Quality Assessment & Improvement and Home & Community-Based Settings Rule Licensing Inspection

Statewide Report

Pennsylvania Office of Developmental Programs

QA&I Cycle 2 (Year 1, Year 2 & Year 3) ~ Fiscal Year 2024-2025

Table of Contents

Acronyms

AAW	Adult Autism Waiver	ID/A	Intellectual Disability/Autism
AE	Administrative Entity	IM	Incident Management
ARP	Annual Review Plan	IM4Q	Independent Monitoring for Quality
ARUD	Annual Review Update Date	ISAC	Information Sharing & Advisory Committee
AWC	Agency with Choice	ISP	Individual Support Plan
AWC FMS	Agency with Choice - Financial Management Services	LEP	Limited English Proficiency
C2	Cycle 2	LOC	Level of Care
C2Y1	Cycle 2 Year 1	ME	Managing Employer
C2Y2	Cycle 2 Year 2	ODP	Office of Developmental Programs
C2Y3	Cycle 2 Year 3	OVR	Office of Vocational Rehabilitation
CI	Certified Investigator	PDS	Participant Directed Services
CLW	Community Living Waiver	P/FDS	Person/Family Directed Supports
CMS	Centers for Medicare & Medicaid Services	PM	Performance Measure
CPS	Community Participation Support	PUNS	Prioritization of Urgency of Need for Services
CQI	Continuous Quality Improvement	QA&I	Quality Assessment & Improvement Process
DHS	Department of Human Services	QDDP	Qualified Developmental Disabilities Professional
EDL	Everyday Lives	QI	Quality Improvement
EIM	Enterprise Incident Management	QM	Quality Management
FMS	Financial Management Services	QMP	Quality Management Plan
FR	Full Review	RPM	Regional Program Manager
FY	Fiscal Year	SA	Self-Assessment
HCBS	Home and Community Based Services	SC	Supports Coordinator
HCQU	Health Care Quality Unit	SCO	Supports Coordination Organization
HCSIS	Home & Community Services Information System	SME	Subject Matter Expert
HRC	Human Rights Committee	SWtCIE	Subminimum Wage to Competitive Integrated Employment
ICF	Intermediate Care Facility	TA	Technical Assistance
ICF/ORC	Intermediate Care Facility for Other Related Conditions	TSM	Targeted Support Management

Executive Summary

About the QA&I Process

The Office of Developmental Programs (ODP) Quality Assessment and Improvement (QA&I) process 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 usable 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 AEs/county programs, 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. Since a cycle includes 100% review of all AEs, SCOs, and Providers, this report includes averages of results across the 3 years in the cycle to give a more complete look at overall system performance. The report continues to be organized to call attention to specific areas

that AEs, SCOs and providers need to focus quality improvement (QI) activities on, and includes Metrics to Watch, Reasons to Celebrate, and Opportunities for Improvement.

For C2Y3 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 November, either in-person or virtually with video capability, based on individual preference. Of 494 individuals offered interviews, 412 (83%) chose to participate and 82 declined the opportunity. Results from 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 C2 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 C2 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, but it should be noted that AAW results include SCOs and providers that are 'shared' with ID/A waivers. 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 for C2 in the body of this report, all findings from C2Y3 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.

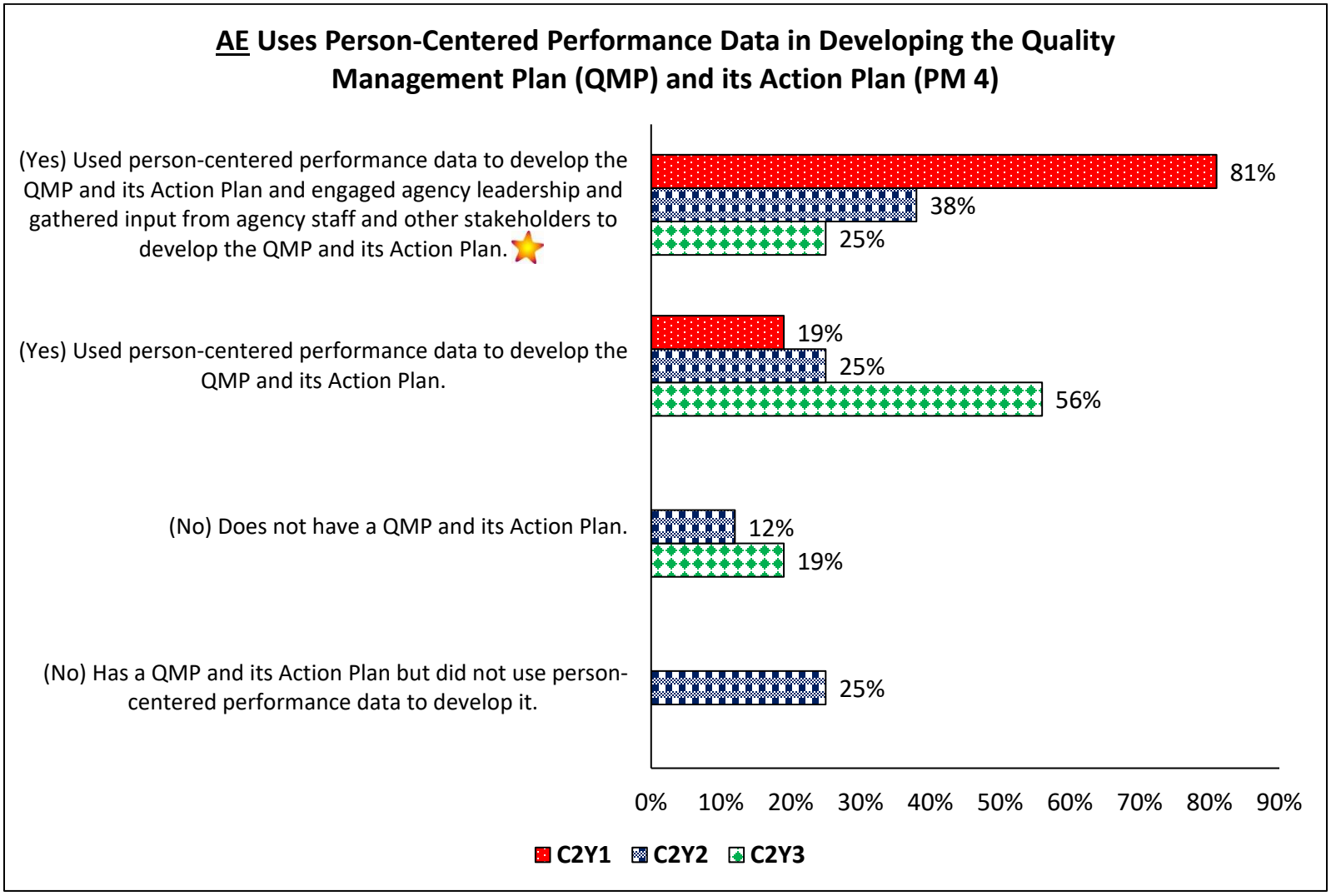
Variation Responses

For QA&I C2, the use of variation responses was introduced 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

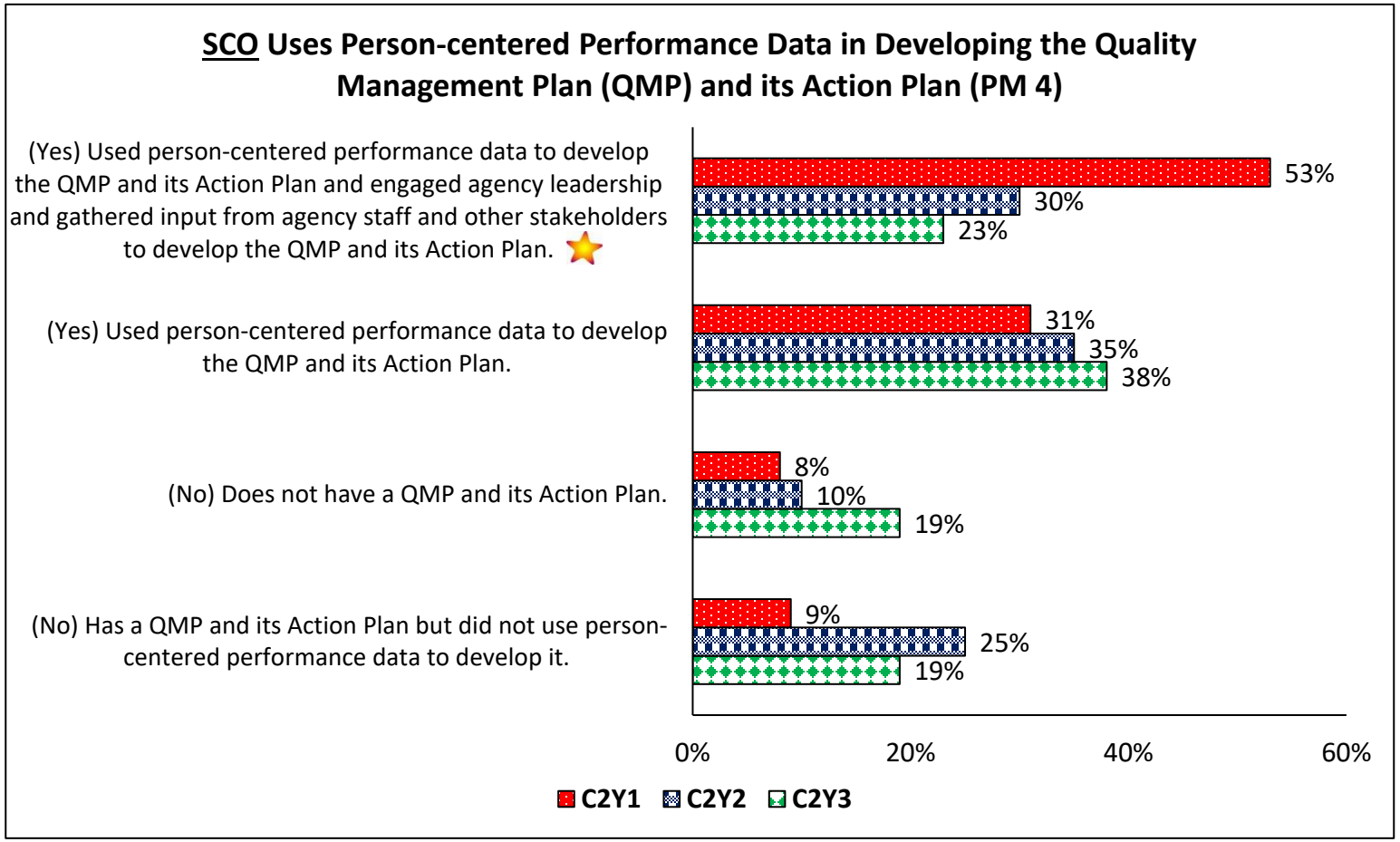
meeting best practice standards that improve the likelihood of success, then responses help them to identify what they need to improve upon to increase the likelihood of success. The following charts display a couple of examples of QM planning questions for AEs, SCOs, and providers that included variation responses in QA&I C2. C2 includes results across the 3 years in the cycle, which gives a more complete look at overall system performance, as a cycle includes 100% review of all AEs, SCOs, and providers. The gold star in the charts indicates the best practice standard we strive to have everyone meet. The "Yes" option below that shows those who meet basic requirements.

Note that charts in this section that show results for SCOs and providers include ID/A and AAW SCOs and providers combined. See Appendix F for the full list of C2 questions with variation responses, and the C2Y3 results.

This chart is of QA&I C2 AE results for 1 of 2 ISAC performance measures. C2 results show that AE performance has significantly improved year to year with using person-centered data to develop their QM plan and its action plan (19%-25%-56%), although there is room for improvement towards meeting the best practice standard, which helps to ensure the success of the QM plan.

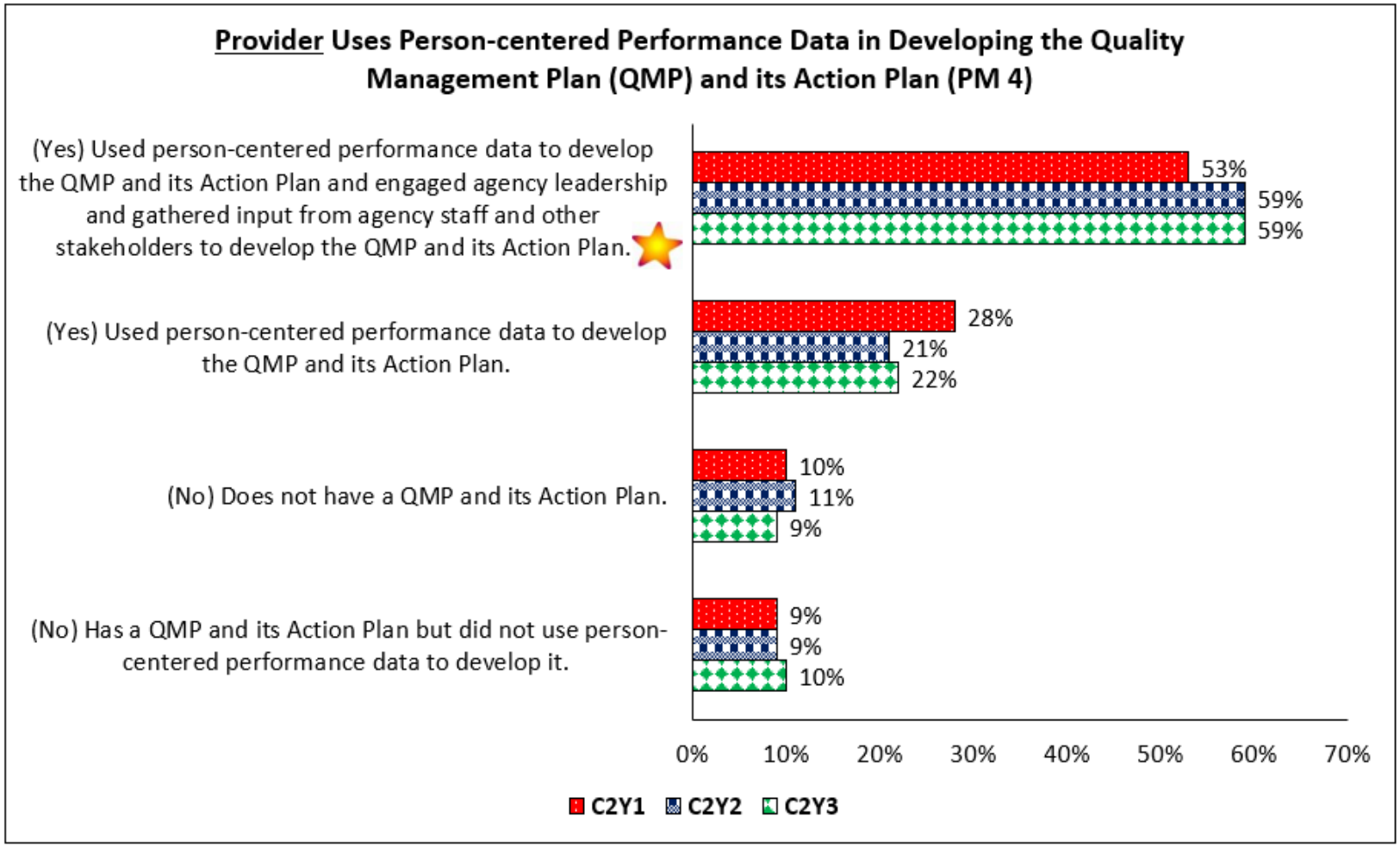


This chart is of QA&I C2 SCO results for 1 of 2 ISAC performance measures. This performance measure has also been incorporated into Performance-Based Contracting (PBC) measures for SCOs. Similar to AE results, SCO C2 results showed that SCO performance is steadily improving year to year with using person-centered data to develop their QM plan and its action plan (31%-35%-38%), although there is room for improvement towards meeting the best practice standard, which helps to ensure the success of the QM plan.

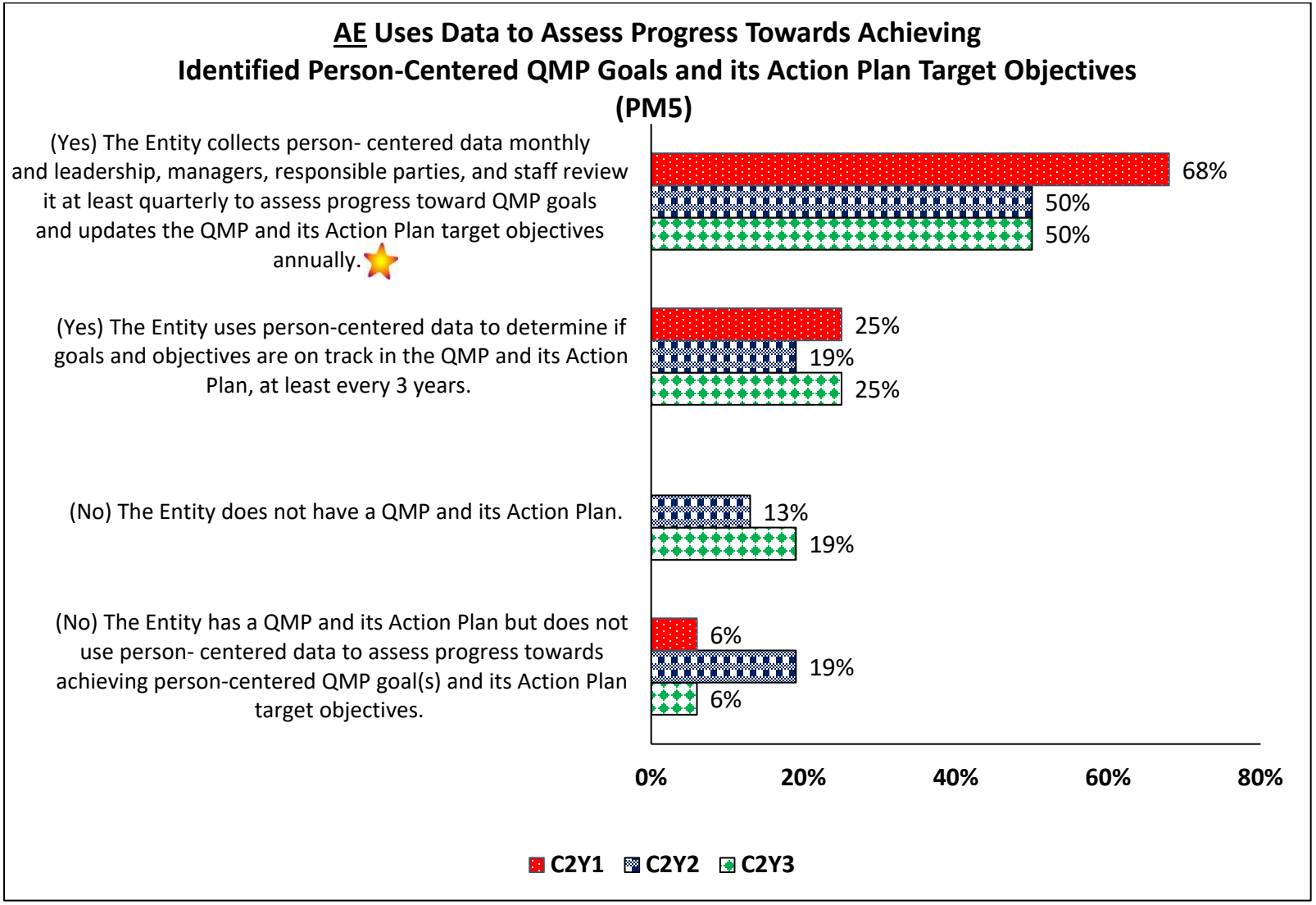


* Question is used to answer a CMS performance measure. ** Question is associated with ODP's ISAC recommendations. NS = Question is non-scored.

