable concern, results for one question (Q43), related to SCO notification to the AE or Regional Program Office regarding imminent risk to the health and welfare of individuals, dipped by 15%.

ID/A SCO Opportunities: QA&I Questions *(Q#s are for C2Y1)*	IY2	C2Y1	% Change
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan	82%	83%	+1%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	75%	70%	-5%
Q3. **The SCO engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	NA	74%	NA
Q9. The SCO completes monitoring of delegated or purchased incident management function(s).	NA	60%	NA
Q10. The SCO has a written policy that supports the release of the incident information upon request.	NA	78%	NA
Q11. The SCO has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	NA	74%	NA
Q12. The SCO completes monthly individual incident data monitoring.	NA	61%	NA
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months. (*NS*)	NA	50%	NA
Q26. The SC conducted all monitoring at the required frequency. (*NS*)	79%	84%	-6%

ID/A SCO Opportunities: QA&I Questions *(Q#s are for C2Y1 – continued)*	IY2	C2Y1	% Change
Q42. *The individual's identified physical and mental health care needs are addressed.	87%	78%	-9%
Q43. 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.	100%	85%	-15%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	NA	77%	NA

For IY2, 11 AAW SCO questions made it into the opportunities table below, with all 11 showing results below the 86% threshold. Of those 11 questions, 5 showed a decrease from IY2 results and 1 question showed an increase of 8%. Five of these 11 questions were not included in the IY2 survey, so a comparison from IY2 to C2Y1 cannot be made. It is important to note that in many cases for the AAW, the denominator was very small, and a minimal finding of noncompliance could cause significant impacts on the overall results for a question. For example, for question 13, there were only 8 SCOs in the sample and 5 were compliant. Scores for questions 10 and 11 indicate that 4 of 10 SCOs in the sample were compliant and for question 12, 5 of 9 SCOs in the sample were compliant. To address these areas of noncompliance, BSASP will be offering Virtual Office Hours for SCOs that focus on improvement.

AAW SCO Opportunities: QA&I Questions *(Q#s are for C2Y1)*	IY2	C2Y1	% Change
Q10. The SCO has a written policy that supports the release of the incident information upon request.	NA	40%	NA
Q11. The SCO has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	NA	40%	NA
Q12. The SCO completes monthly individual incident data monitoring.	NA	56%	NA
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months. (*NS*)	NA	63%	NA
Q19. *The individual's ISP was updated when a change in need was identified.	86%	85%	-1%
Q24. *The SC developed a person-centered ISP to address all assessed needs.	92%	85%	-7%
Q26. The SC conducted all monitoring at the required frequency.	71%	79%	+8%
Q28. The Individual Monitoring Tools met quality standards.	NA	57%	NA
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	95%	85%	-10%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	89%	82%	-7%
Q42. *The individual's identified physical and mental health care needs are addressed.	92%	85%	-7%

Section 3: Providers

Reasons to Celebrate

Statewide, there were many areas where ID/A providers are maintaining positive scores in areas monitored by ODP, through AEs, via the QA&I process. The 15 questions in the table below scored 96% or above during C2Y1. When compared against IY2, 2 questions showed slightly improved scores. The remaining 13 questions were not included in IY2, so there is no comparison data. An additional 13 questions scored between 86% and 94%.

ID/A Provider Reasons to Celebrate: QA&I C2Y1 Questions	%
Q4. The Therapy Provider renders the service in a home and community location.	100%
Q5. The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals.	98%
Q29. The individual has a current signed Department-approved room and board residency agreement on file.	96%
Q30. The Department-approved room and board residency agreement is completed at least annually.	96%
Q38. The Provider assists the individual in the identification of potential career options using a person-centered approach and based upon the interests and strengths of the individual.	99%
Q41. The individual is supported in exploring competitive integrated employment opportunities.	96%
Q43. The Provider supports the individual in maintaining employment.	99%
Q44. The Provider supports the individual to maintain competitive integrated employment by facilitating transportation.	100%
Q45. 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. (*NS*)	100%
Q47. The Provider ensures the individual completes all health care appointments, screenings, and follow-up as prescribed.	98%
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	97%
Q52. The individual has the right to have a key, access card, keypad code or other entry mechanism to lock and unlock the entrance door of their home.	96%
Q53. The individual has the right to lock their bedroom door.	97%
Q54. The individual has privacy in their home when audio and/or visual monitoring systems are used in their home.	99%
Q55. The individual chose how to decorate their bedroom and the common areas of their home such as the living room or kitchen.	98%

AAW providers are also maintaining positive scores in the areas monitored by ODP via QA&I. The 12 questions in the table below scored 100% during C2/Y1. Of those 12 questions, 3 maintained the same scores when compared to IY2. The remaining 9 questions were not applicable to AAW providers during IY2, so comparison data is not available. One additional question scored 88%, which is a slight improvement as compared to IY2. For questions 35 and 43, it is notable that the sample included just 1 individual each for whom the question applied.

AAW Provider Reasons to Celebrate: QA&I C2Y1 Questions	%
Q5. The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals.	100%
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider.	100%
Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service.	100%
Q29. The individual has a current signed Department-approved room and board residency agreement on file.	100%
Q30. The Department-approved room and board residency agreement is completed at least annually.	100%
Q32. 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.	100%
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP.	100%
Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication.	100%
Q43. The Provider supports the individual in maintaining employment.	100%
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan. (*NS*)	100%
Q49. 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.	100%
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	100%

Highlighting Opportunities

For C2Y1, 22 ID/A provider questions resulted in findings below the 86% threshold. Of these 22 questions, 4 showed significant decreases in score, ranging from 5% to 16%, over IY2 results. The score for 1 question improved by 15% from IY2 to C2Y1, and for another question, the score remained the same. The 16 remaining questions were not included in the IY2 survey, so a comparison from one year to the next cannot be made.

ID/A Provider Opportunities: QA&I Questions (Q#s are for C2Y1)	IY2	C2Y1	% Change
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan.	91%	80%	-11%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives.	NA	72%	NA
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	NA	71%	NA
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider.	68%	83%	+15%
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses.	NA	81%	NA
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	NA	80%	NA
Q14. New Provider staff completed orientation training core courses as required prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual.	87%	82%	-5%
Q15. Provider staff completed the required number of training hours in the training year.	NA	85%	NA
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	85%	85%	0%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. (*NS*)	NA	74%	NA
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).	NA	74%	NA
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management.	NA	71%	NA
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s).	NA	65%	NA
Q21. The Provider has a written policy that supports the release of the incident report information upon request.	NA	54%	NA
Q22. The Provider has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	NA	51%	NA

** Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.*

ID/A Provider Opportunities: QA&I Questions (Q#s are for C2Y1 - *continued*)	IY2	C2Y1	% Change
Q23. The Provider completes monthly individual incident data monitoring.	NA	52%	NA
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months.	NA	53%	NA
Q28. The Provider maintains a signed statement acknowledging that the individual has received information on individual rights.	NA	78%	NA
Q33. The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome.	84%	76%	-8%
Q39. The individual's ISP includes a competitive integrated employment outcome/objective(s).	NA	85%	NA
Q46. There is documentation of a fading plan or fading schedule for the individual's ongoing use as part of Supported Employment. (*NS*)	NA	79%	NA
Q49. 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.	100%	84%	-16%

For C2Y1, 10 AAW provider questions resulted in findings below the 86% threshold. Of these 10 questions, 2 showed significant decreases in score, ranging from 7% to 31%, over IY2 results. The 8 remaining questions were not included in the IY2 survey, so a comparison from one year to the next cannot be made. Small sample sizes for several questions should be considered when reviewing these findings. For example, results for questions 17 (denominator of 2), and 46 and 51 (denominators of 1), were significantly affected by the small samples.

AAW Provider Opportunities: QA&I Questions *(Q#s are for C2Y1)*	IY2	C2Y1	% Change
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan.	82%	75%	-7%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives.	NA	75%	NA
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	NA	75%	NA
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses.	NA	75%	NA
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	NA	75%	NA
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	94%	63%	-31%

AAW Provider Opportunities: QA&I Questions *(Q#s are for C2Y1 - continued)*	IY2	C2Y1	% Change
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. (*NS*)	NA	50%	NA
Q34. The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP. (*NS*)	NA	65%	NA
Q46. There is documentation of a fading plan or fading schedule for the individual's ongoing use as part of Supported Employment. (*NS*)	NA	0%	NA
Q51. The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM. (*NS*)	NA	0%	NA

QA&I FULL REVIEW MONITORING RESULTS

Fiscal Year (FY) 22-23, QA&I Cycle 2, Year 1 (C2Y1)

All results for statewide full reviews of AEs, SCOs and providers, collectively known as "entities," can be found on the following pages.

ABOUT THE DATA

When there is a marked difference (more than 10 percentage points) between the full review and self-assessment compliance percentages, the self-assessment data has been included and noted in red. This difference is being highlighted to indicate that ODP expectations are not being met across that entity type, for that question, and that entities may need to ensure a more accurate self-assessment is completed in those areas.

Some questions and answers from the full reviews are not included because they are non-scored.

Appendix A: Administrative Entity Results for QA&I, C2Y1 (FY 22-23)

Note: Demographic questions 43, 44 and 50 are not included in this table.