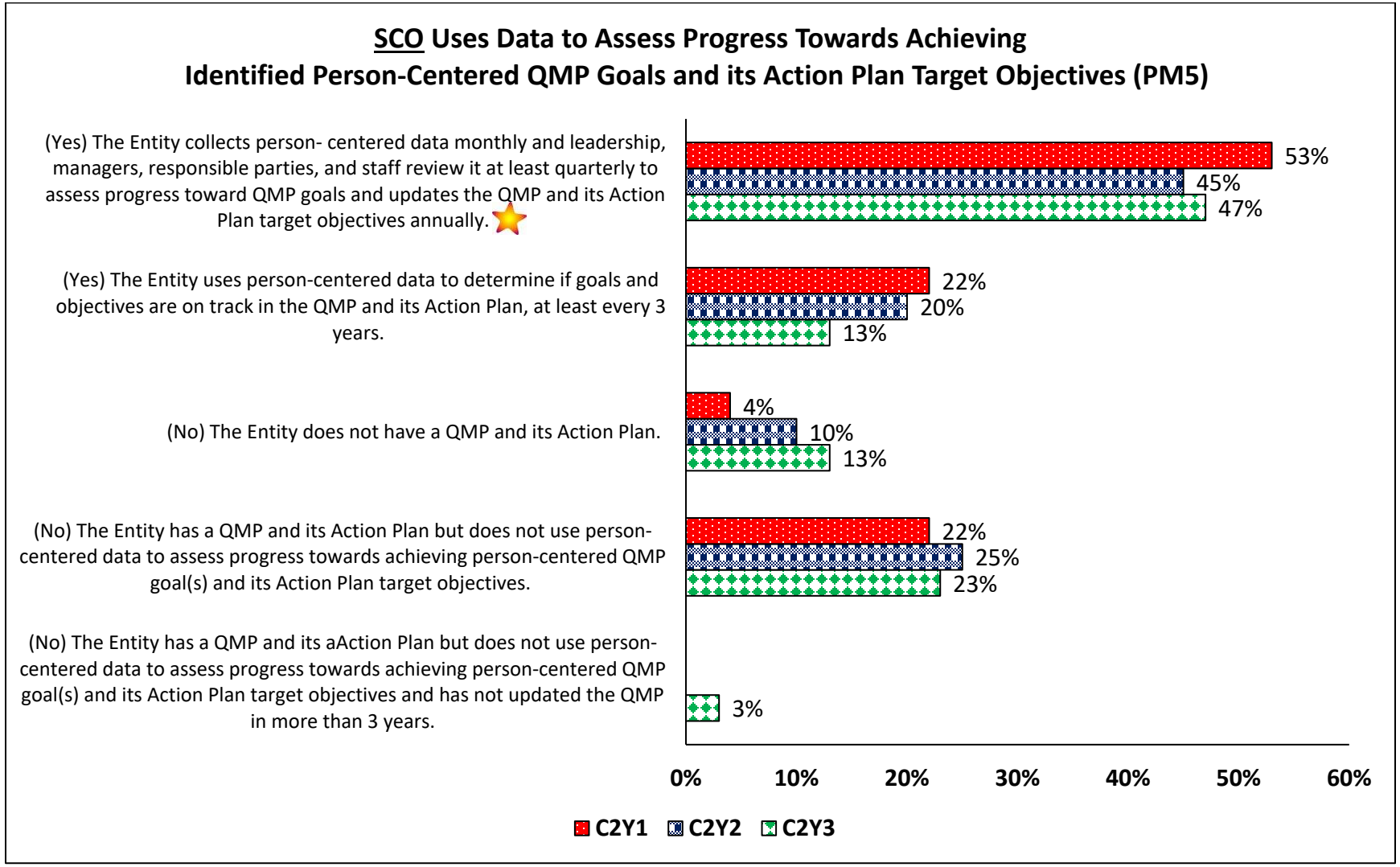
This chart is of QA&I C2 provider results for 1 of 2 ISAC performance measures. This performance measure has also been incorporated into Performance-Based Contracting (PBC) measures for residential providers. Unlike AE and SCO results, C2 results for providers showed that provider performance with the best practice standard improved from C2Y1 to C2Y2 (53% to 59%) and remained steady in C2Y3 but declined with using person-centered data to develop their QM plan and its action plan (28%-21%-22%), highlighting a need for improvement.



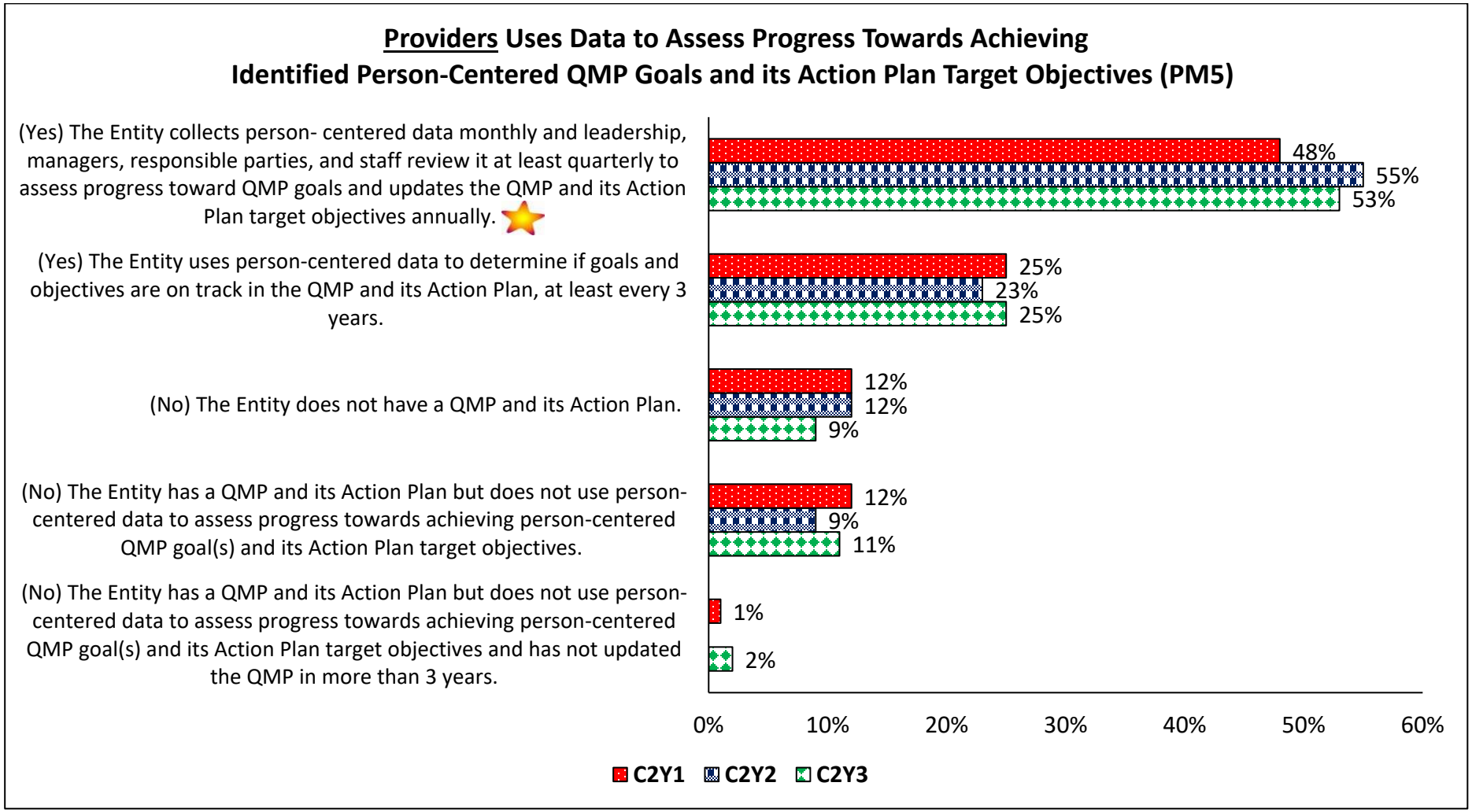
This chart is of QA&I AE C2 results for ISAC performance measure #5. C2 compliance results for AE use of person-centered data to measure progress with QM plans ranged from a high of 93% (adding both Yes options) in C2Y1 to a low of 69% in C2Y2 to slight improvement to 75% in C2Y3 but shows that this remains an area in which significant improvements are needed.



This chart is of QA&I SCO C2 results for ISAC performance measure #5. C2 compliance results for SCO use of person-centered data to measure progress with QM plans ranged from a high of 75% (adding both Yes options) in C2Y1 to 65% in C2Y2 and a low of 60% in C2Y3 and shows that this remains an area in which significant improvements are needed.



This chart is of QA&I provider C2 results for ISAC performance measure #5. Unlike AEs and SCOs, the provider C2Y2 performance results on this measure improved in compliance with best practices from results from C2Y1. C2 compliance results for provider use of person-centered data to measure progress with QM plans ranged from a low of 69% (adding both Yes options) in C2Y1 to 78% in C2Y2 and C2Y3 and show that this remains an area in which significant improvements are needed.



About the Full Reviews

A QA&I full review is the oversight process during which all AEs, SCOs and providers receive a comprehensive quality review, in a 3-year cycle. Full reviews include a self-assessment, individual interviews, Managing Employer (ME) interviews and onsite documentation reviews, by ODP or the AE, to evaluate performance related to data/policy and record review questions 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 (for SCOs) or the AE (for providers).

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 report and may be required to complete remediation, a plan to prevent recurrence, and/or quality improvement activities. The tables below provide count details for full reviews conducted in C2Y3 and also the completed C2 cycle.

Number of Entities Engaged in QA&I, C2Y3, Full Review Process					
	Central	**Northeast**	**Southeast**	**Western**	**Statewide**
AEs	3	5	2	6	16
ODP SCOs	3	6	14	7	30
ODP Providers	77	57	182	115	431
TOTAL	**83**	**68**	**200**	**128**	**479**

Number of Entities Engaged in QA&I, C2, Full Review Process					
	Central	**Northeast**	**Southeast**	**Western**	**Statewide**
AEs	14	10	5	19	48
ODP SCOs	16	15	26	26	83
ODP Providers	192	144	435	281	1,052
TOTAL	**225**	**170**	**474**	**330**	**1,199**

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 of Everyday Lives. Data and findings from the QA&I process are used to measure and inform progress toward achieving the desired outcomes stated in many ISAC recommendation areas, including but not limited to assuring effective communication, increasing employment, and improving quality. In this report, ODP has highlighted the findings related to ISAC performance measures by identifying them with double-asterisks (**) in the tables.

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 assurance 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 sometimes 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 proactively identify issues and make improvements before full reviews are conducted. See some examples of a few significant differences between C2Y3 self-assessment results versus full review results below. AAW-only results were not included due to small sample sizes that might not be statistically significant. 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 Versus Full Review (FR) Results	SA	FR
Q7. The AE follows ODP's record retention policy for individual closed records.	100%	81%
Q8. The AE follows ODP's record retention policy for individual active records.	100%	75%
Q15. The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis.	100%	31%

ID/A SCO Self-assessment (SA) Data Versus Full Review (FR) Results	SA	FR
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	100%	64%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	99%	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.	96%	60%
Q12. The SCO completes monthly individual incident data monitoring.	90%	48%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months	88%	28%

ID/A Provider Self-assessment (SA) Data Versus Full Review (FR) Results	SA	FR
Q1. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	99%	81%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	99%	79%
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.	97%	70%
Q12. The SCO completes monthly individual incident data monitoring.	98%	74%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months	95%	77%

Metrics to Watch

The tables below highlight some key findings from C2Y3 that have either improved or declined significantly from C2Y2, and/or are hovering around the 86% compliance threshold, and/or have remained or slipped below that threshold for satisfactory performance. The C2 average (AVG) is also included for reference. 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 1 asterisk (*) are used to inform a CMS performance measure. Questions highlighted with 2 asterisks (**) are used to inform an ISAC performance measure. Significant decline and/or consistently poor performance areas in CMS and ISAC performance measures are in red font to call special attention to these areas.

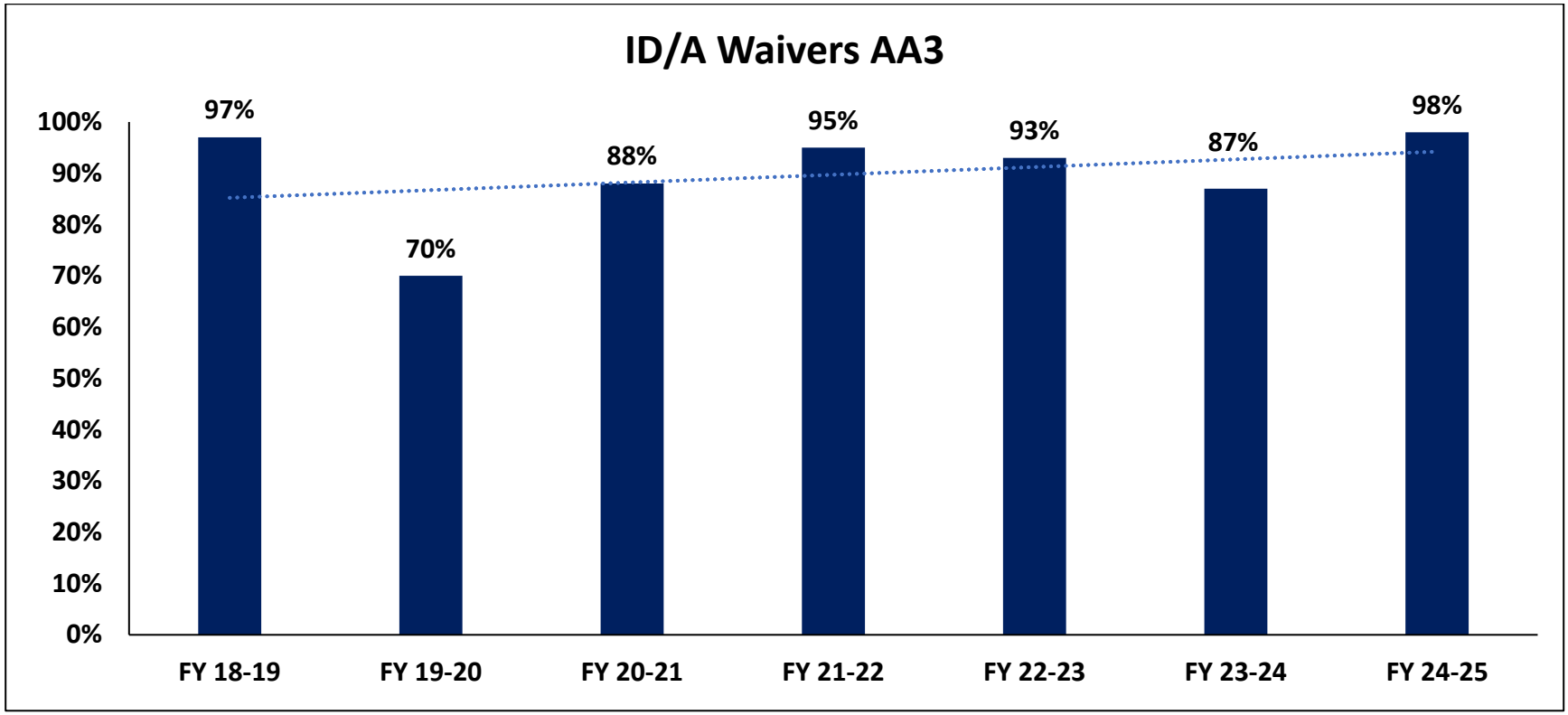
Metrics to Watch: Administrative Entities (AEs)	C2Y2	C2Y3	C2 AVG
Q17.The AE operates a Human Rights Committee (HRC) in accordance with ODP requirements.	100%	81%	92%
Q27.The AE promotes competitive integrated employment as a priority.	100%	81%	94%
Q35.*The AE qualifies PROVIDER 2 utilizing ODP standardized procedures.	100%	80%	93%
Q46.*The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.	92%	83%	89%
Q51. *Due process rights information was provided to the individuals with a change(s) in need.	100%	88%	96%

Metrics to Watch: SCOs		C2Y2	C2Y3	C2 AVG
ID/A	Q5. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual.	97%	88%	93%
ID/A	Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	95%	85%	92%
ID/A	Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	98%	88%	95%
AAW	Q26. The SC conducted all monitorings at the required frequency. Note: C2Y2 and C2 AVG are not included here due to a change in how results for AAW were calculated for C2Y3. Shared SCOs were included in C2Y3 but were not previously.	76%	87%	81%
AAW	Q48. The SCO educates individuals based on the circumstances of incidents for which the SCO is required to file in EIM. Note: C2Y2 and C2 AVG are not included here due to a change in how results for AAW were calculated for C2Y3. Shared SCOs were included in C2Y3 but were not previously.	80%	86%	87%

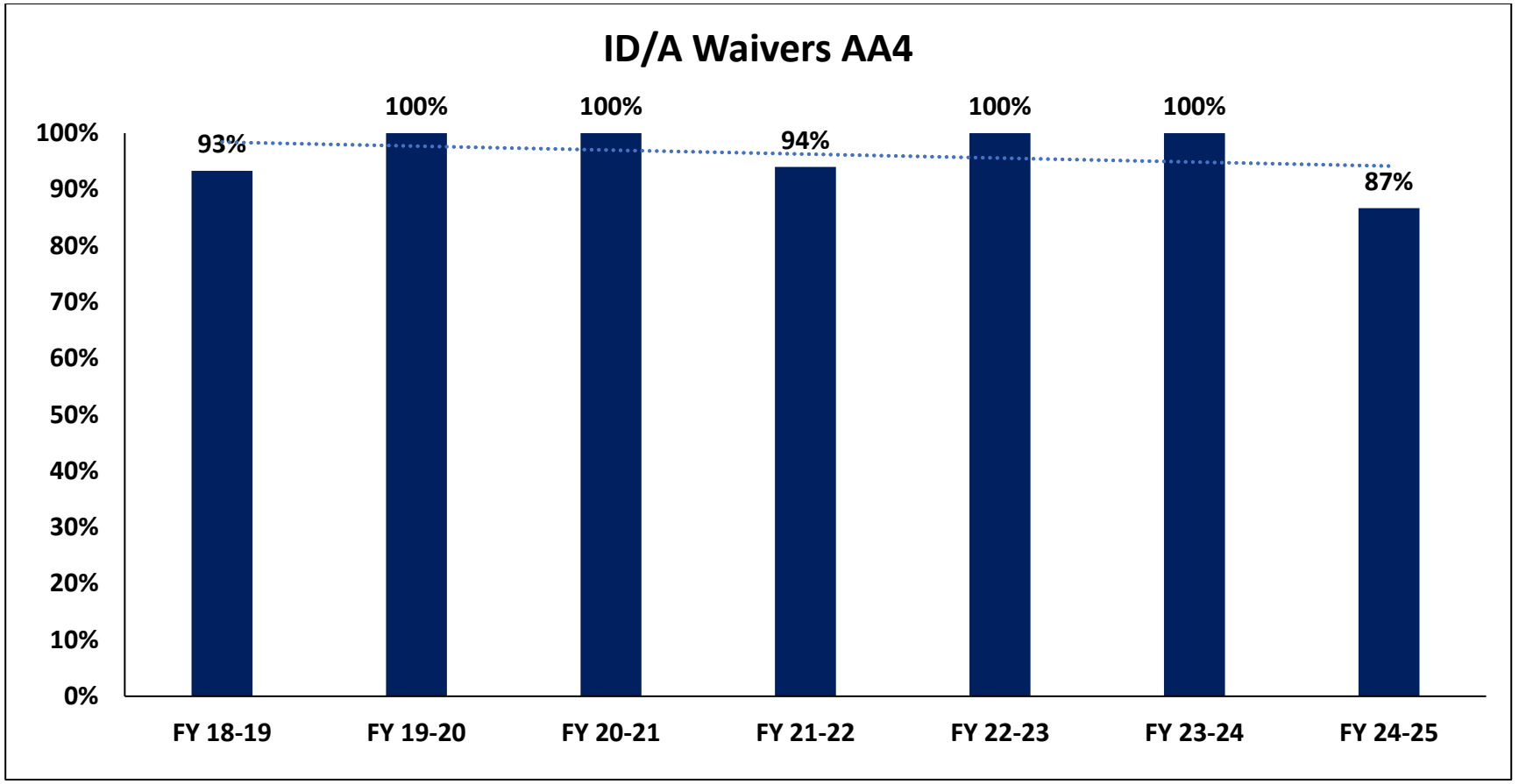
Metrics to Watch: Providers		C2Y2	C2Y3	C2 AVG
ID/A	Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan.	79%	81%	80%
ID/A	Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives.	79%	77%	76%
ID/A	Q15. Provider staff completed the required number of training hours in the training year.	89%	77%	84%
ID/A	Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication.	94%	85%	90%
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.	96%	86%	89%