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q1. **The AE engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	**13**	**16**	**81%**	3	4	75%	2	3	67%	1	2	50%	7	7	100%
Q2. The AE ensures that any delegated or purchased administrative functions are established in writing pursuant to a subcontract or agreement.	**10**	**10**	**100%**	1	1	100%	1	1	100%	1	1	100%	7	7	100%
Q3. The AE completes monitoring of delegated or purchased administrative functions.	**9**	**10**	**90%**	1	1	100%	1	1	100%	1	1	100%	6	7	86%
Q4. The AE maintains written documentation of any delegated or purchased function related to incident management (IM).	**14**	**14**	**100%**	4	4	100%	2	2	100%	1	1	100%	7	7	100%
Q5. The AE completes monitoring of delegated or purchased IM function(s).	**11**	**14**	**79%**	2	4	50%	2	2	100%	1	1	100%	6	7	86%
Q6. The AE's designated point person for claims resolution uses ODP's claims resolution support process to assist Providers when claims are denied.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q7. The AE follows ODP's record retention policy for individual closed records. *Note: Self-Assessment data reflects 100% for this question.*	**12**	**16**	**75%**	1	4	25%	2	3	67%	2	2	100%	7	7	100%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q8. The AE follows ODP's record retention policy for individual active records.	**15**	**16**	**94%**	4	4	100%	2	3	67%	2	2	100%	7	7	100%
Q9. The AE has a process to manage vacated capacity to ensure waiting list emergent needs are addressed timely. (*NS*)	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q10. The AE demonstrates the management of reserved capacity for transitions to a short-term facility.	**15**	**16**	**94%**	4	4	100%	3	3	100%	2	2	100%	6	7	86%
Q11. The AE implements its established protocols for management of unanticipated emergencies.	**15**	**15**	**100%**	3	3	100%	3	3	100%	2	2	100%	7	7	100%
Q12. The AE implements the ODP Provider risk screening process.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q13. The AE has a written policy that supports the release of the incident report information upon request. (*NS*)	**13**	**16**	**81%**	3	4	75%	3	3	100%	2	2	100%	5	7	71%
Q14. The AE has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect. *Note: Self-Assessment data reflects 77% for this question.*	**9**	**16**	**56%**	1	4	25%	2	3	67%	1	2	50%	5	7	71%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q15. The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis. *Note: Self-Assessment data reflects 98% for this question.*	**9**	**16**	**56%**	2	4	50%	1	3	33%	0	2	0%	6	7	86%
Q16. The AE has a policy to develop mitigation plans to address medical, behavioral, and socioeconomic crisis situations.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q17. The AE operates a Human Rights Committee (HRC) in accordance with ODP requirements.	**15**	**16**	**94%**	3	4	75%	3	3	100%	2	2	100%	7	7	100%
Q18. The AE engages with the Health Care Quality Unit (HCQU).	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q19. The AE has a protocol in place for when an individual is not or is no longer eligible for the ID/A Waivers or the AAW.	**14**	**16**	**88%**	3	4	75%	2	3	67%	2	2	100%	7	7	100%
Q20. The AE conducts oversight of the Priority of Urgency of Need for Services (PUNS) as per ODP's PUNS policy.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q21. The AE provides information and resources to individuals and families.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q22. The AE has a process to identify prospective individuals for waiver enrollment.	**15**	**16**	**94%**	4	4	100%	3	3	100%	2	2	100%	6	7	86%
Q23. The AE follows ODP's process regarding the move and transfer of ID/A Waiver individuals to another AE.	**14**	**15**	**93%**	3	4	75%	3	3	100%	2	2	100%	6	6	100%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q24. The AE has a protocol for supporting individuals and families to resolve issues with SCOs and/or Providers. (*NS*) *Note: Self-Assessment data reflects 77% for this question.*	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q25. The AE implements a quality review protocol of auto-approval and authorization of ISPs. *Note: Self-Assessment data reflects 98% for this question.*	**14**	**16**	**88%**	4	4	100%	2	3	67%	1	2	50%	7	7	100%
Q26. The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis. (*NS*) *Note: Self-Assessment data reflects 79% for this question.*	**11**	**16**	**69%**	4	4	100%	1	3	33%	1	2	50%	5	7	71%
Q27. The AE promotes competitive integrated employment as a priority.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q28. **The AE has assigned a point person as a Subject Matter Expert (SME) in employment.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q29. The AE has worked with community stakeholders to develop a local employment coalition if none exists or has enhanced its current coalition.	**14**	**16**	**88%**	3	4	75%	2	3	67%	2	2	100%	7	7	100%
Q30. The AE ensures that fair hearing and appeal activities are conducted in compliance with all ODP requirements.	**10**	**10**	**100%**	2	2	100%	1	1	100%	2	2	100%	5	5	100%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q31. The AE actively expands and builds capacity of the Provider network. (*NS*)	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q32. The AE identifies, develops, and implements strategies regarding the areas of need in the community and the resources available. (*NS*)	**15**	**16**	**94%**	4	4	100%	2	3	67%	2	2	100%	7	7	100%
Q33. *The AE qualifies AWC FMS Provider utilizing ODP standardized procedures.	**3**	**3**	**100%**	1	1	100%	2	2	100%	0	0	--	0	0	--
Q34. *The AE qualifies PROVIDER 1 utilizing ODP standardized procedures.	**14**	**14**	**100%**	3	3	100%	3	3	100%	2	2	100%	6	6	100%
Q35. *The AE qualifies PROVIDER 2 utilizing ODP standardized procedures.	**10**	**10**	**100%**	2	2	100%	2	2	100%	2	2	100%	4	4	100%
Q36. *The AE qualifies a COMMUNITY PARTICIPATION SUPPORT (CPS) PROVIDER utilizing ODP standardized procedures.	**9**	**9**	**100%**	2	2	100%	3	3	100%	2	2	100%	2	2	100%
Q37. **The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q38. **The AE uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	**15**	**16**	**94%**	4	4	100%	3	3	100%	2	2	100%	6	7	86%

** Question is used to answer a CMS performance measure.* *** Question is associated with ODP's ISAC recommendations.* *NS = Question is non-scored.*

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q39. The AE actively uses a process to share independent Monitoring for Quality (IM4Q) information with stakeholders. *Note: Self-Assessment data reflects 94% for this question.*	**13**	**16**	**81%**	1	4	25%	3	3	100%	2	2	100%	7	7	100%
Q40. The AE attends and participates in all trainings that includes AEs as the target audience and/or is relative to the AE's staff role functions.	**15**	**16**	**94%**	3	4	75%	3	3	100%	2	2	100%	7	7	100%
Q41. The AE provides the SCOs and Providers with assistance to support individuals with complex physical and behavioral needs.	**16**	**16**	**100%**	4	4	100%	3	3	100%	2	2	100%	7	7	100%
Q42. The AE worked with the individual and their team to develop mitigation strategies when there are medical, behavioral, or socio-economic crisis situations.	**20**	**22**	**91%**	4	4	100%	2	4	50%	1	1	100%	13	13	100%
Q45. *The individual has an approved Annual ISP (Annual Review Update) in HCSIS.	**292**	**298**	**98%**	45	46	98%	68	68	100%	35	35	100%	144	149	97%
Q46. *The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.	**249**	**271**	**92%**	35	37	95%	54	54	100%	25	35	71%	135	145	93%
Q47. The AE ensures that the individual's ISP includes all assessed needs and includes services that adequately address the assessed needs.	**253**	**275**	**92%**	30	38	79%	54	54	100%	35	35	100%	134	148	91%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q48. The AE ensures that the individual's ISP includes information about ongoing opportunities and supports necessary to participate in community activities of the individual's choice.	**285**	**286**	**100%**	35	36	97%	66	66	100%	35	35	100%	149	149	100%
Q49. The AE authorizes services consistent with the service definitions.	**335**	**335**	**100%**	44	44	100%	61	61	100%	62	62	100%	168	168	100%
Q51. *Due process rights information was provided to the individuals with a change(s) in need.	**69**	**70**	**99%**	6	6	100%	4	4	100%	7	7	100%	52	53	98%
Q52. A referral is made and the eligibility determination or case closure letter from OVR is in the individual's record for those individuals who are under age 25, authorized for the prevocational component of CPS, and are paid subminimum wage.	**13**	**13**	**100%**	0	0	--	5	5	100%	2	2	100%	6	6	100%
Q53. If Q52 is yes, the service is eligible for waiver funding.	**13**	**13**	**100%**	0	0	--	5	5	100%	2	2	100%	6	6	100%
Q54. The DP 251 form is complete.	**314**	**314**	**100%**	41	41	100%	54	54	100%	62	62	100%	157	157	100%
Q55. The DP 251 is timely.	**313**	**314**	**100%**	40	41	98%	54	54	100%	62	62	100%	157	157	100%
Q56. The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.	**107**	**107**	**100%**	0	0	--	1	1	100%	2	2	100%	104	104	100%
Q57. The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251.	**106**	**106**	**100%**	0	0	--	1	1	100%	2	2	100%	103	103	100%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q58. The AE used the Waiver reevaluation tool to complete the reevaluation process.	**304**	**304**	**100%**	40	40	100%	53	53	100%	60	60	100%	151	151	100%
Q59. The annual reevaluation date is entered into HCSIS.	**310**	**314**	**99%**	40	41	98%	54	54	100%	59	62	95%	157	157	100%
Q60. 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.	**195**	**202**	**97%**	24	27	89%	41	41	100%	50	51	98%	80	83	96%
Q61. *The AE provides notification of Due process rights at waiver enrollment.	**183**	**202**	**91%**	15	27	56%	41	41	100%	46	51	90%	81	83	98%
Q62. The AE completed the initial level of care (LOC) evaluation and determination prior to entry into the waiver.	**198**	**202**	**98%**	25	27	93%	41	41	100%	50	51	98%	82	83	99%
Q63. Certification of Need for ICF/ID or ICF/ORC LOC DP 250 completed (signed and dated). *Note: Self-Assessment data reflects 99% for this question.*	**99**	**202**	**49%**	19	27	70%	38	41	93%	22	51	43%	20	83	24%
Q64. The AE ensures that the program diagnosis corresponds with the correct criteria of LOC. Note: Self-Assessment data reflects 96% for this question.	**87**	**202**	**43%**	17	27	63%	40	41	98%	12	51	24%	18	83	22%
Q65. *The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC. Note: Self-Assessment data reflects 97% for this question.	**158**	**202**	**78%**	19	27	70%	41	41	100%	49	51	96%	49	83	59%

CYCLE 2, YEAR 1 (FY 22-23): ADMINISTRATIVE ENTITIES	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q66. *The medical evaluation occurs within the 365-day period prior to the Qualified Developmental Disabilities Professional signature on the LOC DP 250 or DP 251 Form.	**200**	**202**	**99%**	27	27	100%	40	41	98%	50	51	98%	83	83	100%
Q67. *The psychological evaluation meets ODP standards. *Note: Self-Assessment data reflects 98% for this question.*	**164**	**202**	**81%**	27	27	100%	41	41	100%	28	51	55%	68	83	82%
Q68. *A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning. *Note: Self-Assessment data reflects 99% for this question.*	**165**	**202**	**82%**	25	27	93%	41	41	100%	39	51	76%	60	83	72%
Q69. *A record contains evidence that the disability occurred during the developmental period which is prior to the individual's 22nd birthday.	**197**	**202**	**98%**	27	27	100%	41	41	100%	46	51	90%	83	83	100%
Q70. The AE maintains documentation of financial eligibility for waiver services.	**200**	**202**	**99%**	26	27	96%	40	41	98%	51	51	100%	83	83	100%
Q71. Waiver services are initiated within forty-five (45) calendar days. *Note: Self-Assessment data reflects 91% for this question.*	**146**	**202**	**72%**	19	27	70%	34	41	83%	36	51	71%	57	83	69%

Appendix B: ID/A SCO Results for QA&I, C2Y1 (FY 22-23)

Note: Demographic questions 14 and 15 are not included in this table.

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan. *Note: Self-Assessment data reflects 98% for this question.*	**19**	**23**	**83%**	3	4	75%	2	2	100%	5	6	83%	9	11	82%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives. *Note: Self-Assessment data reflects 96% for this question.*	**16**	**23**	**70%**	2	4	50%	2	2	100%	5	6	83%	7	11	64%
Q3. **The SCO engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	**17**	**23**	**74%**	0	4	0%	2	2	100%	4	6	67%	11	11	100%
Q4. *The SCO's staff completed annual training core courses as required in the training year. (# of staff reviewed)	**145**	**152**	**95%**	21	22	95%	16	19	83%	43	43	100%	65	68	95%
Q5. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days	**63**	**67**	**94%**	3	3	100%	8	9	89%	26	27	96%	26	28	93%
Q6. SCO staff completed the required number of training hours in the training year.	**20**	**23**	**87%**	4	4	100%	2	2	100%	6	6	100%	8	11	73%

** Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.*

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	**22**	**23**	**96%**	4	4	100%	2	2	100%	5	6	83%	11	11	100%
Q8. The SCO maintains written documentation of any delegated or purchased function related to incident management.	**5**	**5**	**100%**	1	1	100%	0	0	--	2	2	100%	2	2	100%
Q9. The SCO completes monitoring of delegated or purchased incident management function(s). *Note: Self-Assessment data reflects 89% for this question.*	**3**	**5**	**60%**	0	1	0%	0	0	--	2	2	100%	1	2	50%
Q10. The SCO has a written policy that supports the release of the incident information upon request.	**18**	**23**	**78%**	4	4	100%	1	2	50%	6	6	100%	7	11	64%
Q11. The SCO has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	**17**	**23**	**74%**	3	4	75%	2	2	100%	4	6	67%	8	11	73%
Q12. The SCO completes monthly individual incident data monitoring. *Note: Self-Assessment data reflects 82% for this question.*	**14**	**23**	**61%**	0	4	0%	2	2	100%	2	6	33%	10	11	91%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months. *Note: Self-Assessment data reflects 81% for this question.*	**11**	**22**	**50%**	1	4	25%	2	2	100%	0	6	0%	8	10	80%

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q16. The SC documents the individual was provided with information about on-going opportunities and support necessary to participate in community activities of the individual's choice. *Note: Self-Assessment data reflects 96% for this question.*	**295**	**296**	**100%**	40	41	98%	36	36	100%	62	62	100%	157	157	100%
Q17. The SC offers information about services and resources to the family.	**184**	**206**	**89%**	14	35	40%	18	18	100%	56	57	98%	96	96	100%
Q19. *The individual's ISP was updated when a change in need was identified.	**146**	**146**	**100%**	17	17	100%	11	11	100%	30	30	100%	88	88	100%
Q20. The Service Notes (SNs) met quality standards.	**275**	**296**	**93%**	37	41	90%	36	36	100%	53	62	85%	149	157	95%
Q21. If there were identified issues, the SC followed up on the issues.	**168**	**179**	**94%**	23	26	88%	10	10	100%	43	44	98%	92	99	93%
Q22. *The SC documented a risk assessment.	**288**	**296**	**97%**	35	41	85%	36	36	100%	62	62	100%	155	157	99%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	**267**	**296**	**90%**	35	41	85%	36	36	100%	51	62	82%	145	157	92%
Q24. *The SC developed a person-centered ISP to address all assessed needs.	**268**	**296**	**91%**	33	41	80%	35	36	97%	61	62	98%	139	157	89%
Q25. *An ISP was developed that supports the outcomes/objectives throughout the entire plan.	**295**	**296**	**100%**	41	41	100%	36	36	100%	62	62	100%	156	157	99%

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q26. The SC conducted all monitorings at the required frequency.	**248**	**296**	**84%**	31	41	76%	33	36	92%	48	62	77%	136	157	87%
Q28. The Individual Monitoring Tools met quality standards.	**270**	**296**	**91%**	31	41	76%	36	36	100%	59	62	95%	144	157	92%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	**284**	**296**	**96%**	36	41	88%	36	36	100%	62	62	100%	150	157	96%
Q30. The SC provided due process rights information at the annual ISP meeting.	**291**	**296**	**98%**	38	41	93%	36	36	100%	62	62	100%	155	157	99%
Q31. *Choice of Providers was offered to the individual/family.	**294**	**296**	**99%**	40	41	98%	36	36	100%	62	62	100%	156	157	99%
Q32. *Choice of services was offered to the individual/family.	**293**	**296**	**99%**	40	41	98%	36	36	100%	62	62	100%	155	157	99%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	**294**	**296**	**99%**	40	41	98%	36	36	100%	62	62	100%	156	157	99%
Q34. 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.	**275**	**278**	**99%**	40	41	98%	36	36	100%	49	51	96%	150	150	100%
Q35. The SC follows ODP's PUNS policy based on the individual's current need(s).	**291**	**295**	**99%**	40	41	98%	36	36	100%	59	62	95%	156	156	100%

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q36. If the individual has Limited English Proficiency, the SCO has staff or contractors/language services who are trained to communicate with the individual.	**11**	**11**	**100%**	2	2	100%	4	4	100%	2	2	100%	3	3	100%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.	**295**	**296**	**100%**	41	41	100%	36	36	100%	61	62	98%	157	157	100%
Q38. If there is documentation in the individual's record of interest in employment or a goal of employment, the ISP supports how this interest or goal will be pursued.	**100**	**101**	**99%**	17	17	100%	15	15	100%	24	24	100%	44	45	98%
Q39. **At the annual ISP meeting, the SC provided education and information to the individual about employment services (i.e., competitive, integrated employment, OVR services, benefits counseling or the "Guidance for Conversations about Employment").	**294**	**296**	**99%**	40	41	98%	36	36	100%	62	62	100%	156	157	99%

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q40. A referral is made and the eligibility determination or case closure letter from OVR is in the individual's record for those individuals who are under age 25, authorized for the prevocational component of CPS, and are paid subminimum wage.	**9**	**9**	**100%**	0	0	--	1	1	100%	3	3	100%	5	5	100%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	**58**	**59**	**98%**	5	5	100%	7	7	100%	12	12	100%	34	35	97%
Q42. *The individual's identified physical and mental health care needs are addressed. *Note: Self-Assessment data reflects 98% for this question.*	**232**	**296**	**78%**	29	41	71%	34	36	94%	58	62	94%	111	157	71%
Q43. 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.	**11**	**13**	**85%**	4	6	67%	1	1	100%	2	2	100%	4	4	100%
Q44. The ISP includes all identified medical personnel seen during the review period.	**292**	**296**	**99%**	40	41	98%	36	36	100%	61	62	98%	155	157	99%
Q45. The individual's preferences for wellness activities are documented in the ISP.	**295**	**296**	**100%**	40	41	98%	36	36	100%	62	62	100%	157	157	100%

CYCLE 2, YEAR 1 (FY 22-23): ID/A SCO Data & Policy	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	**238**	**240**	**99%**	21	21	100%	21	21	100%	60	60	100%	136	138	99%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	**118**	**121**	**98%**	24	25	96%	10	10	100%	18	18	100%	66	68	97%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (*NS*)	**31**	**32**	**97%**	4	4	100%	0	0	--	5	5	100%	22	23	96%
Q49. The SCO identified and took action for issues identified upon review of initial incident reports in EIM. *Note: Self-Assessment data reflects 100% for this question.*	**30**	**34**	**88%**	13	15	87%	0	0	--	6	6	100%	11	13	85%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	**17**	**22**	**77%**	8	10	80%	0	0	--	2	2	100%	7	10	70%

Appendix C: ID/A Provider Results for QA&I, C2Y1 (FY 22-23)

Note: Demographic questions 10, 25, and 26 are not included in this table.