QA&I Informed CMS Waiver Assurance Performance Measures Trending – AE Accountable

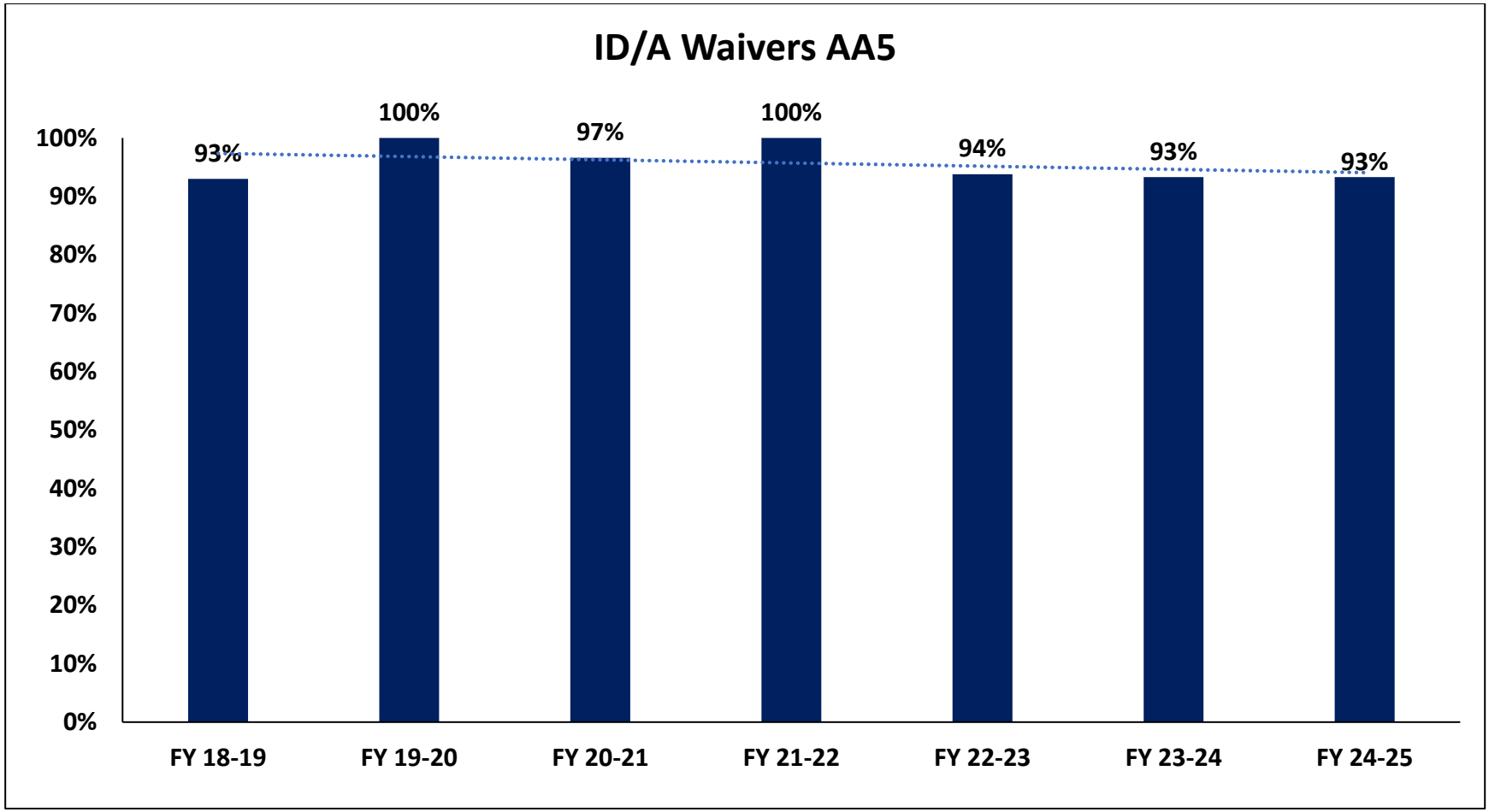
Note: Some data for some performance measures in FY 19-20 may have been impacted by issues related to the COVID-19 pandemic.



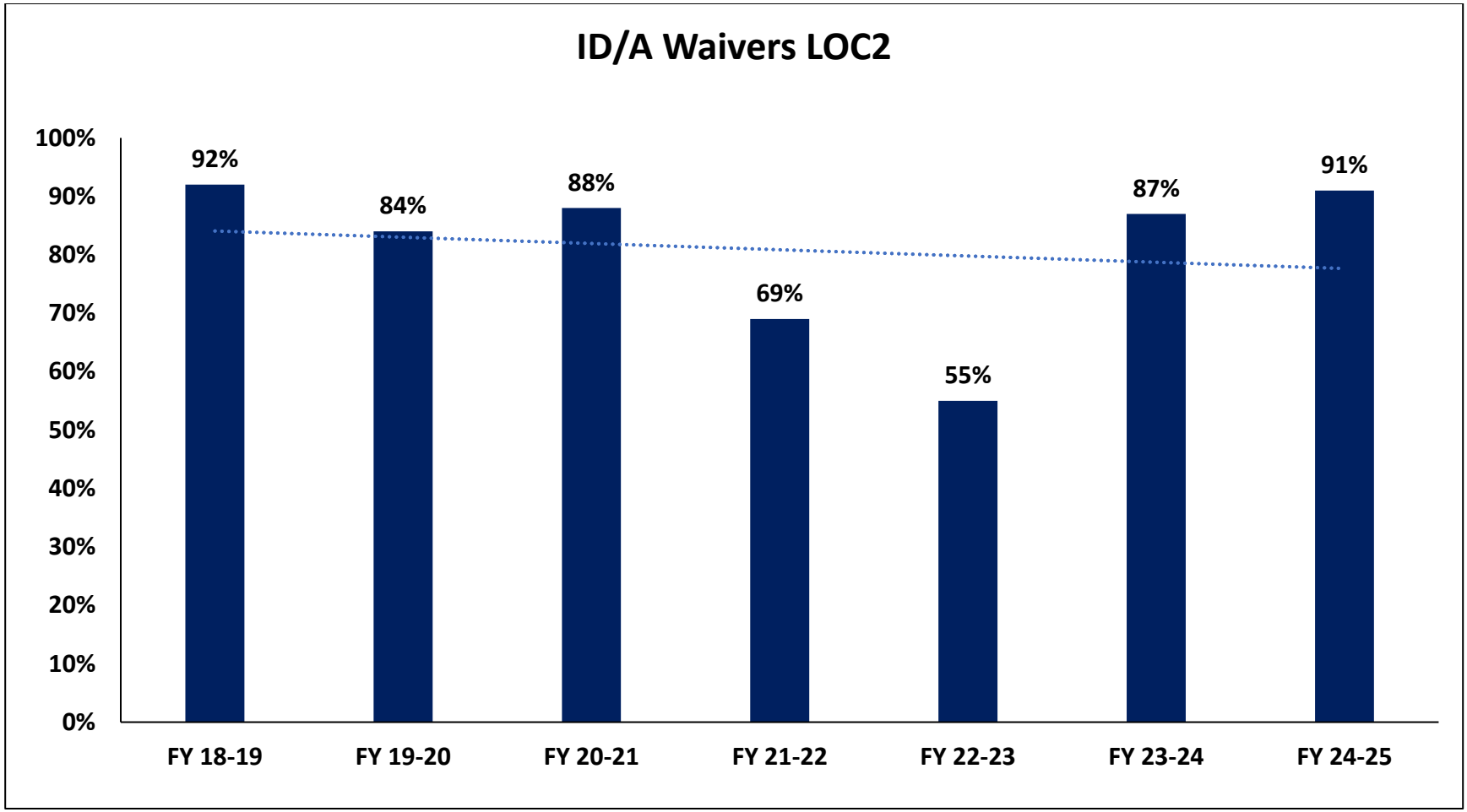
AA3: Number and percentage of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures.
Note: Compliance rates are statewide results across all ID/A waivers.



AA4: Number and percentage of AEs that qualify providers using qualification criteria as outlined in the current approved waiver.
Note: Compliance rates are statewide results across all ID/A waivers.

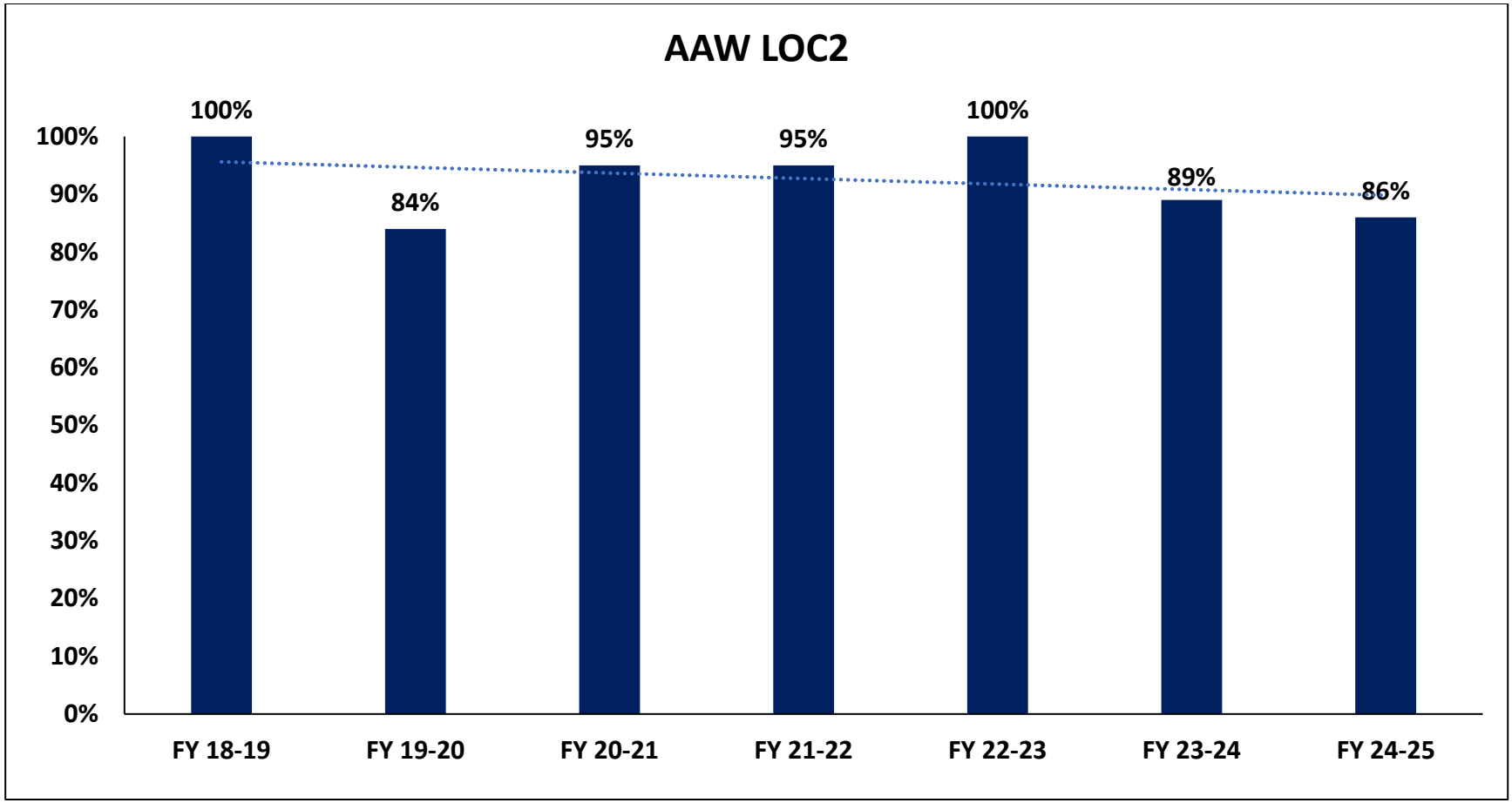


AA5: Number and percentage of AEs that monitor Providers using the standard tool and monitoring processes developed by ODP.
Note: Compliance rates are statewide results across all ID/A waivers.



LOC2: Number and percentage of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used.

Note: Compliance rates are statewide results across all ID/A waivers.

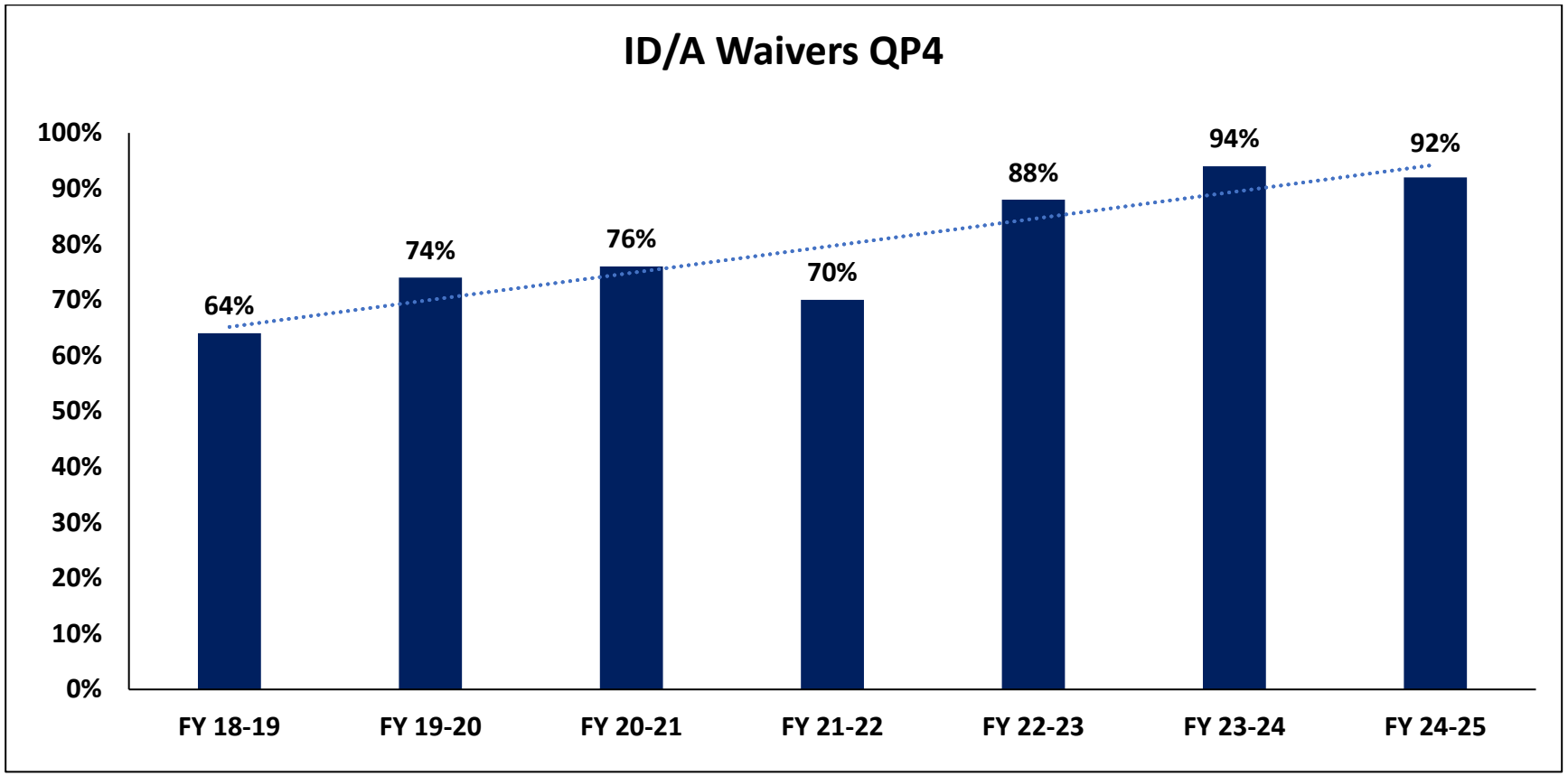


LOC2: Number and percentage of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used.

Note: Compliance rates are statewide results for AAW.

QA&I Informed CMS Waiver Assurance Performance Measures Trending – SCO Accountable

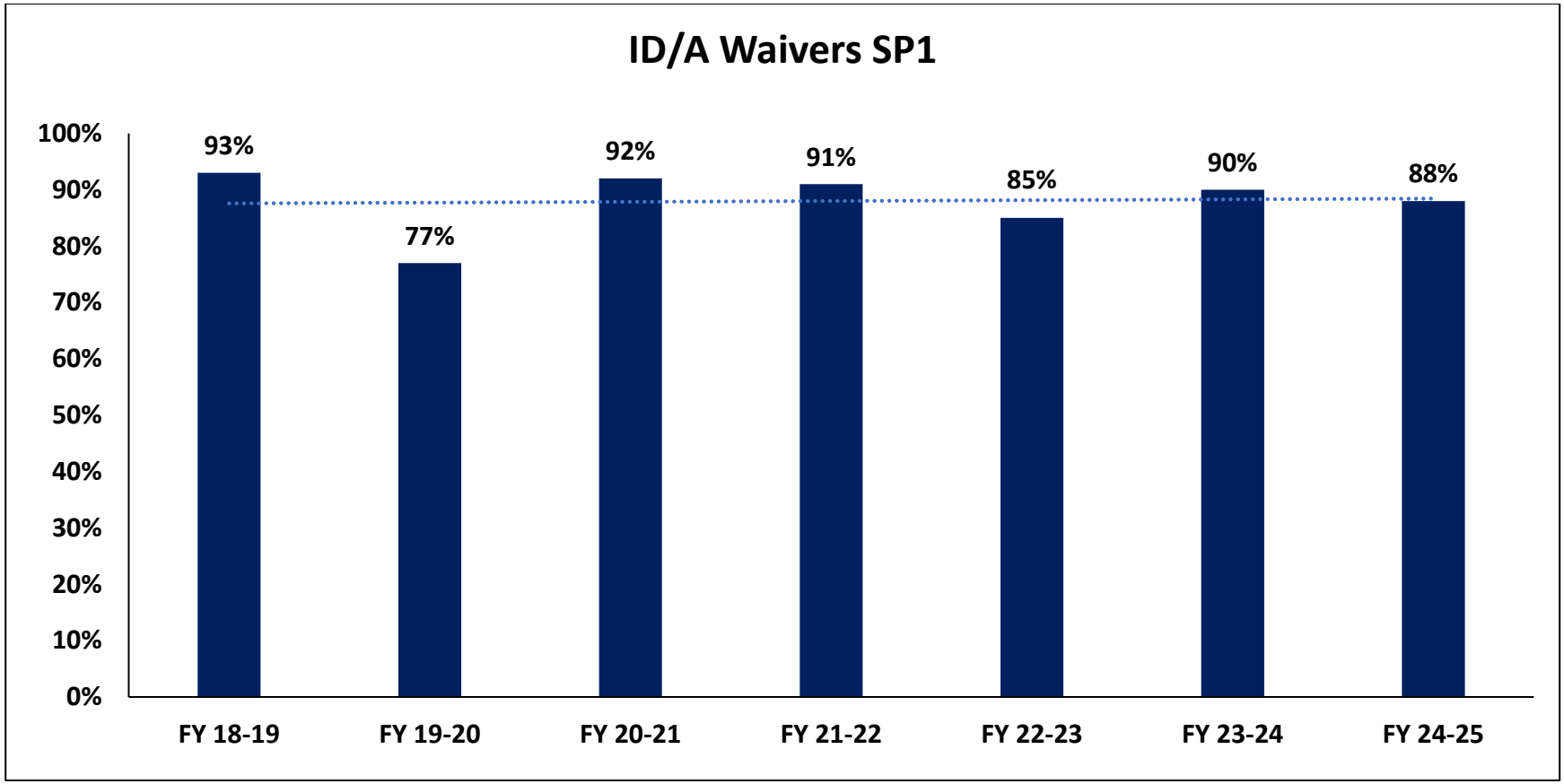
Note: Some data for some performance measures in FY 19-20 may have been impacted by issues related to the COVID-19 pandemic.