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan. *Note: Self-Assessment data reflects 91% for this question.*	**239**	**298**	**80%**	57	58	98%	36	41	88%	90	121	74%	56	78	72%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives. *Note: Self-Assessment data reflects 90% for this question.*	**215**	**298**	**72%**	53	58	91%	33	41	80%	77	121	64%	52	78	67%
Q3. ** The Provider engages in activities, or has a written policy, to improve racial equity performance. (*NS*)	**242**	**343**	**71%**	43	66	65%	30	48	63%	98	131	75%	71	98	72%
Q4. The Therapy Provider renders the service in a home and community location.	**8**	**8**	**100%**	0	0	--	3	3	100%	3	3	100%	2	2	100%
Q5. The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals.	**42**	**43**	**98%**	11	11	100%	13	13	100%	7	7	100%	11	12	92%

** Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.*

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider. *Note: Self-Assessment data reflects 94% for this question.*	**44**	**53**	**83%**	10	11	91%	8	12	67%	10	13	77%	16	17	94%
Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service. *Note: Self-Assessment data reflects 98% for this question.*	**47**	**54**	**87%**	8	9	89%	9	11	82%	10	12	83%	20	22	91%
Q9. The Provider has a written policy regarding individual choice when sharing a bedroom with another individual.	**42**	**47**	**89%**	6	6	100%	3	3	100%	12	14	86%	21	24	88%
Q10. The Provider has a policy which ensures that all individuals receiving service(s) have access to food at any time and has the flexibility about where and when individuals eat within the home or in the community during the provision of services consistent with non-Medicaid recipients in the same and/or similar settings.	**48**	**55**	**87%**	8	10	80%	6	6	100%	15	18	83%	19	21	90%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses. *Note: Self-Assessment data reflects 94% for this question.*	**206**	**254**	**81%**	38	51	75%	28	32	88%	75	98	77%	65	73	89%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service. *Note: Self-Assessment data reflects 99% for this question.*	**275**	**343**	**80%**	47	66	71%	38	48	79%	101	131	77%	89	98	91%
Q13. *The Provider's staff completed annual training core courses as required in the training year.	**1980**	**2260**	**88%**	389	449	87%	377	407	93%	508	640	79%	706	764	93%
Q14. New Provider staff completed orientation training core courses as required prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual. *Note: Self-Assessment data reflects 92% for this question.*	**1060**	**1295**	**82%**	240	282	85%	229	252	91%	244	361	68%	347	400	87%
Q15. Provider staff completed the required number of training hours in the training year.	**1811**	**2122**	**85%**	367	422	87%	337	374	90%	4336	596	73%	671	730	92%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	**293**	**343**	**85%**	52	66	79%	42	48	88%	112	131	85%	87	98	89%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. (*NS*) *Note: Self-Assessment data reflects 92% for this question.*	**148**	**201**	**74%**	21	38	55%	16	22	73%	62	81	77%	49	60	82%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI). *Note: Self-Assessment data reflects 87% for this question.*	**53**	**72**	**74%**	6	13	46%	6	10	60%	19	24	79%	22	25	88%
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management. *Note: Self-Assessment data reflects 92% for this question.*	**51**	**72**	**71%**	8	13	62%	5	10	50%	22	24	92%	16	25	64%
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s). *Note: Self-Assessment data reflects 88% for this question.*	**45**	**69**	**65%**	3	10	30%	4	10	40%	19	24	79%	19	25	76%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q21. The Provider has a written policy that supports the release of the incident report information upon request. *Note: Self-Assessment data reflects 94% for this question.*	**34**	**63**	**54%**	7	13	54%	2	10	20%	16	24	67%	9	16	56%
Q22. The Provider has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect. *Note: Self-Assessment data reflects 93% for this question.*	**37**	**72**	**51%**	2	13	15%	3	10	30%	18	24	75%	14	25	56%
Q23. The Provider completes monthly individual incident data monitoring. *Note: Self-Assessment data reflects 93% for this question.*	**17**	**33**	**52%**	1	6	17%	3	8	38%	8	10	80%	5	9	56%
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months. *Note: Self-Assessment data reflects 89% for this question.*	**17**	**32**	**53%**	2	7	29%	1	6	17%	8	10	80%		9	67%
Q27. **Staff are trained on the individual's communication profile and/or formal communication system. *Note: Self-Assessment data reflects 97% for this question.*	**116**	**135**	**86%**	38	43	88%	35	37	95%	9	17	53%	34	38	89%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q28. The Provider maintains a signed statement acknowledging that the individual has received information on individual rights. *Note: Self-Assessment data reflects 95% for this question.*	**674**	**861**	**78%**	123	187	66%	123	153	80%	174	225	77%	254	296	86%
Q29. The individual has a current signed Department-approved room and board residency agreement on file.	**302**	**315**	**96%**	59	59	100%	35	45	78%	83	83	100%	125	128	98%
Q30. The Department-approved room and board residency agreement is completed at least annually.	**294**	**307**	**96%**	58	60	97%	33	43	77%	81	81	100%	122	123	99%
Q31. The individual is offered opportunities for, and provided support to, participate in integrated community activities consistent with the individual's preferences, choices, and interests.	**987**	**1052**	**94%**	204	225	91%	157	161	98%	275	306	90%	351	360	98%
Q32. 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.	**899**	**967**	**93%**	162	186	87%	124	126	98%	302	330	92%	311	325	96%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q33. The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome. *Note: Self-Assessment data reflects 96% for this question.*	**528**	**699**	**76%**	87	132	66%	103	121	85%	150	189	79%	188	257	73%
Q34. The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP.	**1182**	**1317**	**90%**	252	272	93%	185	198	93%	373	419	89%	372	428	87%
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP. *Note: Self-Assessment data reflects 99% for this question.*	**144**	**162**	**89%**	26	33	79%	56	56	100%	18	28	64%	44	45	98%
Q36. The Provider submitted an incident report of neglect into Enterprise Incident Management (EIM) if the individual's back-up/contingency plan was not implemented as specified in the ISP. *Note: Self-Assessment data reflects 100% for this question.*	**15**	**25**	**60%**	6	6	100%	6	9	67%	2	8	25%	1	2	50%
Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication.	**184**	**201**	**92%**	42	55	76%	45	46	98%	47	49	96%	50	51	98%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q38. The Provider assists the individual in the identification of potential career options using a person-centered approach and based upon the interests and strengths of the individual.	**70**	**71**	**99%**	5	5	100%	16	16	100%	31	31	100%	18	19	95%
Q39. The individual's ISP includes a competitive integrated employment outcome/objective(s). *Note: Self-Assessment data reflects 97% for this question.*	**105**	**124**	**85%**	31	34	91%	31	35	89%	11	18	61%	32	37	86%
Q40. The individual was supported to make progress towards the outcome of competitive integrated employment. *Note: Self-Assessment data reflects 99% for this question.*	**111**	**126**	**88%**	32	35	91%	31	33	94%	13	19	68%	35	39	90%
Q41. The individual is supported in exploring competitive integrated employment opportunities.	**65**	**68**	**96%**	14	14	100%	11	12	92%	20	20	100%	20	22	91%
Q42. The Provider supports the individual in obtaining competitive integrated employment. (*NS*)	**59**	**64**	**92%**	9	12	75%	10	10	100%	19	19	100%	21	23	91%
Q43. The Provider supports the individual in maintaining employment.	**96**	**97**	**99%**	20	20	100%	18	19	95%	31	31	100%	27	27	100%
Q44. The Provider supports the individual to maintain competitive integrated employment by facilitating transportation.	**46**	**46**	**100%**	5	5	100%	10	10	100%	11	11	100%	20	20	100%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q45. 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. (*NS*)	**4**	**4**	**100%**	3	3	100%	0	0	--	1	1	100%	0	0	--
Q46. There is documentation of a fading plan or fading schedule for the individual's ongoing use as part of Supported Employment. (*NS*) *Note: Self-Assessment data reflects 96% for this question.*	**49**	**62**	**79%**	11	15	73%	8	12	67%	18	20	90%	12	15	80%
Q47. The Provider ensures the individual completes all health care appointments, screenings, and follow-up as prescribed.	**212**	**216**	**98%**	30	30	100%	15	18	83%	84	85	99%	83	83	100%
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan. (*NS*)	**1222**	**1310**	**93%**	254	272	93%	180	198	91%	373	413	90%	415	427	97%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q49. 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. *Note: Self-Assessment data reflects 100% for this question.*	**16**	**19**	**84%**	1	1	100%	6	7	86%	5	6	83%	4	5	80%
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	**328**	**339**	**97%**	83	86	97%	53	58	91%	47	49	96%	145	146	99%
Q51. The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM. (*NS*)	**280**	**316**	**89%**	61	71	86%	42	48	88%	54	59	92%	123	138	89%
Q52. The individual has the right to have a key, access card, keypad code or other entry mechanism to lock and unlock the entrance door of their home.	**177**	**185**	**96%**	18	21	86%	17	19	89%	59	59	100%	83	86	97%
Q53. The individual has the right to lock their bedroom door.	**190**	**195**	**97%**	25	25	100%	16	17	94%	67	67	100%	82	86	95%
Q54. The individual has privacy in their home when audio and/or visual monitoring systems are used in their home.	**88**	**89**	**99%**	6	6	100%	7	7	100%	19	20	95%	56	56	100%

CYCLE 2, YEAR 1 (FY 22-23): ID/A PROVIDERS	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q55. The individual chose how to decorate their bedroom and the common areas of their home such as the living room or kitchen.	**233**	**237**	**98%**	32	32	100%	25	25	100%	65	65	100%	111	115	97%

CYCLE 2, YEAR 1 (FY 22-23): AGENCY WITH CHOICE (AWC) PROVIDERS *These questions were answered for any ID/A Provider that also rendered AWC services.*	STATEWIDE Final Compliance		
Question	**N**	**D**	**%**
Q56. The AWC Provider demonstrates application of the core value of individual choice & control as a pillar to ODP's mission, vision and values. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	9	9	**100%**
Q57. The AWC Provider takes action and documents when Supports Service Professionals (SSPs) are scheduled for more than 40 hours per week. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	9	9	**100%**
Q58. The AWC Provider takes action and documents when the maximum allowable hours of care provided by relatives are exceeded. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	9	9	**100%**
Q59. The AWC Provider has and implements a process for ensuring that MEs comply with the ME agreement, and the action taken when MEs do not follow the agreement requirements. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 2/3*	8	9	**89%**
Q60. The AWC Provider provides MEs with information about the AWC Provider's roles and responsibilities. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	8	9	**100%**
Q61. The AWC Provider has and implements policies to ensure ME's report incidents to the AWC. *By region: Central = 3/3, Northeast = 1/2, Southeast = 1/1, West = 3/3*	8	9	**89%**
Q62. The AWC Provider has and implements a process for analyzing customer satisfaction responses. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	9	9	**100%**
Q63. The AWC Provider utilizes customer satisfaction findings to improve AWC services. *By region: Central = 2/2, Northeast = 2/2, Southeast = 1/1, West = 2/3*	8	9	**89%**
Q64. The AWC Provider takes action to fulfill unmet responsibilities of the ME. *By region: Central = 3/3, Northeast = 1/2, Southeast = 1/1, West = 3/3*	7	8	**88%**
Q65. The AWC Provider ensures that MEs are able to schedule SSPs up to 40 hours as needed and allowed within the participant's waiver budget limits. *By region: Central = 3/3, Northeast = 2/2, Southeast = 1/1, West = 3/3*	9	9	**100%**

CYCLE 2, YEAR 1 (FY 22-23): AGENCY WITH CHOICE (AWC) PROVIDERS *(continued)* ***These questions were answered for any ID/A Provider that also rendered AWC services.***	STATEWIDE Final Compliance		
Question	**N**	**D**	**%**
Q66. The AWC Provider produces service utilization reports and provides them to the Managing Employers (MEs) within seven calendar days of the last day of each payroll period. *By region: Central = 15/15, Northeast = 4/18, Southeast = 11/11, West = 35/41*	65	85	**76%**
Q67. The AWC Provider provides Managing Employer skills training. *By region: Central = 12/15, Northeast = 5/18, Southeast = 11/11, West = 40/41*	68	85	**80%**
Q68. The AWC Provider ensures that SSPs receive training on medication assistance. *By region: Central = 12/15, Northeast = 5/18, Southeast = 11/11, West = 40/41*	68	85	**80%**
Q69. The AWC Provider has an implements a written policy on restrictive procedures and a means to monitor and ensure appropriate use of restrictive procedures by MEs and SSPs. *By region: Central = 15/15, Northeast = 18/18, Southeast = 11/11, West = 40/41*	84	85	**99%**

Appendix D: AAW SCO Results for QA&I, C2Y1 (FY 22-23)

Note: Demographic questions 14 and 15 are not included in the following table. For the AAW, these SCO questions also did not apply, or the sample size was 0, so those questions are not shown in the table: 4, 5, 6, 8, 9, 35, 36 and 40.

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan. *Note: Self-Assessment data reflects 100% for this question.*	**8**	**9**	**89%**	2	2	100%	3	3	100%	2	2	100%	1	2	50%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives. *Note: Self-Assessment data reflects 100% for this question.*	**8**	**9**	**89%**	2	2	100%	3	3	100%	2	2	100%	1	2	50%
Q3. **The SCO engages in activities, or has a written policy, to improve racial equity performance. (*NS*) *Note: Self-Assessment data reflects 65% for this question.*	**9**	**10**	**90%**	2	2	100%	3	3	100%	3	3	100%	1	2	50%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	**10**	**10**	**100%**	2	2	100%	3	3	100%	3	3	100%	2	2	100%
Q10. The SCO has a written policy that supports the release of the incident information upon request. *Note: Self-Assessment data reflects 83% for this question.*	**4**	**10**	**40%**	1	2	50%	2	3	67%	0	3	0%	1	2	50%

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q11. The SCO has a policy to monitor EIM restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect. *Note: Self-Assessment data reflects 83% for this question.*	**4**	**10**	**40%**	1	2	50%	2	3	67%	0	3	0%	1	2	50%
Q12. The SCO completes monthly individual incident data monitoring. *Note: Self-Assessment data reflects 100% for this question.*	**5**	**9**	**56%**	1	2	50%	3	3	100%	1	2	50%	0	2	0%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months. *Note: Self-Assessment data reflects 80% for this question.*	**5**	**8**	**63%**	1	2	50%	3	3	100%	0	2	0%	1	1	100%
Q16. The SC documents the individual was provided with information about on-going opportunities and support necessary to participate in community activities of the individual's choice.	**56**	**61**	**92%**	12	13	92%	12	15	80%	12	13	92%	20	20	100%
Q17. The SC offers information about services and resources to the family. - Dynamic Comment	**46**	**52**	**88%**	10	10	100%	13	14	93%	10	10	100%	13	18	72%
Q19. *The individual's ISP was updated when a change in need was identified. Note: Self-Assessment data reflects 100% for this question.	**40**	**48**	**83%**	5	8	63%	14	14	100%	8	9	89%	13	17	76%

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q20. The Service Notes (SNs) met quality standards.	**55**	**61**	**90%**	9	13	69%	15	15	100%	12	13	92%	19	20	95%
Q21. If there were identified issues, the SC followed up on the issues. *Note: Self-Assessment data reflects 100% for this question.*	**47**	**54**	**87%**	9	11	82%	8	10	80%	11	13	85%	19	20	95%
Q22. *The SC documented a risk assessment.	**57**	**61**	**93%**	12	13	92%	15	15	100%	11	13	85%	19	20	95%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	**55**	**58**	**95%**	12	13	92%	12	13	92%	13	13	100%	18	19	95%
Q24. *The SC developed a person-centered ISP to address all assessed needs. *Note: Self-Assessment data reflects 99% for this question.*	**52**	**61**	**85%**	10	13	77%	12	15	80%	13	13	100%	17	20	85%
Q25. *An ISP was developed that supports the outcomes/objectives throughout the entire plan.	**57**	**61**	**93%**	10	13	77%	15	15	100%	13	13	100%	19	20	95%
Q26. The SC conducted all monitorings at the required frequency.	**48**	**61**	**79%**	8	13	62%	8	15	53%	13	13	100%	19	20	95%
Q28. The Individual Monitoring Tools met quality standards.	**35**	**61**	**57%**	4	13	31%	13	15	87%	6	13	46%	12	20	60%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	**52**	**61**	**85%**	12	13	92%	9	15	60%	12	13	92%	19	20	95%

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q30. The SC provided due process rights information at the annual ISP meeting. *Note: Self-Assessment data reflects 100% for this question.*	**54**	**61**	**89%**	13	13	100%	13	15	87%	9	13	69%	19	20	95%
Q31. *Choice of Providers was offered to the individual/family.	**54**	**61**	**89%**	13	13	100%	13	15	87%	9	13	69%	19	20	95%
Q32. *Choice of services was offered to the individual/family. *Note: Self-Assessment data reflects 99% for this question.*	**54**	**61**	**89%**	13	13	100%	13	15	87%	9	13	69%	19	20	95%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually. *Note: Self-Assessment data reflects 99% for this question.*	**50**	**61**	**82%**	13	13	100%	9	15	60%	9	13	69%	19	20	95%
Q34. 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.	**60**	**61**	**98%**	13	13	100%	14	15	93%	13	13	100%	20	20	100%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.	**61**	**61**	**100%**	13	13	100%	15	15	100%	13	13	100%	20	20	100%