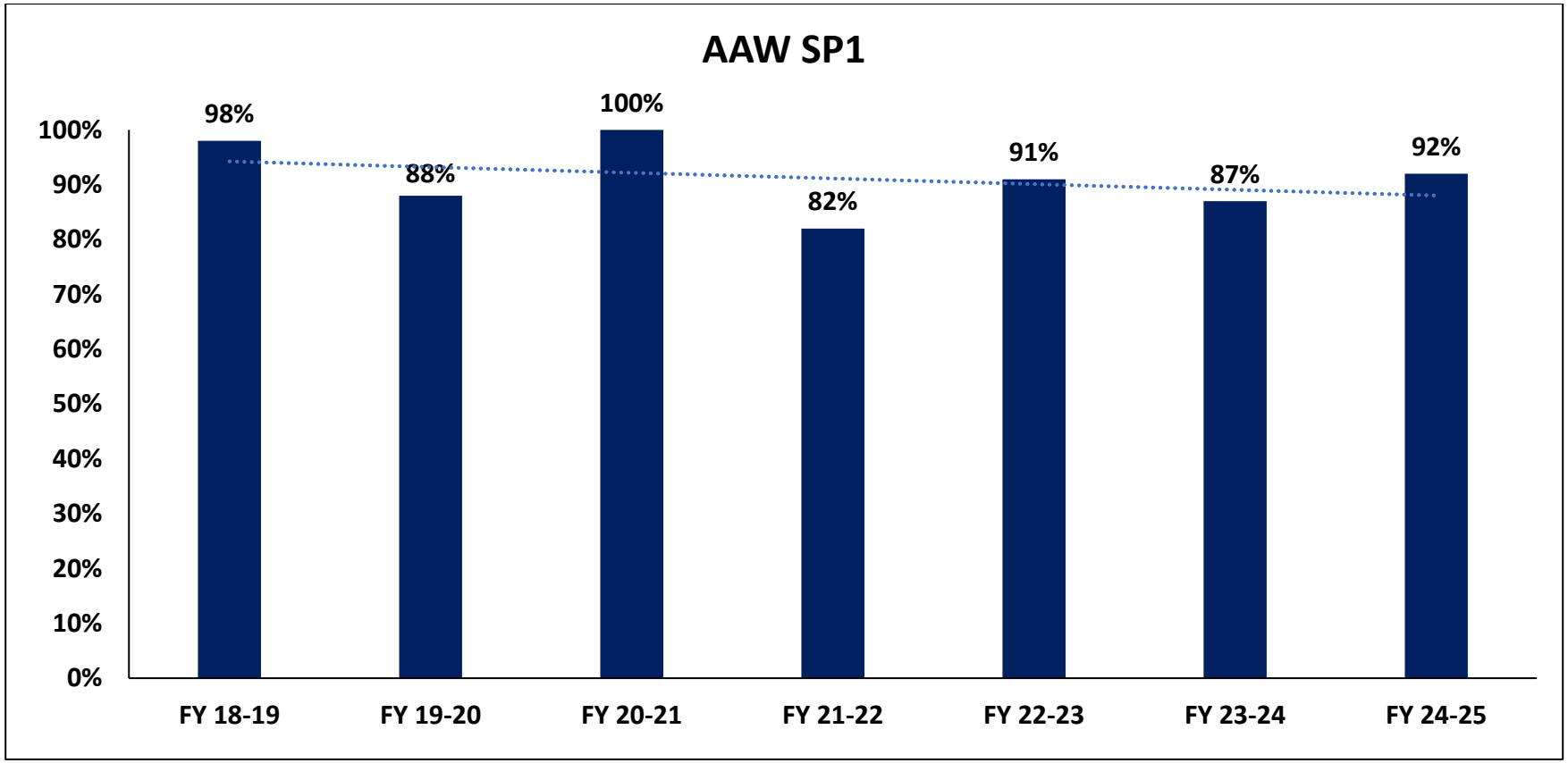
QP4: Number and percentage of providers that meet annual training requirements in accordance with state requirements in the approved waiver.

Notes: Compliance rates are statewide results across all ID/A waivers. Additionally, results for QP4 were previously calculated at the entity level. Since QA&I Interim Year 2 (FY21-22), results have been calculated at the staff level, which is considered to be a more accurate reflection of performance. Lastly, QP4 performance includes both SCO (Q4) and Provider (Q13) results.

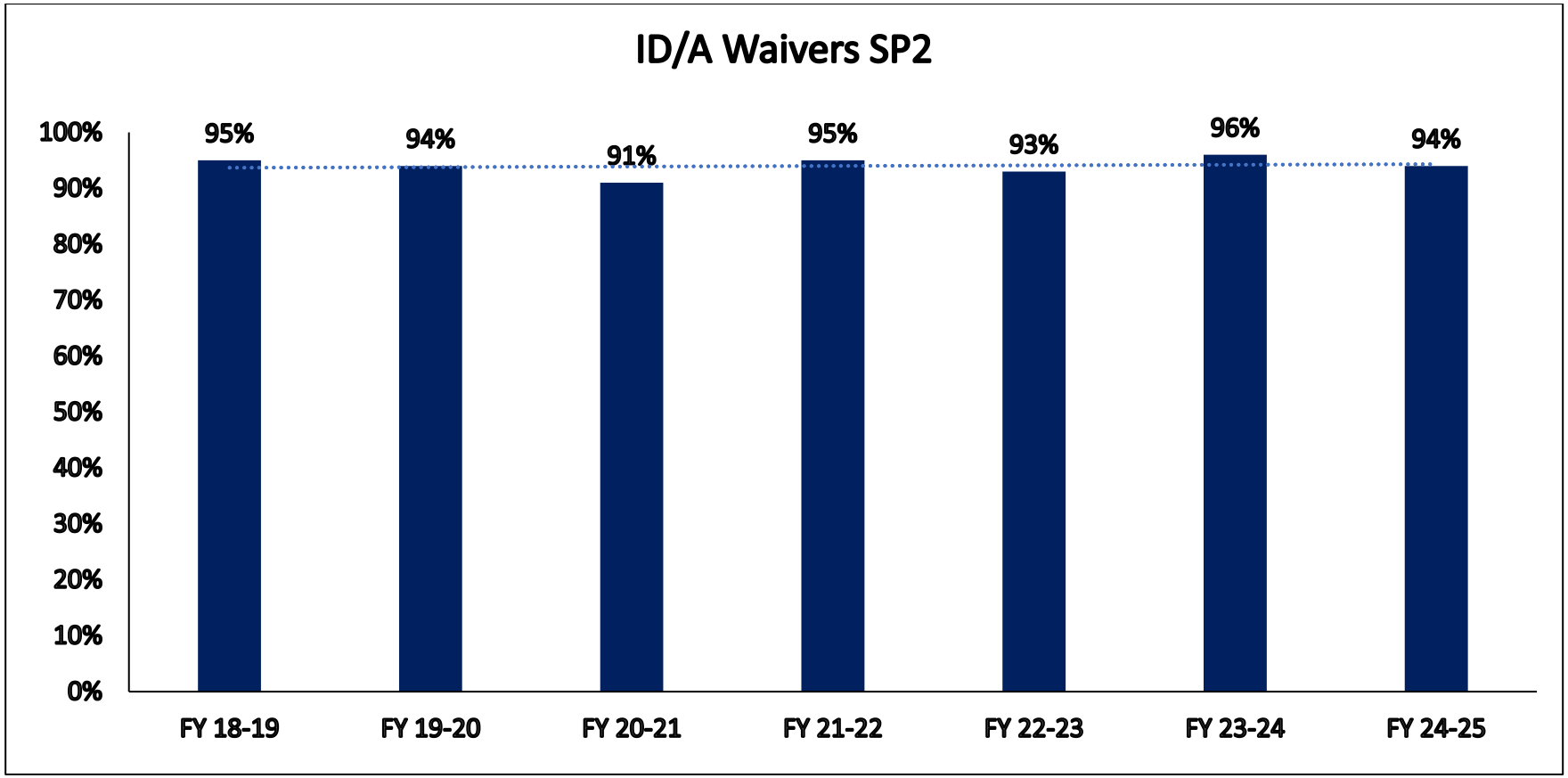
QP4 results for AAW are informed by the Provider Requalification process, not QA&I, and therefore are not provided in this report.



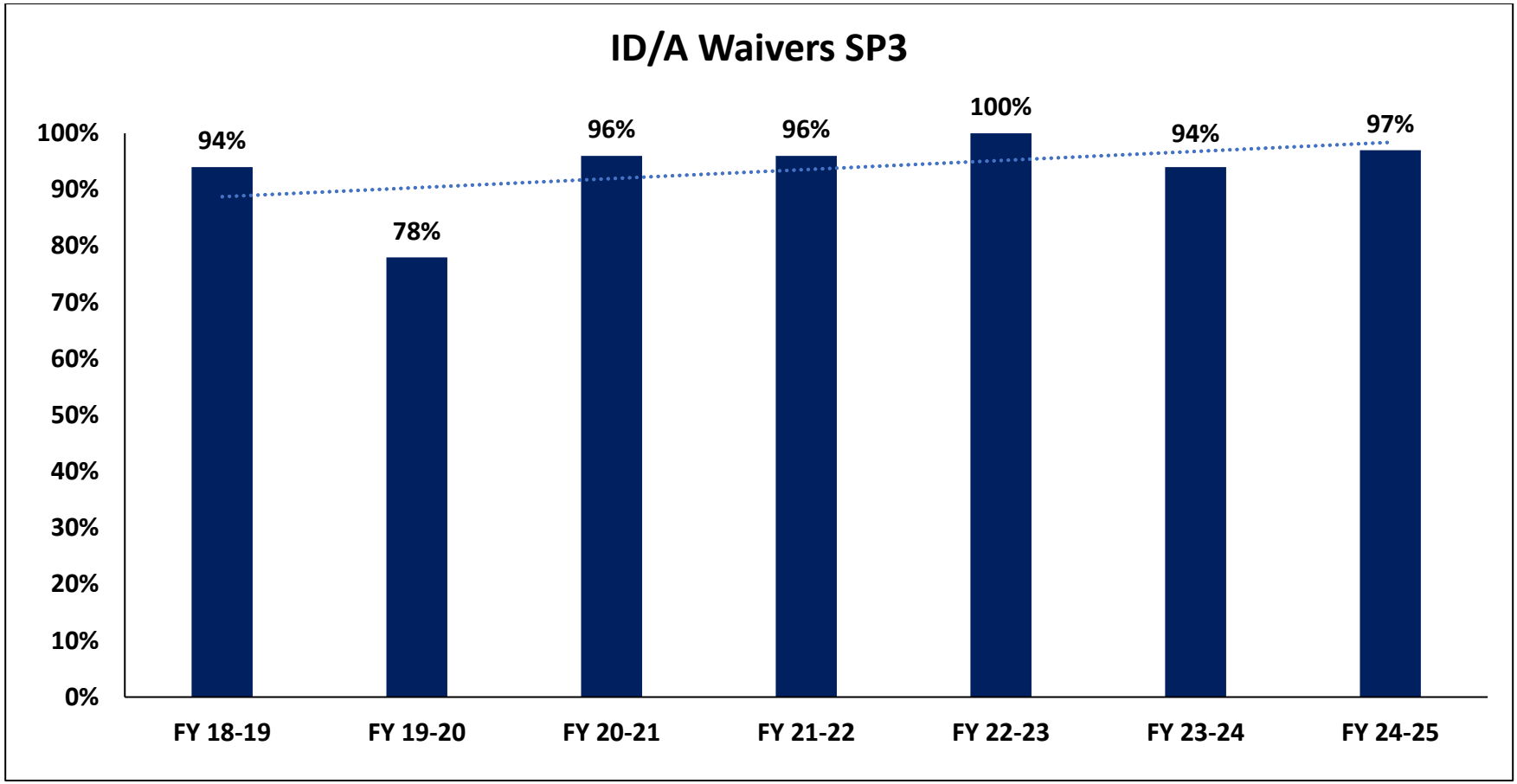
SP1: Number and percentage of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports.
Note: Compliance rates are statewide results across all ID/A waivers.



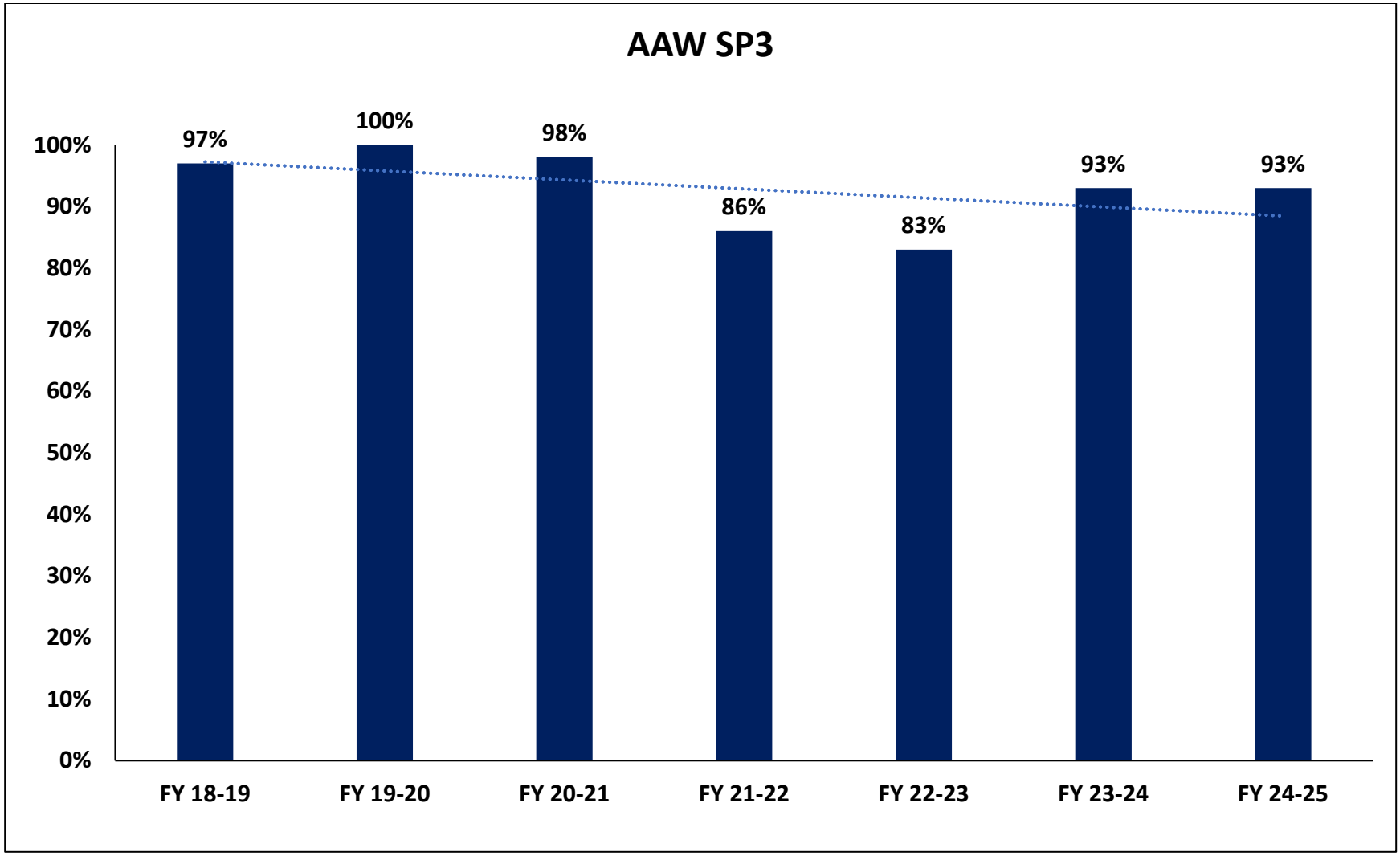
SP1: Number and percentage of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports.
Note: Compliance rates are statewide results for AAW.



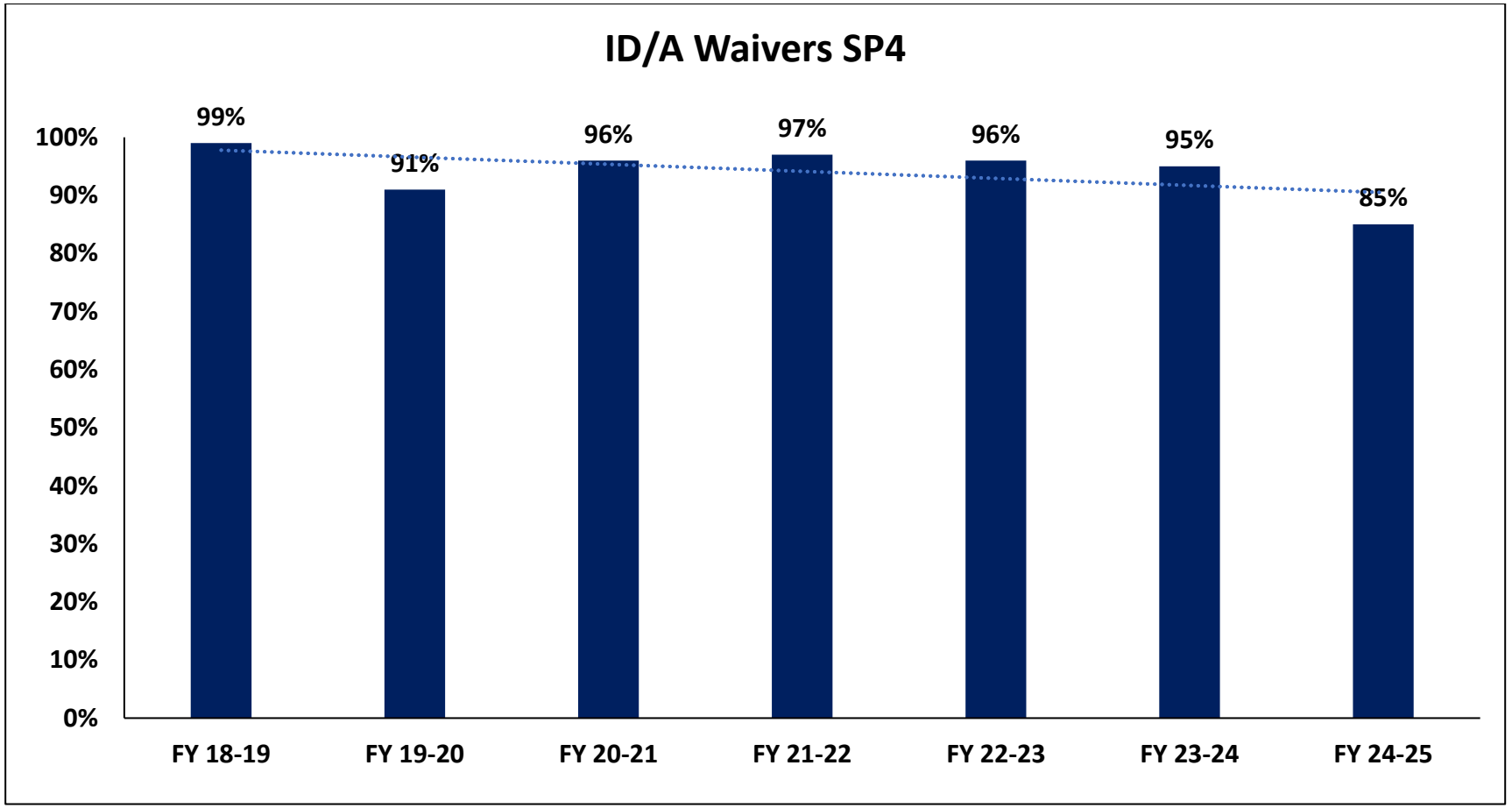
SP2: Number and percentage of participants whose service plans are updated or revised at least annually.
Note: Compliance rates are statewide results across all ID/A waivers.