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q38. If there is documentation in the individual's record of interest in employment or a goal of employment, the ISP supports how this interest or goal will be pursued.	**34**	**37**	**92%**	8	9	89%	8	8	100%	7	7	100%	11	13	85%
Q39. **At the annual ISP meeting, the SC provided education and information to the individual about employment services (i.e., competitive, integrated employment, OVR services, benefits counseling or the "Guidance for Conversations about Employment"). *Note: Self-Assessment data reflects 100% for this question.*	**55**	**61**	**90%**	13	13	100%	14	15	93%	9	13	69%	19	20	95%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	**19**	**20**	**95%**	5	5	100%	6	6	100%	4	5	80%	4	4	100%
Q42. *The individual's identified physical and mental health care needs are addressed. *Note: Self-Assessment data reflects 97% for this question.*	**52**	**61**	**85%**	12	13	92%	13	15	87%	11	13	85%	16	20	80%
Q43. 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.	**10**	**10**	**100%**	6	6	100%	0	0	--	2	2	100%	2	2	100%

CYCLE 2, YEAR 1 (FY 22-23): AAW SCOs	STATEWIDE Final Compliance			CENTRAL Final Compliance			NORTHEAST Final Compliance			SOUTHEAST Final Compliance			WEST Final Compliance		
Question	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
Q44. The ISP includes all identified medical personnel seen during the review period.	**54**	**61**	**89%**	13	13	100%	13	15	87%	13	13	100%	15	20	75%
Q45. The individual's preferences for wellness activities are documented in the ISP.	**61**	**61**	**100%**	13	13	100%	15	15	100%	13	13	100%	20	20	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	**46**	**47**	**98%**	10	10	100%	12	12	100%	6	6	100%	18	19	95%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	**21**	**23**	**91%**	4	4	100%	5	6	83%	4	4	100%	8	9	89%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (*NS*)	**22**	**23**	**96%**	3	4	75%	6	6	100%	5	5	100%	8	8	100%
Q49. The SCO identified and took action for issues identified upon review of initial incident reports in EIM.	**13**	**13**	**100%**	4	4	100%	5	5	100%	2	2	100%	2	2	100%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	**10**	**10**	**100%**	4	4	100%	4	4	100%	2	2	100%	0	0	--

Appendix E: AAW Provider Results for QA&I, C2Y1 (FY 22-23)

Note: Demographic questions 10, 25, and 26 are not included in the following table. For the AAW, these Provider questions also did not apply, or the sample size was 0, so they are not shown in the table: 4, 8, 9, 13, 14, 15, 18-24, 27, 28, 31, 36, 38-42, 44, 45, 47, 52, 53, 54, 55.

C2Y1 (FY 22-23): AAW-ONLY PROVIDERS	STATEWIDE Final Compliance		
Question	**N**	**D**	**%**
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan. *By region: Central = 0/1, Northeast = 0/0, Southeast = 2/2, West 1/1; Note: Self-Assessment data reflects 99% for this question.*	**3**	**4**	**75%**
Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives. *By region: Central = 0/1, Northeast = 0/0, Southeast = 2/2, West 1/1; Note: Self-Assessment data reflects 98% for this question.*	**3**	**4**	**75%**
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance. (*NS*) *By region: Central = 1/3, Northeast = 1/1, Southeast = 3/3, West 1/1; Note: Self-Assessment data reflects 86% for this question.*	**6**	**8**	**75%**
Q5. The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals. *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/0, West 1/1*	**1**	**1**	**100%**
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider. *By region: Central = 1/1, Northeast = 0/0, Southeast = 0/0, West 0/0*	**1**	**1**	**100%**
Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service. *By region: Central = 1/1, Northeast = 0/0, Southeast = 0/0, West 0/0*	**1**	**1**	**100%**
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses. *By region: Central = 1/1, Northeast = 1/1, Southeast = 0/1, West 1/1; Note: Self-Assessment data reflects 91% for this question.*	**3**	**4**	**75%**
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service. *By region: Central = 2/3, Northeast = 1/1, Southeast = 2/3, West 1/1; Note: Self-Assessment data reflects 97% for this question.*	**6**	**8**	**75%**
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines. *By region: Central = 1/3, Northeast = 1/1, Southeast = 2/3, West 1/1; Note: Self-Assessment data reflects 92% for this question.*	**5**	**8**	**63%**
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. (*NS*) *By region: Central = 0/0, Northeast = 1/1, Southeast = 0/1, West 0/1; Note: Self-Assessment data reflects 92% for this question.*	**1**	**2**	**50%**

C2Y1 (FY 22-23): AAW-ONLY PROVIDERS	STATEWIDE Final Compliance		
Question	**N**	**D**	**%**
Q29. The individual has a current signed Department-approved room and board residency agreement on file. *By region: Central = 2/2, Northeast = 0/0, Southeast = 0/0, West 0/0*	**2**	**2**	**100%**
Q30. The Department-approved room and board residency agreement is completed at least annually. *By region: Central = 2/2, Northeast = 0/0, Southeast = 0/0, West 0/0*	**2**	**2**	**100%**
Q32. 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. *By region: Central = 0/0, Northeast = 2/2, Southeast = 3/3, West 10/10*	**15**	**15**	**100%**
Q33. The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome. *By region: Central = 0/2, Northeast = 2/2, Southeast = 3/3, West 10/10*	**15**	**17**	**88%**
Q34. The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP. *By region: Central = 2/2, Northeast = 0/2, Southeast = 3/3, West 6/10*	**11**	**17**	**65%**
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP. *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/0, West 1/1;*	**1**	**1**	**100%**
Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication. *By region: Central = 1/1, Northeast = 0/0, Southeast = 0/0, West 1/1*	**2**	**2**	**100%**
Q43. The Provider supports the individual in maintaining employment. *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/0, West 1/1*	**1**	**1**	**100%**
Q46. There is documentation of a fading plan or fading schedule for the individual's ongoing use as part of Supported Employment. (*NS*) *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/0, West 0/1; Note: Self-Assessment data reflects 100% for this question.*	**0**	**1**	**0%**
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan. (*NS*) *By region: Central = 2/2, Northeast = 2/2, Southeast = 3/3, West 10/10*	**17**	**17**	**100%**
Q49. 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. *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/0, West 2/2*	**2**	**2**	**100%**
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required. *By region: Central = 1/1, Northeast = 2/2, Southeast = 2/2, West 1/1*	**6**	**6**	**100%**
Q51. The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM. (*NS*) *By region: Central = 0/0, Northeast = 0/0, Southeast = 0/1, West 0/0; Note: Self-Assessment data reflects 99% for this question.*	**0**	**1**	**0%**

Appendix F: Variation Responses for QA&I, C2Y1 (FY 22-23)

C2Y1 VARIATION RESPONSES: ADMINISTRATIVE ENTITIES	#	%
Q5.5 The AE completes monitoring of delegated or purchased IM function(s). Quality Management and Trend Analysis		
(Yes) The AE completes monitoring of delegated or purchased Quality Management and Trend Analysis and has written documentation of all the listed requirements.	3	100%
(No) The AE completes monitoring of delegated or purchased Quality Management and Trend Analysis but did not have written documentation of all the listed requirements.	0	0%
(No) The AE did not complete monitoring of delegated or purchased Quality Management and Trend Analysis and did not have written documentation of all the listed requirements.	0	0%
Q5.6 The AE completes monitoring of delegated or purchased IM function(s). Data Entry		
(Yes) The AE completes monitoring of delegated or purchased IM Data Entry and has written documentation of all the listed requirements.	3	100%
(No) The AE completes monitoring of delegated or purchased IM Data Entry but did not have written documentation of all the listed requirements.	0	0%
(No) The AE did not complete monitoring of delegated or purchased IM Data Entry and did not have written documentation of all the listed requirements.	0	0%
Q5.7 The AE completes monitoring of delegated or purchased IM function(s). IM Representative Functions		
(Yes) The AE completes monitoring of delegated or purchased IM Representative function and has written documentation of all the listed requirements.	3	100%
(No) The AE completes monitoring of delegated or purchased IM Representative function but did not have written documentation of all the listed requirements.	0	0%
(No) The AE did not complete monitoring of delegated or purchased IM Representative function and did not have written documentation of all the listed requirements.	0	0%
Q5.8 The AE completes monitoring of delegated or purchased IM function(s). Management Review of Incidents		
(Yes) The AE completes monitoring of delegated or purchased Management Review of Incidents and has written documentation of all the listed requirements.	3	100%
(No) The AE completes monitoring of delegated or purchased Management Review of Incidents but did not have written documentation of all the listed requirements.	0	0%
(No) The AE did not complete monitoring of delegated or purchased Management Review of Incidents and did not have written documentation of all the listed requirements.	0	0%

C2Y1 VARIATION RESPONSES: ADMINISTRATIVE ENTITIES *(continued)*	#	%
Q6. The AE's designated point person for claims resolution uses ODP's claims resolution support process to assist Providers when claims are denied.		
(Yes) The AE's documentation and other evidence indicates there is a point person assigned to handle claims resolution issues and demonstrates use of the claim resolution process to assist providers when claims are denied.	16	100%
(No) The AE's documentation or other evidence did not identify a designated point person for claims resolution and does not demonstrate use of the claim resolution process to help providers with denied claims.	0	0%
(No) The AE does not have a designated point person for claims resolution.	0	0%
Q11. The AE implements its established protocols for management of unanticipated emergencies.		
(Yes) The AE demonstrates it is following written protocols to handle unanticipated emergencies.	15	100%
(No) The AE did not implement their protocol to effectively manage unanticipated emergencies.	0	0%
(No) The AE doesn't have a protocol to manage unanticipated emergencies.	0	0%
Q16. The AE has a policy to develop mitigation plans to address medical, behavioral, and socioeconomic crisis situations.		
(Yes) The AE has a policy that addresses all requirements.	16	100%
(No) The AE has a policy, however, one or more of the identified requirements were not satisfied.	0	0%
(No) The AE does not have a policy.	0	0%
Q19. The AE has a protocol in place for when an individual is not or is no longer eligible for the ID/A Waivers or the AAW.		
(Yes) The AE has a protocol that includes all requirements.	14	88%
(No) The AE has a protocol but one or more of the requirements is not met.	2	13%
(No) The AE does not have a protocol.	0	0%
Q22. The AE has a process to identify prospective individuals for waiver enrollment.		
(Yes) The AE has a process to identify prospective individuals for waiver enrollment that addresses all requirements.	15	94%
(No) The AE has a process, however, one or more of the identified requirements were not met.	0	0%
(No) The AE does not have a process.	1	6%
Q24. The AE has a protocol for supporting individuals and families to resolve issues with SCOs and/or Providers.		
(Yes) The AE has a protocol.	16	100%
(No) The AE has a protocol, but it does not include the areas identified.	0	0%
(No) The AE does not have a protocol.	0	0%

C2Y1 VARIATION RESPONSES: ADMINISTRATIVE ENTITIES *(continued)*	#	%
Q25. The AE implements a quality review protocol of auto-approval and authorization of ISPs.		
(Yes) The AE implements its protocol to complete a quality review of auto approved and authorized ISPs.	14	88%
(No) The documentation provided does not demonstrate that the AE completed a quality review of auto approved and authorized ISPs.	2	13%
(No) The AE does not have a protocol to complete a quality review of auto approved and authorized ISPs.	0	0%
Q26. The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis.		
(Yes) The AE evaluates trends in ISP disapprovals and engages in TA as needed to improve the quality of ISPs.	11	69%
(No) The AE evaluated trends in ISP disapprovals and did not engage in TA as needed to improve the quality of ISPs.	4	25%
(No) The AE did not evaluate trends in ISP disapprovals and did not engage in TA as needed to improve the quality of ISPs.	1	6%
Q31. The AE actively expands and builds capacity of the Provider network.		
(Yes) The AE actively works to expand and build the capacity of its Provider network.	16	100%
(No) The information reviewed does not demonstrate sufficient activities by the AE to expand and build the capacity of the Provider network.	0	0%
(No) The AE does not have a protocol for Provider network capacity building and expansion.	0	0%
Q37. **The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.		
(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.	13	81%
(Yes) The AE used person-centered performance data to develop the QMP and its Action Plan.	3	19%
(No) The AE does not have a QMP and its Action Plan.	0	0%
(No) The AE has a QMP and its Action Plan but did not use person-centered performance data to develop it.	0	0%
Q38. **The AE uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.		
(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.	11	69%
(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.	4	25%
(No) The AE does not have a QMP and its Action Plan.	0	0%
(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.	1	6%
(No) The AE has not updated the QMP in more than 3 years.	0	0%
(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").	0	0%

C2Y1 VARIATION RESPONSES: ADMINISTRATIVE ENTITIES *(continued)*	#	%
Q40. The AE attends and participates in all trainings that includes AEs as the target audience and/or is relative to the AE's staff role functions.		
(Yes) The AE attended and participated in ODP offered training intended for AEs and/or the AE's staff role functions.	15	94%
(No) The documentation provided does not sufficiently demonstrate training attendance.	0	0%
(No) The AE did not attend training.	1	6%
Q46. *The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.		
(Yes) The AE approved the ISP within 365 days.	40	100%
(No) The AE did not approve the ISP within 365 days.	0	0%
(No) There is not an Annual ISP (Annual Review Update) approved for the individual.	0	0%
Q54. The DP 251 form is complete.		
(Yes) The DP 251, signed and dated within the past year at the time of the QA&I review, is found in the individual's file.	54	100%
(No) The DP 251 is missing either the signature or date.	0	0%
(No) The DP 251 is not in the individual's file.	0	0%
Q55. The DP 251 is timely.		
(Yes) The DP 251 is timely.	54	100%
(No) The DP 251 is not timely.	0	0%
(No) The DP 251 is not in the individual's file.	0	0%
Q56. The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.		
(Yes) The LOC recommendation is indicated on the medical evaluation.	1	100%
(No) The LOC recommendation is not indicated on the medical evaluation.	0	0%
(No) The medical evaluation is not in the individual's file.	0	0%
Q57. The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251.		
(Yes) The medical evaluation is dated within 365 days prior to the QDDP signature.	1	100%
(No) The medical evaluation is not dated within 365 days prior to the QDDP signature.	0	0%
(No) The medical evaluation is not in the individual's file.	0	0%
Q59. The annual reevaluation date is entered into HCSIS.		
(Yes) The most current date is entered into HCSIS in the correct location.	54	100%
(No) There is no annual reevaluation date in HCSIS.	0	0%
(No) The annual reevaluation date is incorrect (old).	0	0%

C2Y1 VARIATION RESPONSES: ID/A SCOs	#	%
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.		
(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.	12	52%
(Yes) The SCO used person-centered performance data to develop the QMP and its Action Plan.	7	30%
(No) The SCO does not have a QMP and its Action Plan.	2	9%
(No) The SCO has a QMP and its Action Plan but did not use person-centered performance data to develop it.	2	9%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.		
(Yes) The SCO 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.	11	48%
(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.	5	22%
(No) The SCO does not have a QMP and its Action Plan.	1	4%
(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.	6	26%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).		
(Yes) There is evidence that the SCO has an IM Representative that is a CI, or the IM Representative assumed their role less than 12 months ago.	22	96%
(No) There is no evidence that the SCO has an IM Representative.	1	4%
(No) The IM Representative did not have a CI certificate within the required timeframe.	0	0%
Q9.2 The SCO completes monitoring of delegated or purchased incident management function(s). Investigations conducted by a Department CI		
(Yes) The SCO completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	2	50%
(No) The SCO completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	2	50%
(No) The SCO did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	0	0%

C2Y1 VARIATION RESPONSES: ID/A SCOs *(continued)*	#	%
Q9.6 The SCO completes monitoring of delegated or purchased incident management function(s).		
(Yes) The SCO completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	0	0%
(No) The SCO completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	1	100%
(No) The SCO did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	0	0%
Q19. *The individual's ISP was updated when a change in need was identified.		
(Yes) The ISP was updated when change(s) in need were identified.	145	99%
(Yes) The SC documented justification if the ISP was not updated when change(s) in need were identified.	1	1%
(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.	0	0%
Q21. If there were identified issues, the SC followed up on the issues.		
(Yes) The SC followed up on identified issues, including notification of the Provider.	168	94%
(No) The SC did follow up on identified issues but did not notify the Provider.	1	1%
(No) The SC did not follow up on identified issues.	10	6%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.		
(Yes) The ISP includes information about how the individual communicates and, if necessary, communication supports and services to assure effective communication.	295	100%
(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.	1	0%
(No) The ISP does not include information about how the individual communicates and, if necessary, communication supports and services to assure effective communication.	0	0%
Q42. *The individual's identified physical and mental health care needs are addressed.		
(Yes) All of the identified physical and mental health care needs have been addressed or if the individual does not take any medications and no physical and mental health care needs have been identified, i.e., “Health is stable” (interpret to mean health care needs are being addressed).	232	78%
(No) Any of the identified physical and mental health care needs are not addressed.	61	21%
(No) The SC did not document follow-up on identified physical and mental health care needs.	3	1%

C2Y1 VARIATION RESPONSES: ID/A PROVIDERS	#	%
Q1. **The Provider uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.		
(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.	164	53%
(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan.	86	28%
(No) The Provider does not have a QMP and its Action Plan.	32	10%
(No) The Provider has a QMP and its Action Plan but did not use person-centered performance data to develop it.	27	9%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.		
(Yes) The Provider 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.	146	48%
(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.	77	25%
(No) The Provider does not have a QMP and its Action Plan.	35	12%
(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.	36	12%
(No) The Provider has not updated the QMP in more than 3 years.	5	2%
(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").	4	1%
Q10. The Provider has a policy which ensures that all individuals receiving service(s) have access to food at any time and has the flexibility about where and when individuals eat within the home or in the community during the provision of services consistent with non-Medicaid recipients in the same and/or similar settings.		
(Yes) The Provider has a policy that addresses all requirements.	48	87%
(No) The Provider has a policy; however, one or more of the identified requirements were not satisfied.	8	7%
(No) The Provider does not have a policy.	3	6%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.		
(Yes) The Provider has written procedures that includes all requirements.	275	80%
(No) The Provider has written procedures, however, it does not include all requirements.	58	17%
(No) The Provider does not have written procedures.	10	3%