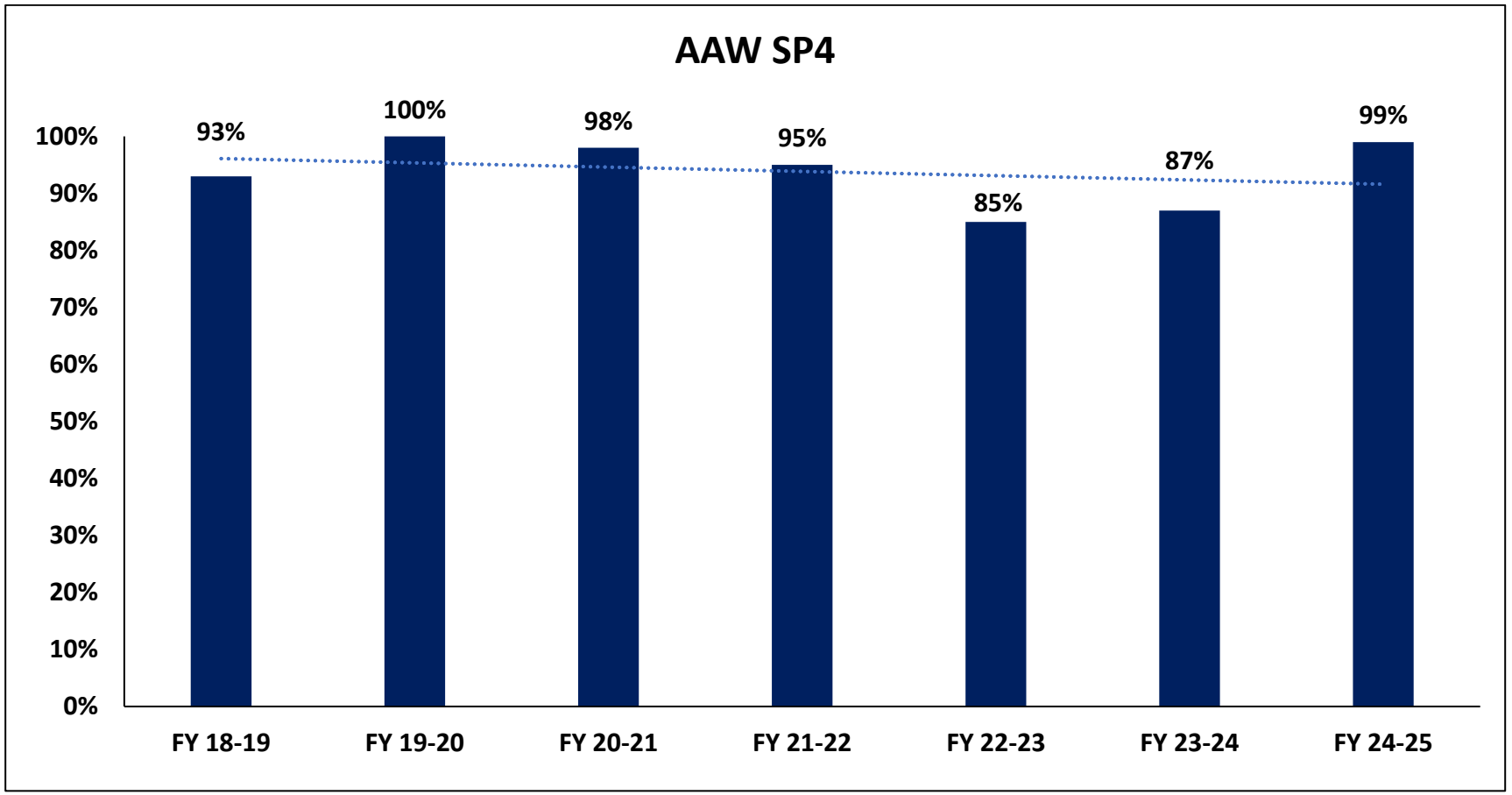
SP3: Number and percentage of participants whose needs changed and whose service plans were revised accordingly.
Note: Compliance rates are statewide results across all ID/A waivers.



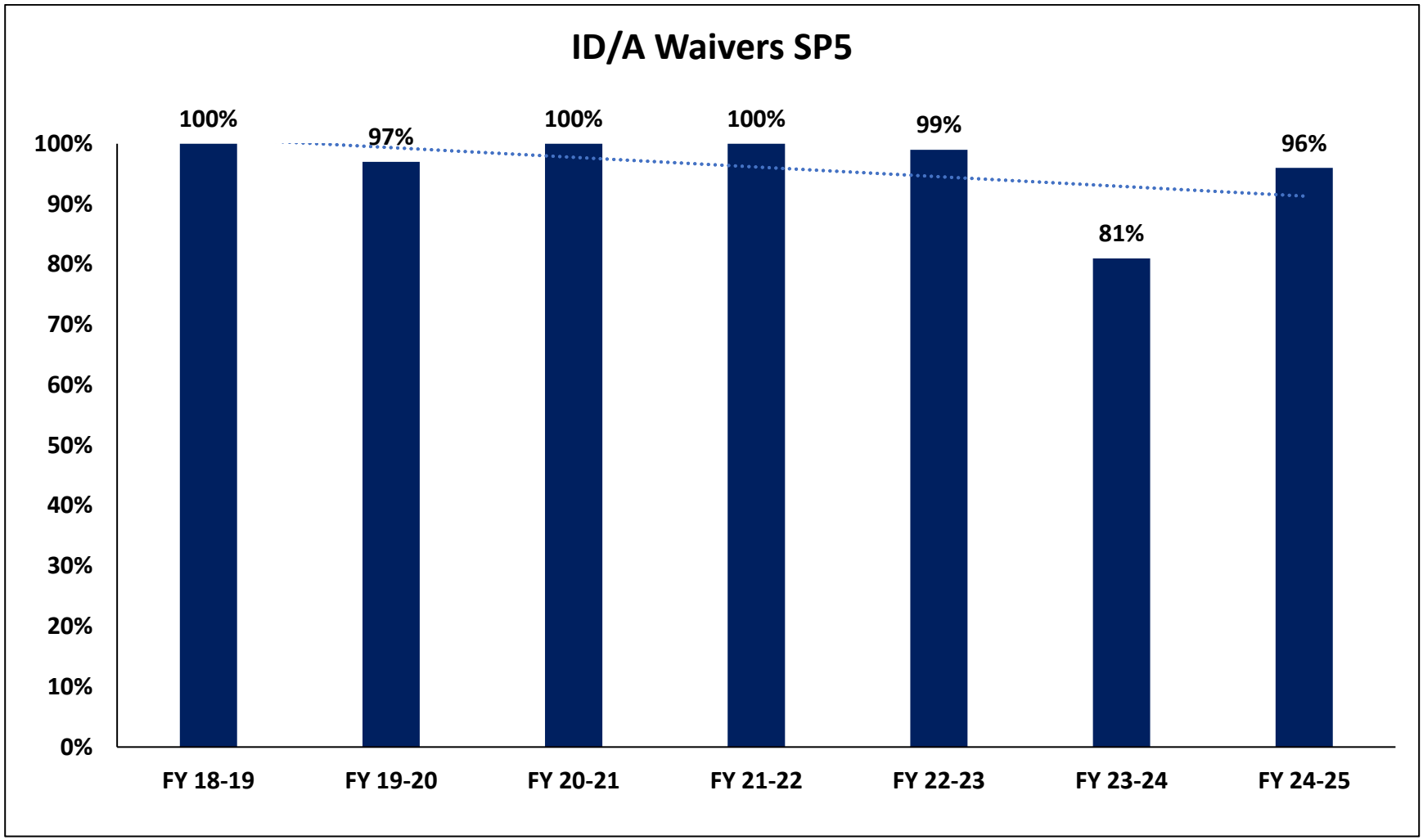
SP3: Number and percentage of participants whose needs changed and whose service plans were revised accordingly.
Note: Compliance rates are statewide results for AAW.



SP4: Number and percentage of participant service plans in which services and supports were delivered in the type, scope, amount, duration, and frequency specified in the service plan.
Note: Compliance rates are statewide results across all ID/A waivers.

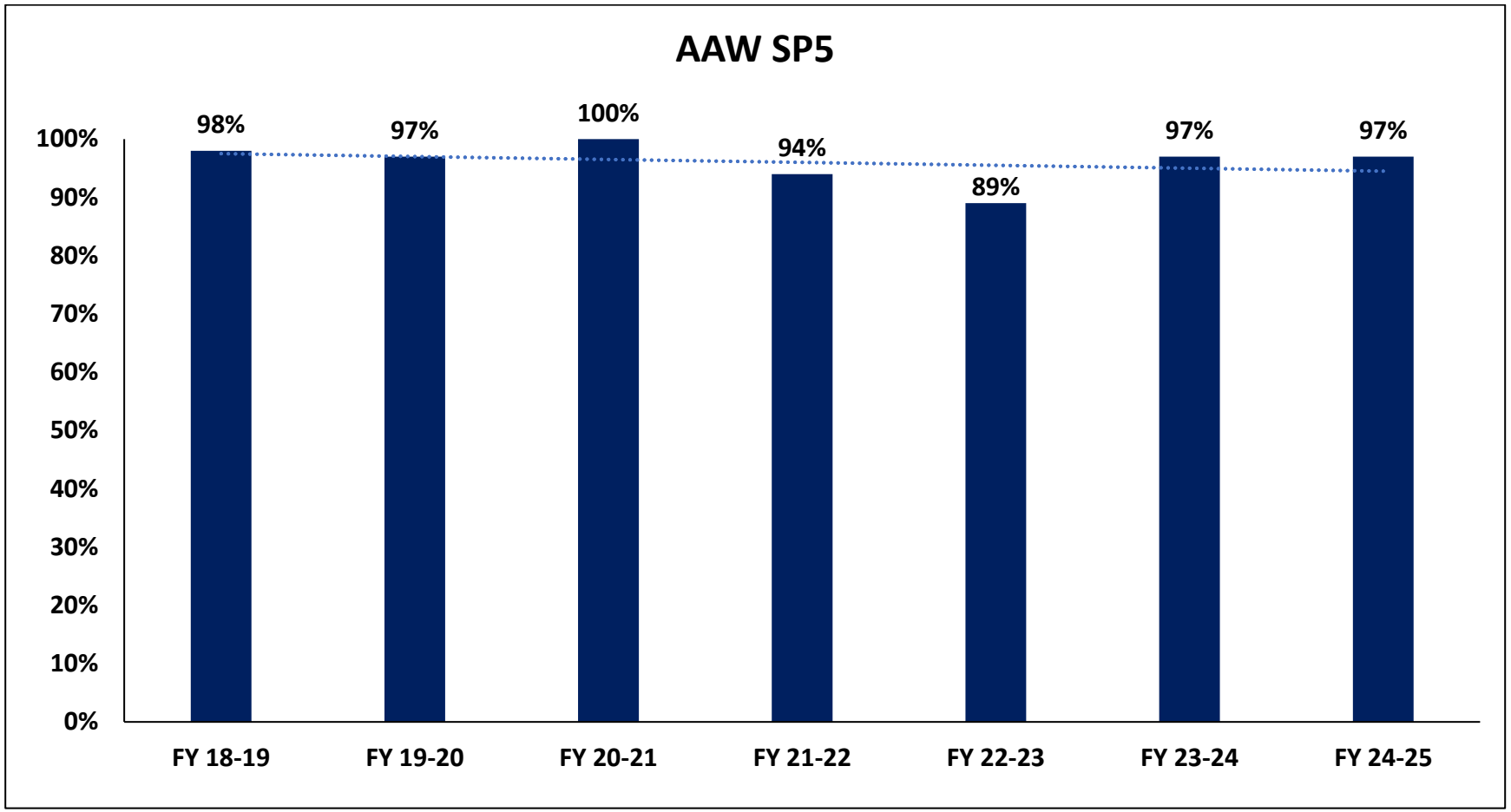


SP4: Number and percentage of participant service plans in which services and supports were delivered in the type, scope, amount, duration, and frequency specified in the service plan.
Note: Compliance rates are statewide results for AAW.

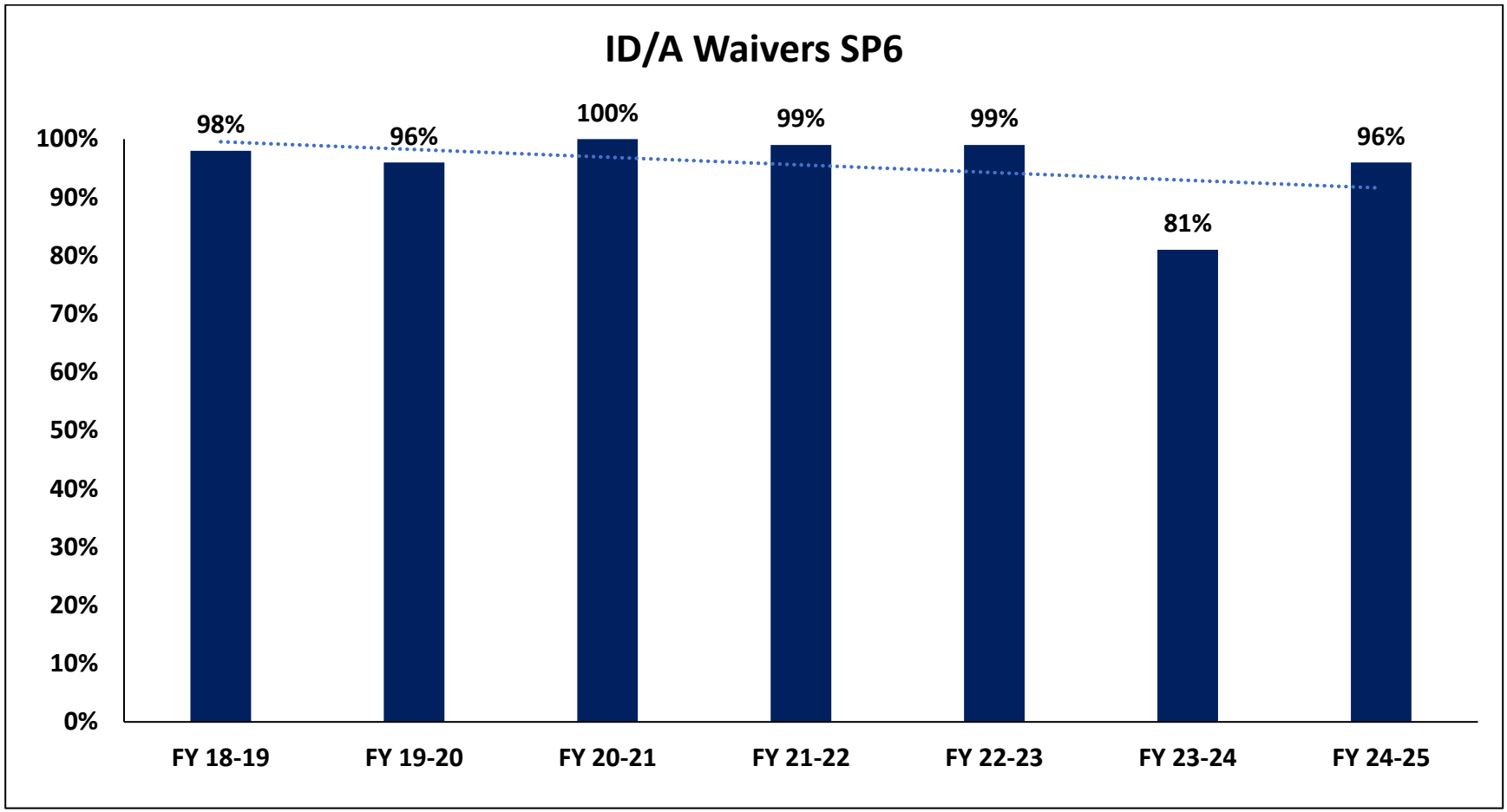


SP5: Number and percentage of participants whose records document choice between and among waiver services and providers was offered to the participant/family.

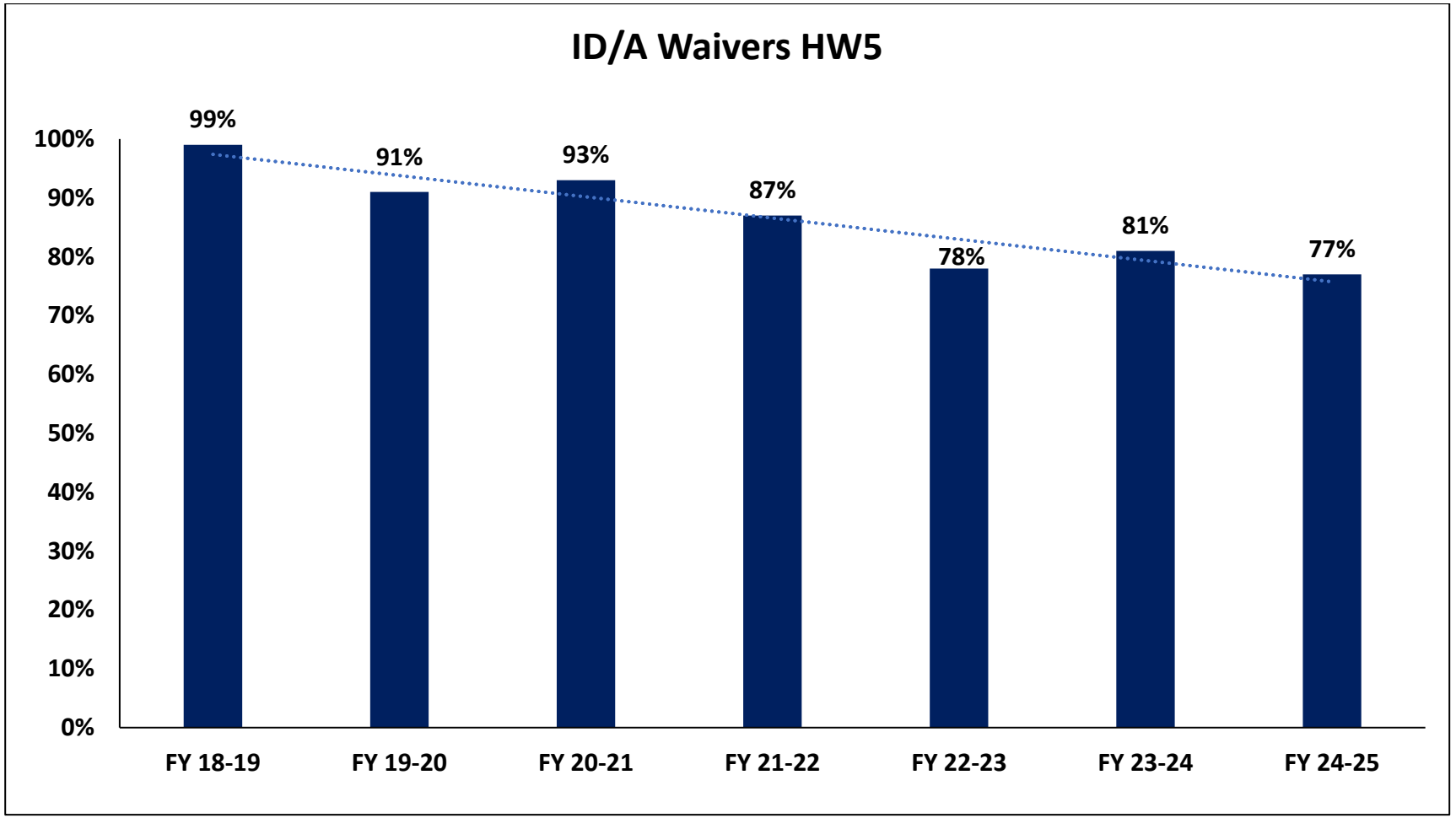
Note: Compliance rates are statewide results across all ID/A waivers.



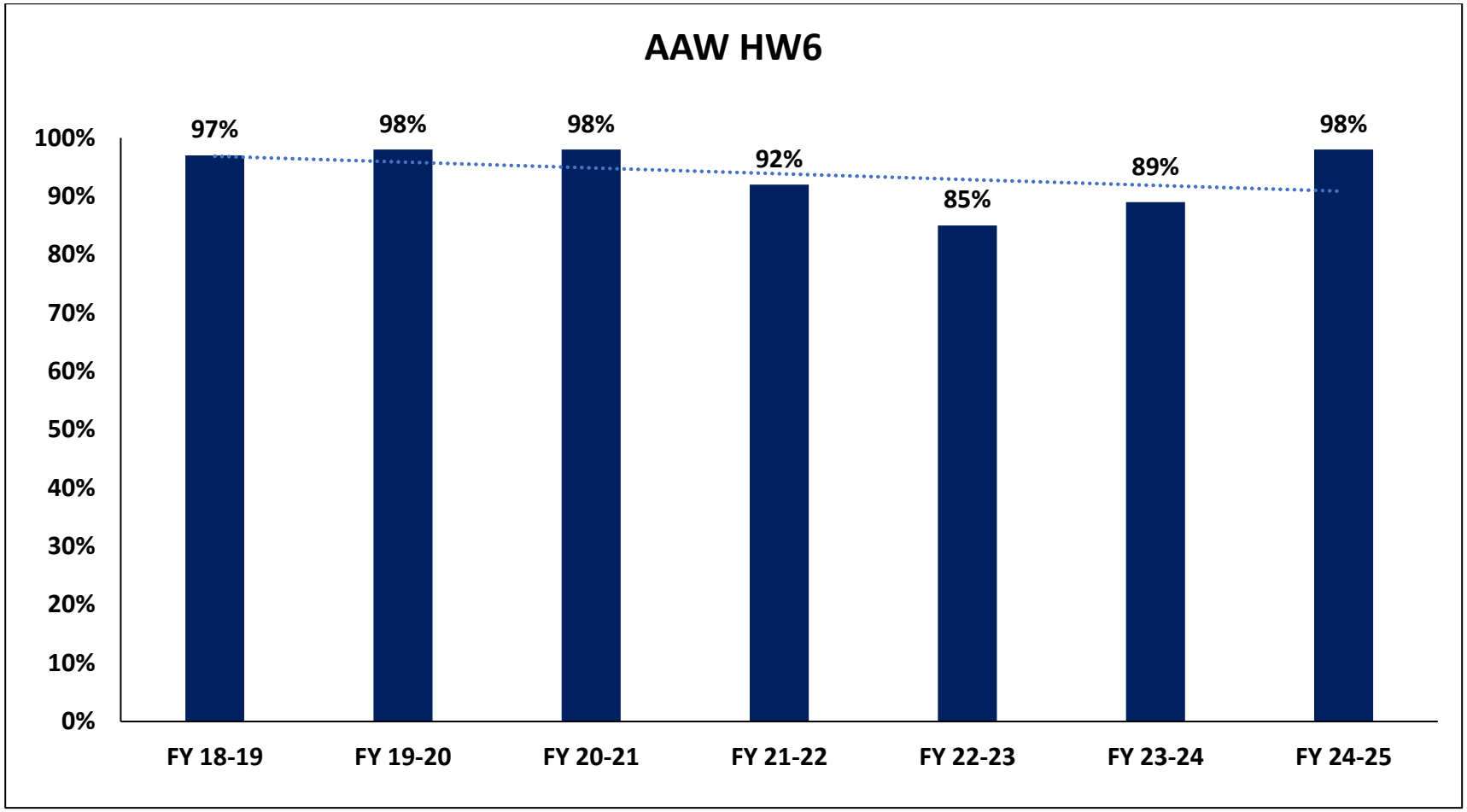
SP5: Number and percentage of participants whose records document choice between and among waiver services and providers was offered to the participant/family.
Note: Compliance rates are statewide results for AAW.



SP6: Number and percentage of participants who are provided with information on participant-directed services.
Note: Compliance rates are statewide results across all ID/A waivers.

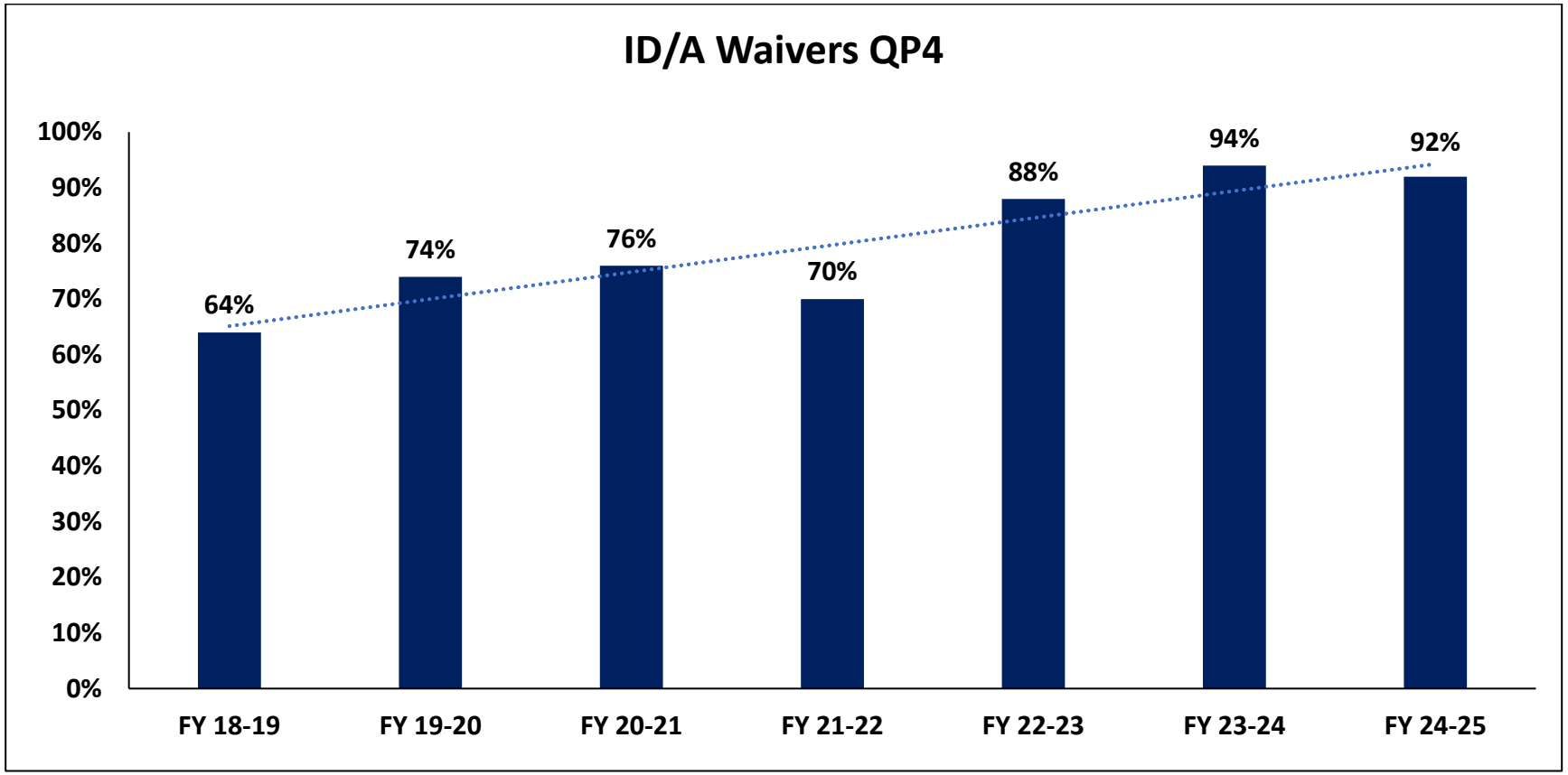


HW5: Number and percentage of participants whose identified health care needs are being addressed.
Note: Compliance rates are statewide results across all ID/A waivers.



HW5: Number and percentage of participants whose identified health care needs are being addressed.
Note: Compliance rates are statewide results for AAW.

QA&I Informed CMS Waiver Assurance Performance Measures Trending – Provider Accountable



QP4: Number and percentage of providers that meet annual training requirements in accordance with state requirements in the approved waiver.

Notes: Compliance rates are statewide results across all ID/A waivers and results from FY 19-20 may have been impacted by issues related to the COVID-19 pandemic. Additionally, results for QP4 were previously calculated at the entity level. Since QA&I Interim Year 2 (FY21-22), results have been calculated at the staff level, which is considered to be a more accurate reflection of performance. Lastly, QP4 performance includes both SCO (Q4) and Provider (Q13) results.

QP4 results for AAW are informed by the Provider Requalification process, not QA&I, and therefore are not provided in this report.

Section 1: Administrative Entities (AEs)

Reasons to Celebrate

Statewide, there are many areas where AEs maintained very positive scores in the areas monitored by ODP, via QA&I Cycle 2 (C2). As seen in the table below, 35 of 68 (51%) questions had an average score of 95% or above for C2, and 16 of those 35 (46%) questions had an average C2 score of 100%. An additional 13 (19%) questions for C2 had average scores in the range of 90-94%.

Significant improvement during C2 was seen with performance for Q63 - Certification of Need for Intermediate Care Facility/Intellectual Disabilities (ICF/ID) or Intermediate Care Facility for Other Related Conditions (ICF/ORC) Level of Care DP 250 form is completed (signed and dated). This measure rose from a score of 49% in C2Y1 to 99% in C2Y3. Although the C2 average is below the 86% compliance threshold, the significant and continual improvement during the cycle is worth celebrating.

Four AE questions showed significant improvement between 12-23% in results from C2Y2 to C2Y3 and had C2 averages ranging from 90-92%. These questions included Q13 – The AE has a written policy that supports the release of the incident report information upon request, Q56 – The medical evaluation included a recommendation for an ICF/ID or ICF/ORC LOC, Q57 – The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251, and Q61 – The AE provides notification of due process rights at waiver enrollment. The improvement in these questions is a reason to celebrate.

Four AE questions directly inform CMS waiver assurance performance measures related to fair hearing and appeal (due process) rights and level of care (LOC). These questions include Q61 - The AE provides notification of due process rights at waiver enrollment, Q65 - The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC, Q67 - The psychological evaluation meets ODP standards, and Q68 - A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning. Quality improvement activities related to performance on these questions were implemented during C2, and as a result, C2

averages for these questions ranged from 92-93% and showed overall improvements in the range of 8-21%, from the beginning to end of C2. These results are reasons to celebrate.

Lastly, 1 exploratory, non-scored, AE question connected to ISAC Recommendation #14 -Promote Racial Equity, finished C2 with an average of 92%, after starting C2 at 81%. This question is Q1 - The AE engages in activities, or has a written policy, to improve racial equity performance. These results are another reason to celebrate.

AE Reasons to Celebrate	C2Y2	C2Y3	C2 AVG
Q2.The AE ensures that any delegated or purchased administrative functions are established in writing pursuant to a subcontract or agreement.	100%	100%	100%
Q04.The AE maintains written documentation of any delegated or purchased function related to incident management (IM).	100%	100%	100%
Q06.The AE's designated point person for claims resolution uses ODP's claims resolution support process to assist Providers when claims are denied.	100%	100%	100%
Q09.The AE has a process to manage vacated capacity to ensure waiting list emergent needs are addressed timely. (NS)	94%	100%	98%
Q10.The AE demonstrates the management of reserved capacity for transitions to a short-term facility.	100%	94%	96%
Q11.The AE implements its established protocols for management of unanticipated emergencies.	92%	94%	95%
Q12.The AE implements the ODP Provider risk screening process.	100%	100%	100%
Q18.The AE engages with the Health Care Quality Unit (HCQU).	100%	100%	100%
Q20.The AE conducts oversight of the Priority of Urgency of Need for Services (PUNS) as per ODP's PUNS policy.	100%	94%	98%
Q21.The AE provides information and resources to individuals and families.	100%	100%	100%
Q22.The AE has a process to identify prospective individuals for waiver enrollment.	94%	100%	96%
Q23.The AE follows ODP's process regarding the move and transfer of ID/A Waiver individuals to another AE.	100%	92%	95%
Q28.**The AE has assigned a point person as a Subject Matter Expert (SME) in employment.	100%	100%	100%
Q30.The AE ensures that fair hearing and appeal activities are conducted in compliance with all ODP requirements.	100%	100%	100%
Q31.The AE actively expands and builds capacity of the Provider network.	100%	94%	98%
Q32.The AE identifies, develops, and implements strategies regarding the areas of need in the community and the resources available.	100%	94%	96%

AE Reasons to Celebrate	C2Y2	C2Y3	C2 AVG
Q33.*The AE qualifies AWC FMS Provider utilizing ODP standardized procedures.	100%	100%	100%
Q34.*The AE qualifies PROVIDER 1 utilizing ODP standardized procedures.	100%	93%	98%
Q36.*The AE qualifies a COMMUNITY PARTICIPATION SUPPORT PROVIDER utilizing ODP standardized procedures.	100%	100%	100%
Q41.The AE provides the SCOs and Providers with assistance to support individuals with complex physical and behavioral needs.	100%	100%	100%
Q45. *The individual has an approved Annual ISP (Annual Review Update) in HCSIS.	100%	99%	99%
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.	100%	99%	100%
Q49.The AE authorizes services consistent with the service definitions.	100%	100%	100%
Q51. *Due process rights information was provided to the individuals with a change(s) in need.	100%	88%	96%
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%	100%	100%
Q53. If Q52 is yes, the service is eligible for waiver funding.	100%	100%	100%
Q54.The DP 251 form is complete.	99%	95%	98%
Q55.The DP 251 is timely.	97%	98%	98%
Q58. The AE used the Waiver reevaluation tool to complete the reevaluation process.	99%	100%	100%
Q59.The annual reevaluation date is entered into HCSIS.	97%	99%	98%
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.	100%	100%	99%
Q62.The AE completed the initial level of care (LOC) evaluation and determination prior to entry into the waiver.	99%	99%	99%
Q66. *The medical evaluation occurs within the 365-day period prior to the Qualified Developmental Disabilities Professional signature on the LOC DP 250 Form.	99%	99%	99%
Q69. *A record contains evidence that the disability occurred during the developmental period which is prior to the individual's 22nd birthday.	99%	98%	98%
Q70.The AE maintains documentation of financial eligibility for waiver services.	100%	99%	99%

Highlighting Opportunities to Improve

Nineteen of 68 (28%) AE questions made it into the AE opportunities for improvement table below based on results at or below the 86% compliance threshold for C2Y3 and/or the C2 average, and/or a double digit decline from C2Y2 to C2Y3. Five (5) AE questions in the table showed some positive gains ranging from 6-18%, between C2Y2 to C2Y3, but the C2 average was less than the 86% compliance threshold. These 5 questions were Q7 - The AE follows ODP's record retention policy for individual closed records, Q37- The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan, Q38 - The AE uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives, Q64 - The AE ensures that the program diagnosis corresponds with the correct criteria of LOC, and Q71 - Waiver services are initiated within forty-five (45) calendar days. Q37 and Q38 inform ISAC performance measures.

The C2 average for 7 AE questions (Q03, Q08, Q17, Q27, Q35, Q40 and Q46) was above the 86% compliance threshold but because the C2Y3 scores declined in the range of 9-20% from C2Y2, these questions were included in the AE opportunities table. Four of these 7 AE questions (Q17, Q27, Q35 and Q46) were also included in the Metrics to Watch section of this report due to the questions informing CMS waiver assurance performance measures or other ODP priorities. An additional 5 AE questions (Q05, Q14, Q15, Q26, and Q39) in the table had double digit declines in performance ranging from 13-25% from C2Y2 to C2Y3 and also had C2 averages below 86%. AEs are encouraged to closely review the opportunities table below and to implement quality improvement activities to work towards improving results in these areas, if applicable to their organization.

AE Opportunities for Improvement	C2Y2	C2Y3	C2 AVG
Q03.The AE completes monitoring of delegated or purchased administrative functions.	100%	83%	91%
Q05.The AE completes monitoring of delegated or purchased IM function(s).	92%	79%	83%
Q07.The AE follows ODP's record retention policy for individual closed records.	75%	81%	77%
Q08.The AE follows ODP's record retention policy for individual active records.	94%	75%	88%

AE Opportunities for Improvement - Continued	C2Y2	C2Y3	C2 AVG
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.	69%	50%	58%
Q15.The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis.	50%	31%	46%
Q17.The AE operates a Human Rights Committee (HRC) in accordance with ODP requirements.	100%	81%	92%
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.	81%	81%	83%
Q26.The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis.	75%	50%	65%
Q27.The AE promotes competitive integrated employment as a priority.	100%	81%	94%
Q35.*The AE qualifies PROVIDER 2 utilizing ODP standardized procedures.	100%	80%	93%
Q37.**The AE uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	63%	81%	81%
Q38**The AE uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	69%	75%	79%
Q39.The AE actively uses a process to share independent Monitoring for Quality (IM4Q) information with stakeholders.	94%	69%	81%
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.	94%	81%	90%
Q42.The AE worked with the individual and their team to develop mitigation strategies when there are medical, behavioral, or socio-economic crisis situations.	79%	71%	80%
Q46.*The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.	92%	83%	89%
Q64.The AE ensures that the program diagnosis corresponds with the correct criteria of LOC.	92%	98%	78%
Q71.Waiver services are initiated within forty-five (45) calendar days.	74%	86%	77%

Section 2: Supports Coordination Organizations (SCOs)

Reasons to Celebrate

Statewide, there are many areas where ID/A SCOs maintained very positive scores in the areas monitored by ODP, via QA&I in Cycle 2 (C2). As seen in the table below, 15 of 48 (31%) SCO questions had an average score of 95% or above for C2, and 3 of those 15 (20%) questions had an average C2 score of 100%. An additional 9 (19%) ID/A SCO questions for C2 had average scores in the range of 91-93%.
Significant improvement during C2 was seen with performance for Q50 - The SCO identified and took action for issues identified upon review of final incident reports in EIM. (Final). This measure rose from a score of 77% in C2Y1 to 91% in C2Y3. Although the C2 average is below the 86% compliance threshold, the significant and continual improvement during the cycle is worth celebrating.

Seven ID/A SCO questions showed significant improvement between 10-15% in results from C2Y2 to C2Y3 and had C2 averages ranging from 90-92%. These questions included Q30 - The SC provided due process rights information at the annual ISP meeting, Q31 - Choice of Providers was offered to the individual/family, Q32 - Choice of services was offered to the individual/family, Q33 - The SC provided the individual information on participant directed services (PDS) options annually, 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, 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"), and Q49 - The SCO identified and took action for issues identified upon review of initial incident reports in EIM. (Initial). Three of these 7 ID/A SCO questions directly inform CMS waiver assurance performance measures related to service planning (Q31, Q32, and Q33) and 1 informs an ISAC performance measure (Q39). The improvement in these questions is a reason to celebrate.

ID/A SCO performance in C2 demonstrated consistency in promoting individual choice with a C2 average of 92% of individuals being offered a choice in providers, services, and participant-directed services options, as well as participating in their Annual ISP meeting, or their SC reviewed

their ISP with them. Person-centered planning was also evident, with the C2 average of 91% of ISPs addressing all assessed needs and 92% of ISP meetings including employment education. Finally, the C2 average for ID/A SCOs taking action on issues identified in initial incident reports in EIM was 91%.

Note that for Q40 in C2Y2 there is an NA in the table below. This is because the question did not apply to any individuals in the sample that was reviewed in C2Y2.

ID/A SCO Reasons to Celebrate	C2Y2	C2Y3	C2 AVG
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.	90%	98%	96%
Q19. *The individual's ISP was updated when a change in need was identified.	93%	97%	97%
Q22. *The SC documented a risk assessment.	100%	100%	99%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	98%	96%	95%
Q25. *An ISP was developed that supports the outcomes/objectives throughout the entire plan.	100%	98%	99%
Q35. The SC follows ODP's PUNS policy based on the individual's current need(s).	98%	96%	98%
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%	96%	99%
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%	100%	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.	97%	95%	97%
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.	NA	100%	100%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	98%	98%	98%
Q44. The ISP includes all identified medical personnel seen during the review period.	92%	97%	96%
Q45. The individual's preferences for wellness activities are documented in the ISP.	100%	100%	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	99%	100%	99%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM.	95%	93%	97%

Statewide, there are many areas where AAW SCOs obtained very positive scores in the areas monitored by ODP, via QA&I Cycle 2 Year 3 (C2Y3). As seen in the table below, 26 of 44 (59%) applicable questions had scores of 95% or above for C2Y3, and 12 of those 26 (46%) questions had a score of 100%. An additional 9 of 44 (20%) applicable questions for C2Y3 had scores in the range of 87-94%. This means that 80% of all applicable AAW SCO questions had C2Y3 scores above the 86% compliance threshold and these results are reasons to celebrate.