C2Y1 VARIATION RESPONSES: ID/A PROVIDERS *(continued)*	**#**	**%**
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.		
(Yes) The Provider has a policy that addresses sexual health, personal relationships, and sexuality consistent with the guidelines.	293	85%
(No) The Provider has a policy; however, it is inconsistent with the guidelines identified in ODP Bulletin 00-18-01.	19	6%
(No) The Provider does not have a policy.	31	9%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration.		
(Yes) The Provider has a policy that addresses providing supports to individuals with medication administration.	148	74%
(No) The Provider has a policy; however, one or more of the identified requirements were not met.	20	10%
(No) The Provider does not have a policy.	33	16%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).		
(Yes) There is evidence that the Provider has an IM Representative that is a CI or the IM Representative assumed their role less than 12 mos. ago.	263	78%
(No) There is no evidence that the Provider has an IM Representative.	32	9%
(No) The IM Representative did not have a CI certificate within the required timeframe.	43	13%

C2Y1 VARIATION RESPONSES: AAW SCOs	#	%
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.		
(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.	6	60%
(Yes) The SCO used person-centered performance data to develop the QMP and its Action Plan.	3	30%
(No) The SCO does not have a QMP and its Action Plan.	0	0%
(No) The SCO has a QMP and its Action Plan but did not use person-centered performance data to develop it.	1	10%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.		
(Yes) The SCO 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.	7	70%
(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.	2	20%
(No) The SCO does not have a QMP and its Action Plan.	0	0%
(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.	1	10%
(No) The SCO has not updated the QMP in more than 3 years.	0	0%
(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").	0	0%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).		
(Yes) There is evidence that the SCO has an IM Representative that is a CI, or the IM Representative assumed their role less than 12 months ago.	11	100%
(No) There is no evidence that the SCO has an IM Representative.	0	0%
(No) The IM Representative did not have a CI certificate within the required timeframe.	0	0%
Q19. *The individual's ISP was updated when a change in need was identified.		
(Yes) The ISP was updated when change(s) in need were identified.	40	83%
(Yes) The SC documented justification if the ISP was not updated when change(s) in need were identified.	0	0%
(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.	8	17%

C2Y1 VARIATION RESPONSES: AAW SCOs *(continued)*	#	%
Q21. If there were identified issues, the SC followed up on the issues.		
(Yes) The SC followed up on identified issues, including notification of the Provider.	47	87%
(No) The SC did follow up on identified issues but did not notify the Provider.	1	2%
(No) The SC did not follow up on identified issues.	6	11%
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.		
(Yes) The ISP includes information about how the individual communicates and, if necessary, communication supports and services to assure effective communication.	61	100%
(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.	0	0%
(No) The ISP does not include information about how the individual communicates and, if necessary, communication supports and services to assure effective communication.	0	0%
Q42. *The individual's identified physical and mental health care needs are addressed		
(Yes) All of the identified physical and mental health care needs have been addressed or if the individual does not take any medications and no physical and mental health care needs have been identified, i.e., “Health is stable” (interpret to mean health care needs are being addressed).	52	85%
(No) Any of the identified physical and mental health care needs are not addressed.	8	13%
(No) The SC did not document follow-up on identified physical and mental health care needs.	1	2%

C2Y1 VARIATION RESPONSES: AAW PROVIDERS	#	%
Q1. **The Provider uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.		
(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.	18	42%
(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan.	19	44%
(No) The Provider does not have a QMP and its Action Plan.	4	9%
(No) The Provider has a QMP and its Action Plan but did not use person-centered performance data to develop it.	2	5%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.		
(Yes) The Provider 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.	20	47%
(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.	17	40%
(No) The Provider does not have a QMP and its Action Plan.	3	7%
(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.	1	2%
(No) The Provider has not updated the QMP in more than 3 years.	0	0%
(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").	2	5%
Q9. The Provider has a written policy regarding individual choice when sharing a bedroom with another individual.		
(Yes) The Provider has a written policy that includes all the listed criteria.	5	83%
(No) The Provider's written policy did not include one or more of the listed criteria.	0	0%
(No) The Provider does not have a written policy.	1	17%
Q10. The Provider has a policy which ensures that all individuals receiving service(s) have access to food at any time and has the flexibility about where and when individuals eat within the home or in the community during the provision of services consistent with non-Medicaid recipients in the same and/or similar settings.		
(Yes) The Provider has a policy that addresses all requirements.	3	60%
(No) The Provider has a policy; however, one or more of the identified requirements were not satisfied.	1	20%
(No) The Provider does not have a policy.	1	20%

C2Y1 VARIATION RESPONSES: AAW PROVIDERS *(continued)*	#	%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.		
(Yes) The Provider has written procedures that includes all requirements.	42	84%
(No) The Provider has written procedures, however, it does not include all requirements.	6	12%
(No) The Provider does not have written procedures.	2	4%
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.		
(Yes) The Provider has a policy that addresses sexual health, personal relationships, and sexuality consistent with the guidelines.	44	88%
(No) The Provider has a policy; however, it is inconsistent with the guidelines identified in ODP Bulletin 00-18-01.	4	8%
(No) The Provider does not have a policy.	2	4%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration.		
(Yes) The Provider has a policy that addresses providing supports to individuals with medication administration.	18	78%
(No) The Provider has a policy; however, one or more of the identified requirements were not met.	1	4%
(No) The Provider does not have a policy.	4	17%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).		
(Yes) There is evidence that the Provider has an IM Representative that is a CI or the IM Representative assumed their role less than 12 months ago.	41	93%
(No) There is no evidence that the Provider has an IM Representative.	0	0%
(No) The IM Representative did not have a CI certificate within the required timeframe.	3	7%
Q20.1 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). Incident Management Training		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	9	75%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	2	17%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	1	8%

C2Y1 VARIATION RESPONSES: AAW PROVIDERS *(continued)*	#	%
Q20.2 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). Investigations conducted by a Department CI		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	9	75%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	2	17%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	1	8%
Q20.3 The Provider completes monitoring of delegated or purchased incident (IM) management function(s). Administrative Review of Investigations		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	9	75%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	1	8%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	2	17%
Q20.4 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). Certified Investigator Peer Review (CIPR) Process		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	10	83%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	1	8%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	1	8%
Q20.5 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). Quality Management and Trend Analysis		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	10	83%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	1	8%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	1	8%

C2Y1 VARIATION RESPONSES: AAW PROVIDERS *(continued)*	#	%
Q20.6 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). Data Entry		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	8	67%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	2	17%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	2	17%
Q20.7 The Provider completes monitoring of delegated or purchased incident management (IM) function(s). IM Representative Functions		
(Yes) The Provider completes monitoring of delegated or purchased IM function(s) and has written documentation of all the listed requirements.	8	67%
(No) The Provider completes monitoring of delegated or purchased IM function(s) but did not have written documentation of all the listed requirements.	2	17%
(No) The Provider did not complete monitoring of delegated or purchased IM function(s) and did not have written documentation of all the listed requirements.	2	17%
Q31. The individual is offered opportunities for, and provided support to, participate in integrated community activities consistent with the individual's preferences, choices, and interests.		
(Yes) The Provider offers opportunities and support for integrated community activities consistent with the individual's preferences, choices, and interests.	12	100%
(No) The community activities offered were not consistent with the individual's preferences, choices, and interests.	0	0%
(No) There is no documentation which shows opportunities and support for integrated community activities are provided to the individual.	0	0%
Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication.		
(Yes) The Provider implemented the communication supports and services that were specified in the individual's ISP.	2	100%
(No) The Provider did not implement communication supports and services as specified in the individual's ISP.	0	0%
(No) There is no documentation which shows communication supports and services were implemented as specified in the individual's ISP.	0	0%
Q51. The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM.		
(Yes) There is evidence that the individual was offered and educated about the circumstances of incidents reported in the EIM system by the Provider.	4	67%
(Yes) There is evidence that the individual was offered education about the circumstances of incidents reported in the EIM system by the Provider but refused the information.	1	17%
(No) There is no evidence that the individual was educated about the circumstances of incidents reported in the EIM system by the Provider.	1	17%

C2Y1 VARIATION RESPONSES: AAW PROVIDERS *(continued)*	#	%
Q58. The AWC Provider takes action and documents when the maximum allowable hours of care provided by relatives are exceeded.		
(Yes) The information reviewed demonstrates the AWC Provider has a policy and took action and documented it when hours of payment of relatives exceeded maximum limits.	0	0%
(Yes) The AWC Provider has a policy but did not take action to document it because an Appendix K exception applied during the review period.	1	100%
(No) Any of the following were found: the AWC Provider is unaware of this requirement or the AWC Provider cannot determine whether any relative hours were exceeded, including an inability to determine whether someone is a relative or the AWC Provider does not have policies or procedures that address hours of care provided by relatives or the AWC Provider did not follow its procedures when the maximum number of relative hours was exceeded (applicable only if noncompliance occurred).	0	0%