Note that previous reporting of AAW SCO QA&I data included AAW-only SCO results however, this report began measuring results including "shared" ID/A and AAW SCOs, along with AAW-only SCOs. For this reason, a C2 average and comparisons with C2Y2 are not available for this report.

AAW SCO Reasons to Celebrate	C2Y3
Q5. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days	100%
Q6 . SCO staff completed the required number of training hours in the training year.	100%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	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.	96%
Q17. The SC offers information about services and resources to the family.	100%
Q18.* The individual has an identified change in need. (NS)	100%
Q19. *The individual's ISP was updated when a change in need was identified.	95%
Q21. The SC followed up on the issues.	100%
Q22. *The SC documented a risk assessment.	100%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	100%
Q24. *The SC developed a person-centered ISP to address all assessed needs.	98%
Q28. The Individual Monitoring Tools met quality standards.	95%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	98%
Q30. The SC provided due process rights information at the annual ISP meeting.	97%
Q31. *Choice of Providers was offered to the individual/family.	97%

AAW SCO Reasons to Celebrate *(continued)*	C2Y3
Q32. *Choice of services was offered to the individual/family.	97%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	95%
Q34. The individual attended the Annual Review Update ISP meeting or Annual Review Plan (ARP) ISP meeting or if the individual did not attend the meeting, the SC reviewed the results with the individual.	98%
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%
39. **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").	98%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	95%
Q42. *The individual's identified physical and mental health care needs are addressed.	98%
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%
Q46. **The SC ensured there are strategies for supports in place to address those needs.	100%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	95%

Highlighting Opportunities to Improve

Twenty-two of 48 (46%) ID/A SCO questions made it into the SCO opportunities for improvement table below based on results at or below the 86% compliance threshold for C2Y3 and/or the C2 average, and/or a significant decline from C2Y2 to C2Y3, and/or trending downward throughout C2. Three (3) ID/A SCO questions showed slight positive gains ranging from 3-6%, between C2Y2 to C2Y3, but the C2 average was less than the 86% compliance threshold. These 3 questions were Q17 - The SC offers information about services and resources to the family, Q26 - The SC conducted all monitorings at the required frequency, and 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.

The C2 average for 8 ID/A SCO questions (Q04, Q05, Q08, Q20, Q21, Q28, Q29 and Q47) was above the 86% compliance threshold but because the C2Y3 scores declined in the range of 9-37% from C2Y2, these questions were included in the opportunities table. Three of these 8 questions (Q05, Q29 and Q47) were also included in the Metrics to Watch section of this report due to 1 question informing a CMS waiver assurance performance measure (Q29) and the others being ODP priorities. Eleven of 22 (50%) questions in the opportunities table (Q04, Q05, Q08, Q09, Q10, Q12, Q13, Q21, Q27, Q29, and Q47) had significant declines in scores from C2Y2 to C2Y3 ranging from 9-37%, and 5 of these questions (Q09, Q10, Q12, Q13, and Q27) also had C2 averages below 86%.

While some ID/A SCO areas remain relatively stronger than others, several key areas experienced notable declines in C2Y3. Incident and risk management practices showed the most significant declines including maintenance of documentation of delegated functions, which dropped to 63% (C2 average of 88%), monitoring of those functions dropped to 25% (C2 average of 45%), and conducting and documenting a trend analysis of incident categories at least every 3 months dropped to 28% (C2 average of 44%). Monthly individual incident data monitoring (48%) and policy support for incident release (56%) further highlight opportunities for improvement in oversight. Service delivery metrics such as SCs conducting monitoring at the required frequency (75%), the individual received services in type, scope, amount, duration, and frequency as defined in the ISP (85%), follow-up on identified issues (85%), and individual's identified physical and mental health needs are addressed (77%)

also fell short. Staff training saw core course completion drop to 85% and new SC orientation drop to 88%. Person-centered, data-driven quality management/improvement remains underdeveloped, with only 64% using person-centered data in QM Plan development and in tracking plan progress. To improve outcomes and performance, targeted efforts are needed. SCOs are encouraged to closely review the opportunities table below and to implement quality improvement activities to work towards improving results in these areas, if applicable to their organization.

ID/A SCO Opportunities for Improvement	C2Y2	C2Y3	C2 AVG
Q01. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	65%	64%	71%
Q02. The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	65%	64%	66%
Q03. **The SCO engages in activities, or has a written policy, to improve racial equity performance.	90%	88%	84%
Q04. *The SCO's staff completed annual training core courses as required in the training year.	97%	93%	92%
Q05. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual. # of staff reviewed - Q5 Response	97%	88%	93%
Q06. SCO staff completed the required number of training hours in the training year.	85%	84%	85%
Q08. The SCO maintains written documentation of any delegated or purchased function related to incident management.	100%	63%	88%
Q09. The SCO completes monitoring of delegated or purchased incident management function(s).	50%	25%	45%
Q10. The SCO has a written policy that supports the release of the incident information upon request.	80%	56%	71%
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.	65%	60%	66%
Q12. The SCO completes monthly individual incident data monitoring.	63%	48%	57%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months.	53%	28%	44%
Q17. The SC offers information about services and resources to the family.	78%	81%	83%
Q20. The Service Notes (SNs) met quality standards.	91%	87%	90%
Q21. If there were identified issues, the SC followed up on the issues.	98%	85%	92%
Q26. The SC conducted all monitorings at the required frequency.	72%	75%	77%

ID/A SCO Opportunities for Improvement (Continued)	C2Y2	C2Y3	C2 AVG
Q27. The SC conducted all monitoring at the required location.	91%	77%	84%
Q28. The Individual Monitoring Tools met quality standards.	89%	87%	89%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	95%	85%	92%
Q42. *The individual's identified physical and mental health care needs are addressed.	81%	77%	79%
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.	72%	78%	78%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	98%	88%	95%

Nine of 44 (20%) applicable AAW SCO questions made it into the AAW SCO opportunities for improvement table below based on results at or below the 86% compliance threshold for C2Y3. One of these questions (Q48) was also included in the Metrics to Watch section of this report.

While many AAW SCO performance areas remain strong, several key areas showed notable issues in C2Y3. Incident and risk management policy and practices accounted for poor performance in 7 of 9 (78%) questions in the opportunities table including completion of monthly individual incident data monitoring (50%), conducting and documenting a trend analysis of incident categories at least every 3 months (25%), having a policy that supports release of incident information upon request (67%) and a policy to monitor EIM restraint and medication error reports to ensure proper procedures are followed to detect abuse and neglect (67%), educating an individual on circumstances of incidents for which the SCO is required to file in EIM (86%), and taking action on identified issues upon review of initial (83%) and final (80%) incident reports in EIM. Person-centered, data-driven quality management/improvement remains underdeveloped, with only 60% using person-centered data in QM Plan development and 40% using person-centered data in tracking plan progress. To improve outcomes and performance, targeted efforts are needed. AAW SCOs are encouraged to closely review the opportunities table and to implement quality improvement activities to work towards improving results in these areas, if applicable to their organization.

Note that previous reporting of AAW SCO QA&I data included AAW-only SCO results however, this report began measuring results including "shared" ID/A and AAW SCOs, along with AAW-only SCOs. For this reason, a C2 average and comparisons with C2Y2 are not available for this report.

AAW SCO Opportunities for Improvement	C2Y3
Q01. **The SCO uses person-centered performance data in developing the Quality Management Plan (QMP) and its Action Plan.	60%
Q02. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	40%
Q10. The SCO has a written policy that supports the release of the incident information upon request.	67%
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.	67%
Q12. The SCO completes monthly individual incident data monitoring.	50%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months.	28%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM.	86%
Q49. The SCO identified and took action for issues identified upon review of initial incident reports in EIM.	83%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	80%

Section 3: Providers

Reasons to Celebrate

Statewide, there were many areas where ID/A providers maintained positive scores in areas monitored by ODP, through AEs, via the QA&I process in Cycle 2 (C2). As seen in the table below, 13 of 52 (25%) ID/A Provider questions had an average score of 94% or above for C2, and 1 of these questions had an average C2 score of 100%. An additional 16 (31%) ID/A SCO questions for C2 had average scores in the range of 87-93%.

Three questions showed small but steady improvement, year over year, throughout C2. These questions included 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, Q16 - The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines, and Q39 - The individual's ISP includes a competitive integrated employment outcome/objective(s). Two questions ended C2 with an average of 89-90%, but showed declines in performance from C2Y2 to C2Y3, in the range of 9-10%, with C2Y3 performance hovering at or below the 86% compliance threshold. These questions included Q37 - The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication and 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. Both questions were also included in the Metrics to Watch section of this report due to the decline in performance in C2Y3. Additionally, Q37 is a question used to inform an ISAC performance measure. Overall, C2 averages in the Reasons to Celebrate table below show consistently strong performance in multiple areas including supporting individuals to explore and maintain competitive and integrated employment based on their interests and strengths, ensuring individuals complete all needed health care appointments, screenings, and follow-ups as prescribed, ensuring all reportable incidents are documented in EIM, and ensuring an individual’s choice to decorate their bedroom and common areas of their home, that individuals have the right to a key, access card, keypad or other entry mechanism to access their home, the right to lock their bedroom and to privacy when audio and/or visual monitoring systems are used in the home.

Providers of ID/A Waiver Services Reasons to Celebrate	C2Y2	C2Y3	C2 AVG
Q4. The Therapy Provider renders the service in a home and community location.	100%	100%	100%
Q29. The individual has a current signed Department-approved room and board residency agreement on file.	96%	94%	95%
Q30. The Department-approved room and board residency agreement is completed at least annually.	95%	93%	95%
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.	89%	94%	94%
Q41. The individual is supported in exploring competitive integrated employment opportunities.	100%	95%	97%
Q43. The Provider supports the individual in maintaining employment.	98%	98%	98%
Q44. The Provider supports the individual to maintain competitive integrated employment by facilitating transportation.	100%	98%	99%
Q47. The Provider ensures the individual completes all health care appointments, screenings, and follow-up as prescribed.	98%	98%	98%
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	94%	92%	94%
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.	100%	98%	98%
Q53. The individual has the right to lock their bedroom door.	100%	99%	99%
Q54. The individual has privacy in their home when audio and/or visual monitoring systems are used in their home.	96%	99%	98%
Q55. The individual chose how to decorate their bedroom and the common areas of their home such as the living room or kitchen.	100%	100%	99%

Statewide, there were many areas where AAW providers had very positive scores in areas monitored via the QA&I process in C2Y3. As seen in the table below, 13 of 21 (62%) applicable AAW provider questions had a score of 95% or above for C2Y3, and 10 of these questions had scores of 100%. An additional 3 (14%) applicable AAW provider questions for C2Y3 had scores in the range of 87-89%. This means that 76% of all applicable AAW provider questions had C2Y3 scores above the 86% compliance threshold and these results are reasons to celebrate.

Note that previous reporting of AAW Provider QA&I data included AAW-only results however, this report began measuring results including "shared" ID/A and AAW Providers, along with AAW-only Providers. For this reason, a C2 average and comparisons with C2Y2 are not available for this report.

Providers of AAW Services Reasons to Celebrate	C2Y3
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance.	96%
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%
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses.	95%
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	98%
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management.	100%
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s).	100%
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.	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%
Q34. The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP.	100%
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP.	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%

Highlighting Opportunities to Improve

Twenty-three of 52 (44%) ID/A provider questions made it into the opportunities for improvement table below based on results at or below the 86% compliance threshold for C2Y3 and/or the C2 average, and/or a significant decline from C2Y2 to C2Y3. Five ID/A provider questions showed slight positive gains ranging from 1-7%, between C2Y2 to C2Y3, but the C2 average was less than the 86% compliance threshold. These 5 questions were Q1 - The Provider uses person-centered performance data in developing the QMP and its Action Plan, Q3 - The Provider engages in activities, or has a written policy, to improve racial equity performance (NS), Q6 - The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider, Q12 - The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service, and Q18 - The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI). Q1 and Q3 are ISAC performance measures. Q1 has also been included in the Metrics to Watch section of this report due to not only being an ISAC performance measure but also because it's an ODP priority that has been included in Performance-Based Contracting (PBC) for all residential providers.

Six of 24 (25%) questions in the opportunities table (Q14, Q15, Q19, Q20, Q33, and Q35) had significant declines in scores from C2Y2 to C2Y3 ranging from 10-27%, and all of these questions also had C2 averages ranging from 74-84%. Eight additional questions (Q2, Q11, Q21, Q22, Q23, Q24, Q28, and Q36) showed smaller declines in scores from C2Y2 to C2Y3 ranging from 1-5% and also had C2 averages ranging from 59-85%. Q2 is an ISAC performance measure and an ODP priority that has been included in PBC for all residential providers, therefore it's. also been included in the Metrics to Watch section of this report.

While some ID/A provider areas remain relatively stronger than others, many key areas are in need of improvement. Eight of 23 (35%) questions in the opportunities for improvement table highlighted incident and risk management practices as predominant areas in need of improvement, followed by 6 (26%) questions related to service provision and documentation, 4 (17%) questions related to policies, 3 (13%) questions related to training, and 2 (8%) questions related to provider quality management practices.

Incident and risk management areas in need of improvement included maintenance of documentation of delegated functions, monitoring of those functions, having an IM representative that is a Certified Investigator, submitting an incident report of neglect if an individual's backup plan was not implemented as specified in the ISP, and conducting and documenting a trend analysis of incident categories at least every 3 months. Drops in monthly individual incident data monitoring and in policy support for release of incident report information upon request, and for monitoring EIM restraint and medication error reports to ensure proper procedures are followed and to detect abuse and neglect further highlight opportunities for improvement in oversight. Person-centered, data-driven quality management/improvement remains underdeveloped, with only 81% using person-centered data in QM Plan development in C2Y3 and 77% using it in tracking plan progress.

Service delivery and documentation metrics showing the need for improvement included implementing an individual's backup plan as specified in the ISP, issuing a written notice to all required parties within required timeframes when transitioning an individual to another service provider, and documenting how progress will be addressed if there is a lack of progress on a desired outcome, documenting an explanation if an individual receiving Supported Employment Career Assessment activities requires in excess of 6 months, or documenting a fading plan/schedule for the individual's ongoing use as part of Supported Employment. Results for completion of new staff orientation, and staff required number of training hours in a training year highlighted additional needs for improvement. Results for staff trained on an individual's communication profile and/or formal communication system remained the same at 82% for C2Y3, and a C2 average of 83%.

Lastly, ID/A providers showed C2 averages below the 86% compliance threshold with having written policies about handling of complaints regarding service delivery, addressing provision of support of individuals with medication administration, facilitating and making accommodations to assist individuals to visit with whom they choose, and to improve racial equity performance. To improve outcomes and performance, targeted efforts are needed. ID/A providers are encouraged to closely review the opportunities table below and to implement quality improvement activities to work towards improving results in these areas, if applicable to their organization.

Providers of ID/A Waiver Services Opportunities for Improvement	C2Y2	C2Y3	C2 AVG
Q1. **The Provider uses person-centered performance data in developing the QMP and its Action Plan.	79%	81%	80%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered QMP goals and its Action Plan target objectives.	79%	77%	76%
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance. (NS)	85%	87%	81%
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider.	78%	85%	82%
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses.	87%	86%	85%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	80%	84%	81%
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.	95%	68%	82%
Q15. Provider staff completed the required number of training hours in the training year.	89%	77%	84%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. (NS)	78%	78%	77%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).	84%	85%	81%
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management.	89%	78%	79%
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s).	85%	72%	74%
Q21. The Provider has a written policy that supports the release of the incident report information upon request.	75%	71%	67%
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.	72%	70%	64%
Q23. The Provider completes monthly individual incident data monitoring.	78%	74%	68%
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months.	79%	77%	70%
Q27. **Staff are trained on the individual's communication profile and/or formal communication system.	82%	82%	83%

Providers of ID/A Waiver Services Opportunities for Improvement (continued)	C2Y2	C2Y3	C2 AVG
Q28. The Provider maintains a signed statement acknowledging that the individual has received information on individual rights.	83%	80%	80%
Q33. The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome.	79%	66%	74%
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP.	81%	71%	80%
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.	61%	56%	59%
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)	0%	100%	67%
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%	79%

Five of 21 (24%) applicable AAW provider questions made it into the opportunities for improvement table below based on results at below the 86% compliance threshold for C2Y3. Note that previous reporting of AAW provider QA&I data included AAW-only provider results however, this report began measuring results including “shared” ID/A and AAW providers, along with AAW-only providers. For this reason, a C2 average and comparisons with C2Y2 are not available for this report.

While many AAW provider performance areas remain strong, a couple of key areas showed a few notable issues in C2Y3. Incident and risk management policy and practices accounted for poor performance in 4 of 5 (80%) questions in the opportunities table including completion of monthly individual incident data monitoring (66%), conducting and documenting a trend analysis of incident categories at least every 3 months (69%), having a policy that supports release of incident information upon request (64%), and having a policy to monitor EIM restraint and medication error reports to ensure proper procedures are followed to detect abuse and neglect (64%). The other area of poor performance noted in C2Y3 was related to providers not having written procedures for handling complaints regarding service delivery (76%). To improve outcomes and performance, targeted efforts are needed in these areas. AAW providers are encouraged to closely review the opportunities table and to implement quality improvement activities to work towards improving results in these areas, if applicable to their organization.

Providers of AAW Services Opportunities for Improvement	C2Y3
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	76%
Q21. The Provider has a written policy that supports the release of the incident report information upon request.	64%
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.	67%
Q23. The Provider completes monthly individual incident data monitoring.	66%
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months.	69%

Section 4: Home & Community-Based Settings Rule Licensing Inspection Results - Fiscal Years 2022-2023, 2023-2024, & 2024-2025

The Home and Community-Based Services (HCBS) Rule became effective in March of 2014 and was created by the Centers for Medicare and Medicaid Services (CMS) to enhance the quality of HCBS, provide protections to individuals, and to ensure individuals receiving HCBS have full access to the benefits of community living and to the opportunity to receive services in the most integrated setting appropriate. This includes opportunities to seek employment, work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as people who do not receive HCBS.

The Office of Developmental Programs (ODP) HCBS waivers include the Consolidated, Community Living (CLW), Person/Family Directed Support (P/FDS), and Adult Autism (AAW) waivers. The CMS HCBS Rule requires states to assess all services and service locations that receive funding or payment through an approved HCBS waiver. To meet these expectations, ODP incorporated requirements to align with the HCBS Rule into licensing and programmatic regulations 55 Pa. Code Chapters 2380, 2390, 6100, 6400, and 6500, which were published on October 5, 2019, with most requirements becoming effective on February 1, 2020.

This section provides results from licensing inspections completed in FY 22-23, FY 23-24, and FY 24-25, for service locations licensed under 55 Pa. Code Chapters 2380 (Adult Training Facilities), 2390 (Vocational Facilities), 6400 (Community Homes), or 6500 (Life Sharing Homes). The source for this data is ODP's Certification and Licensing System (CLS). In addition to licensing inspection results about compliance with the HCBS Rule, this report includes HCBS Rule-related full review results for AEs, SCOs, and Providers, from QA&I C2Y3 in the appendices, and Cycle 2 average results in the body of the report. The table below provides a reference for those QA&I questions, by entity.

QA&I Questions Related to FR § 441.301, 441.530, 441.710	
Administrative Entities (AEs)	Questions: 14, 17, 21, 27, 29, 42, 48, 60
Supports Coordination Organizations (SCOs)	Questions: 11, 12, 16, 23, 31, 32, 36, 37, 38, 39
Providers	Questions: 4, 11, 12, 16, 22, 23, 27, 29, 31, 32, 37, 38, 40, 41, 44, 49

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

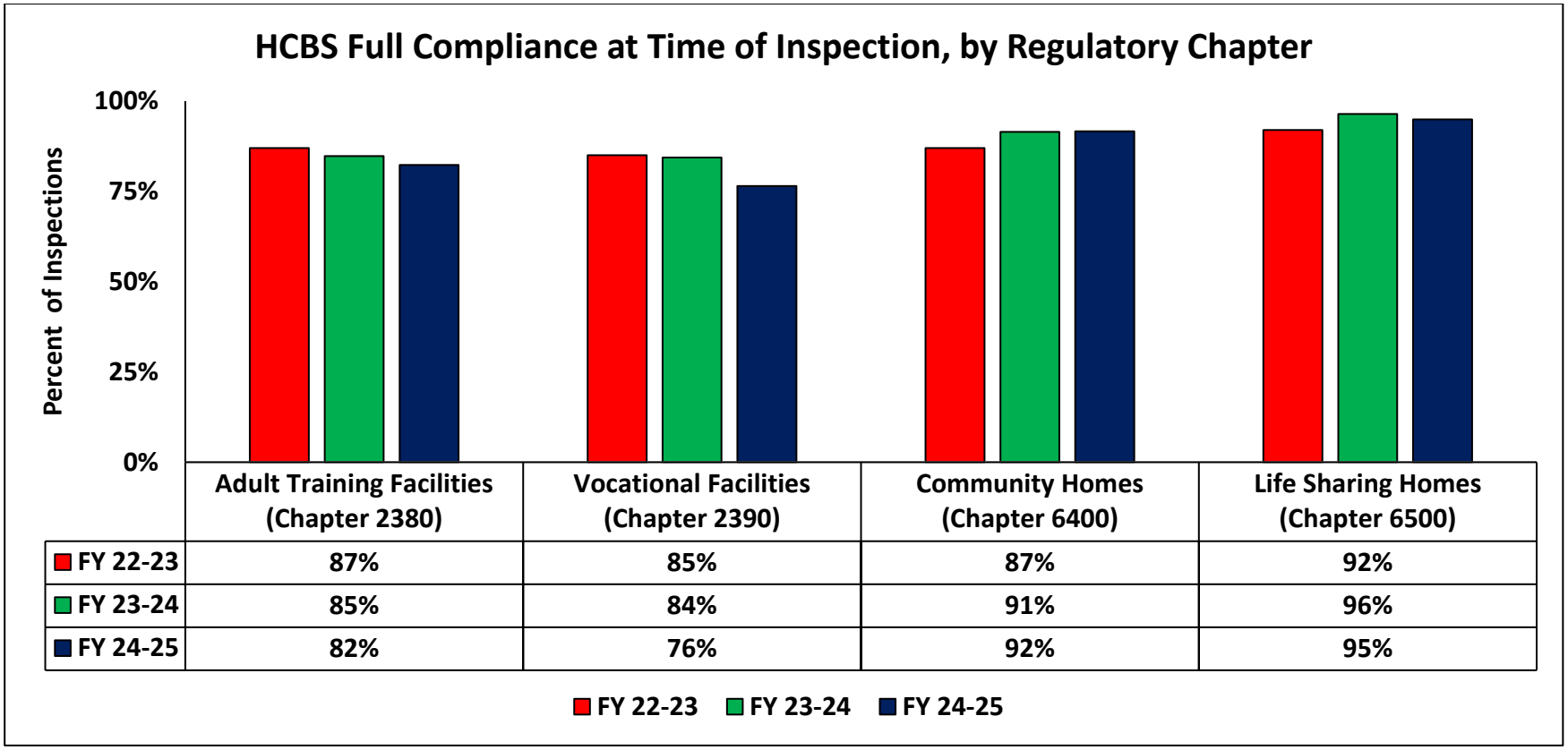
Summary of Notable Licensing Findings and Trends

- Full compliance with HCBS Rule regulations, at the time of inspection, for Adult Training and Vocational Facilities (Chapters 2380 and 2390) has been trending downward. Adult Training Facility results were 87% in FY 22-23, dropped to 85% in FY 23-24, and dropped again to 82% in FY 24-25. Vocational Facility results were 85% in FY 22-23, dropped to 84% in FY 23-24, and dropped again to 76% in FY 24-25.

- Full compliance with HCBS Rule regulations, at the time of inspection, for Community and Life Sharing Homes (Chapters 6400 and 6500) has been trending upward. Community Home results were 87% in FY 22-23, increased to 91% in FY 23-24, and increased again to 92% in FY 24-25. Life Sharing Home results were 92% in FY 22-23, increased to 96% in FY 23-24, but dropped slightly to 95% in FY 24-25.

- In locations where HCBS Rule violations were found, only 1 violation was identified in 83% of those locations.

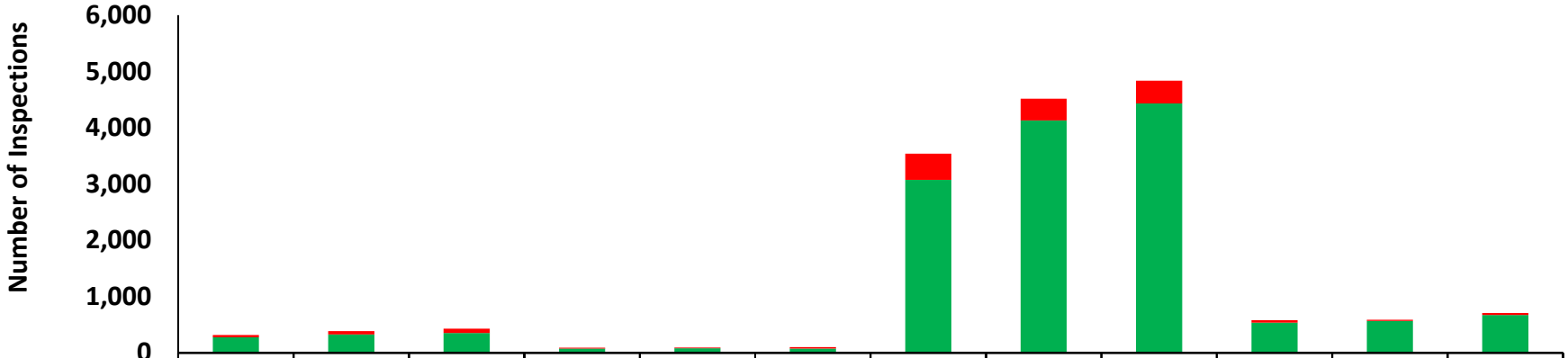
- Most HCBS Rule violations were related to individual rights. The most common violations were failure to inform individuals of their rights and to explain those rights; discrimination against individuals because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age; and not providing individuals the opportunity to lock their bedroom doors.



	Adult Training Facilities (Chapter 2380)	Vocational Facilities (Chapter 2390)	Community Homes (Chapter 6400)	Life Sharing Homes (Chapter 6500)
FY 22-23	87%	85%	87%	92%
FY 23-24	85%	84%	91%	96%
FY 24-25	82%	76%	92%	95%

Number of HCBS Violations

Chapter: 2380 - Adult Training Facilities, 2390 - Vocational Facilities 6400 - Community Homes, 6500 - Life Sharing Homes



	2380			2390			6400			6500		
	FY 22-23	FY 23-24	FY 24-25	FY 22-23	FY 23-24	FY 24-25	FY 22-23	FY 23-24	FY 24-25	FY 22-23	FY 23-24	FY 24-25
1 or More	40	59	76	14	15	24	465	386	404	44	21	36
No Violations	277	328	354	77	81	78	3,074	4,130	4,430	536	567	672

Licensing Sanctions for HCBS Rule Noncompliance

ODP-licensed locations are operated by provider agencies. Provider agencies can have many licenses and locations. In general, there are about 7,000 licensed locations operated by about 600 agencies at any given time.

One or more HCBS violations were found at 464 locations in FY 23-24. These locations were operated by 453 separate provider agencies. 98% of these agencies corrected the violation(s) and remained on regular license status. Of the remaining 11 agencies (all Chapter 6400):

- 6 were placed on provisional license status, were not allowed to serve new individuals, and were not allowed to open new homes. These agencies have since returned to regular status and are allowed to serve new individuals and open new homes.

- 5 had their licenses revoked. Of these, 2 agencies closed, and 3 are operating pending appeal of the revocation. These agencies are not allowed to serve new individuals or to open new homes while they are operating pending appeal.

One or more HCBS violations were found at 540 locations in FY 24-25. These locations were operated by 523 separate provider agencies. 97% of the agencies corrected the violation(s) and remained on regular license status. Of the remaining 15 agencies (all Chapter 6400):

- 11 were placed on provisional license status, were not allowed to serve new individuals, and were not allowed to open new homes. Eight of these agencies have since returned to regular status and are allowed to serve new individuals and open new homes.

- 4 had their licenses revoked. All are operating pending appeal of the revocation. These agencies are not allowed to serve new individuals or to open new homes while they are operating pending appeal.

Quality Assessment & Improvement
Cycle 2, Year 3 (C2Y3) ~ Fiscal Year (FY) 24-25

All FY 24-25 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%) 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 so that they can develop and implement quality improvement activities targeting their low performance areas for improvement.

Some questions and answers from the full reviews are not included because they are demographic questions, were not applicable to the entity, or the FY 24-25 sample size was 0. These specific questions are referenced in the beginning of each appendix.

Appendix A: Administrative Entity Results for QA&I, C2Y3 (FY 24-25)

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

CYCLE 2, YEAR 3 (FY 24-25): 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.	15	16	94%	3	3	100%	4	5	80%	2	2	100%	6	6	100%
Q2. The AE ensures that any delegated or purchased administrative functions are established in writing pursuant to a subcontract or agreement.	12	12	100%	1	1	100%	5	5	100%	0	0	NA	6	6	100%
Q3. The AE completes monitoring of delegated or purchased administrative functions.	10	12	83%	0	1	0%	4	5	80%	0	0	NA	6	6	100%
Q4. The AE maintains written documentation of any delegated or purchased function related to incident management (IM).	14	14	100%	3	3	100%	5	5	100%	1	1	100%	5	5	100%
Q5. The AE completes monitoring of delegated or purchased IM function(s).	11	14	79%	0	3	0%	5	5	100%	1	1	100%	5	5	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.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%
Q7. The AE follows ODP's record retention policy for individual closed records. Note: Self-Assessment data reflects 100% for this question.	13	16	81%	0	3	0%	5	5	100%	2	2	100%	6	6	100%

CYCLE 2, YEAR 3 (FY 24-25): 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. Note: Self-Assessment data reflects 100% for this question.	12	16	75%	0	3	0%	5	5	100%	2	2	100%	5	6	83%
Q9. The AE has a process to manage vacated capacity to ensure waiting list emergent needs are addressed timely.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%
Q10. The AE demonstrates the management of reserved capacity for transitions to a short-term facility.	15	16	94%	3	3	100%	4	5	80%	2	2	100%	6	6	100%
Q11. The AE implements its established protocols for management of unanticipated emergencies.	15	16	94%	3	3	100%	4	5	80%	2	2	100%	6	6	100%
Q12. The AE implements the ODP Provider risk screening process.	14	14	100%	3	3	100%	4	4	100%	2	2	100%	5	5	100%
Q13. The AE has a written policy that supports the release of the incident report information upon request.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%
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.	8	16	50%	0	3	0%	4	5	80%	0	2	0%	4	6	67%
Q15. The AE conducts and documents a trend analysis to identify risks that require intervention to avoid a crisis. Note: Self-Assessment data reflects 100% for this question.	5	16	31%	0	3	0%	2	5	40%	1	2	50%	2	6	33%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q16. The AE has a policy to develop mitigation plans to address medical, behavioral, and socioeconomic crisis situations.	14	16	88%	3	3	100%	4	5	80%	1	2	50%	6	6	100%
Q17. The AE operates a Human Rights Committee (HRC) in accordance with ODP requirements. Note: Self-Assessment data reflects 98% for this question.	13	16	81%	2	3	67%	3	5	60%	2	2	100%	6	6	100%
Q16. The AE has a policy to develop mitigation plans to address medical, behavioral, and socioeconomic crisis situations.	14	16	88%	3	3	100%	4	5	80%	1	2	50%	6	6	100%
Q17. The AE operates a Human Rights Committee (HRC) in accordance with ODP requirements. Note: Self-Assessment data reflects 98% for this question.	13	16	81%	2	3	67%	3	5	60%	2	2	100%	6	6	100%
Q18. The AE engages with the Health Care Quality Unit (HCQU).	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	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.	13	16	81%	1	3	33%	4	5	80%	2	2	100%	6	6	100%
Q20. The AE conducts oversight of the Priority of Urgency of Need for Services (PUNS) as per ODP's PUNS policy.	15	16	94%	3	3	100%	5	5	100%	1	2	50%	6	6	100%
Q21. The AE provides information and resources to individuals and families.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%
Q22. The AE has a process to identify prospective individuals for waiver enrollment.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q23. The AE follows ODP's process regarding the move and transfer of ID/A Waiver individuals to another AE.	12	13	92%	2	3	67%	4	4	100%	2	2	100%	4	4	100%
Q24. The AE has a protocol for supporting individuals and families to resolve issues with SCOs and/or Providers. (*NS*)	15	16	94%	2	3	67%	5	5	100%	2	2	100%	6	6	100%
Q25. The AE implements a quality review protocol of auto-approval and authorization of ISPs.	15	16	94%	2	3	67%	5	5	100%	2	2	100%	6	6	100%
Q26. The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis. (NS) Note: Self-Assessment data reflects 83% for this question	8	16	50%	1	3	33%	2	5	40%	2	2	100%	3	6	50%
Q27. The AE promotes competitive integrated employment as a priority. Note: Self-Assessment data reflects 100% for this question	13	16	81%	1	3	33%	4	5	80%	2	2	100%	6	6	100%
Q28. **The AE has assigned a point person as a Subject Matter Expert (SME) in employment.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	100%
Q29. The AE has worked with community stakeholders to develop a local employment coalition if none exists or has enhanced its current coalition.	15	16	94%	2	3	67%	5	5	100%	2	2	100%	6	6	100%
Q30. The AE ensures that fair hearing and appeal activities are conducted in compliance with all ODP requirements.	8	8	100%	2	2	100%	3	3	100%	2	2	100%	1	1	100%

CYCLE 2, YEAR 3 (FY 24-25): 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)	15	16	94%	3	3	100%	5	5	100%	2	2	100%	5	6	83%
Q32. The AE identifies, develops, and implements strategies regarding the areas of need in the community and the resources available. (NS)	15	16	94%	3	3	100%	5	5	100%	2	2	100%	5	6	83%
Q33. *The AE qualifies AWC FMS Provider utilizing ODP standardized procedures.	2	2	100%	0	0	NA	0	0	NA	2	2	100%	0	0	NA
Q34. *The AE qualifies PROVIDER 1 utilizing ODP standardized procedures.	13	14	93%	1	2	50%	5	5	100%	2	2	100%	5	5	100%
Q35. *The AE qualifies PROVIDER 2 utilizing ODP standardized procedures. Note: Self-Assessment data reflects 100% for this question.	8	10	80%	0	2	0%	1	1	100%	2	2	100%	5	5	100%
Q36. *The AE qualifies a COMMUNITY PARTICIPATION SUPPORT (CPS) PROVIDER utilizing ODP standardized procedures.	10	10	100%	0	0	NA	4	4	100%	2	2	100%	4	4	100%
Q37. **The AE 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.	13	16	81%	0	3	0%	5	5	100%	2	2	100%	6	6	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. Note: Self-Assessment data reflects 96% for this question.	12	16	75%	0	3	0%	5	5	100%	2	2	100%	5	6	83%

CYCLE 2, YEAR 3 (FY 24-25): 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.	11	16	69%	1	3	33%	2	5	40%	2	2	100%	6	6	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. Note: Self-Assessment data reflects 94% for this question.	13	16	81%	2	3	67%	5	5	100%	2	2	100%	4	6	67%
Q41. The AE provides the SCOs and Providers with assistance to support individuals with complex physical and behavioral needs.	16	16	100%	3	3	100%	5	5	100%	2	2	100%	6	6	16
Q42. The AE worked with the individual and their team to develop mitigation strategies when there are medical, behavioral, or socio-economic crisis situations. Note: Self-Assessment data reflects 100% for this question.	5	7	71%	1	1	100%	1	1	100%	3	5	60%	0	0	NA
Q45. *The individual has an approved Annual ISP (Annual Review Update) in HCSIS.	125	126	99%	23	23	100%	40	40	100%	41	42	98%	21	21	100%
Q46. *The AE ensures the Annual ISP (Annual Review Update) is approved and authorized within 365 days of the prior Annual ISP.	105	126	83%	19	23	83%	36	40	90%	30	42	71%	20	21	95%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q47. The AE ensures that the individual's ISP includes all assessed needs and includes services that adequately address the assessed needs.	122	127	96%	22	23	96%	37	41	90%	42	42	100%	21	21	100%
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.	126	126	100%	23	23	100%	40	40	100%	42	42	100%	21	21	100%
Q49. The AE authorizes services consistent with the service definitions.	360	361	100%	52	53	98%	68	68	100%	181	181	100%	59	59	100%
Q51. *Due process rights information was provided to the individuals with a change(s) in need.	37	42	88%	2	3	67%	7	8	88%	16	19	84%	12	12	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.	1	1	100%	0	0	NA	0	0	NA	1	1	100%	0	0	NA
Q53. If Q52 is yes, the service is eligible for waiver funding.	1	1	100%	0	0	NA	0	0	NA	1	1	100%	0	0	NA
Q54. The DP 251 form is complete. [For reevaluations only.]	351	371	95%	35	53	66%	70	71	99%	186	187	99%	60	60	100%
Q55. The DP 251 is timely. [For reevaluations only.]	362	371	98%	53	53	100%	63	71	89%	186	187	99%	60	60	100%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q56. The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC. [For reevaluations only.]	2	2	100%	0	0	NA	2	2	100%	0	0	NA	0	0	NA
Q57. The medical evaluation occurs within the 365-day period prior to the QDDP signature on the DP 251. [For reevaluations only.] Note: Self-Assessment data reflects 95% for this question.	2	2	100%	0	0	NA	2	2	100%	0	0	NA	0	0	NA
Q58. The AE used the Waiver reevaluation tool to complete the reevaluation process.	370	370	100%	53	53	100%	69	69	100%	187	187	100%	61	61	100%
Q59. The annual reevaluation date is entered into HCSIS. [For reevaluations only.]	370	372	99%	51	53	96%	71	71	100%	187	187	100%	61	61	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. [For initial evaluations only.]	1	1	100%	0	0	NA	0	0	NA	1	1	100%	0	0	NA
Q61. *The AE provides notification of Due process rights at waiver enrollment.	196	196	100%	30	30	100%	34	34	100%	105	105	100%	27	27	100%
Q62. The AE completed the initial level of care (LOC) evaluation and determination prior to entry into the waiver.	195	196	99%	30	30	100%	34	34	100%	104	105	99%	27	27	100%
Q63. Certification of Need for ICF/ID or ICF/ORC LOC DP 250 completed (signed and dated).	194	196	99%	28	30	93%	34	34	100%	105	105	100%	27	27	100%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q64. The AE ensures that the program diagnosis corresponds with the correct criteria of LOC.	192	196	98%	29	30	97%	34	34	100%	102	105	97%	27	27	100%
Q65. *The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC.	194	196	99%	28	30	93%	34	34	100%	105	105	100%	27	27	100%
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.	195	196	99%	30	30	100%	34	34	100%	105	105	100%	26	27	96%
Q67. *The psychological evaluation meets ODP standards.	186	196	95%	28	30	93%	34	34	100%	99	105	94%	25	27	93%
Q68. *A QDDP certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning.	194	196	99%	29	30	97%	34	34	100%	105	105	100%	26	27	96%
Q69. *A record contains evidence that the disability occurred during the developmental period which is prior to the individual's 22nd birthday.	192	196	98%	30	30	100%	34	34	100%	103	105	98%	25	27	93%
Q70. The AE maintains documentation of financial eligibility for waiver services.	194	196	99%	30	30	100%	34	34	100%	103	105	98%	27	27	100%
Q71. Waiver services are initiated within forty-five (45) calendar days.	169	196	86%	23	30	77%	34	34	100%	88	105	84%	24	27	89%

Appendix B: ID/A SCO Results for QA&I, C2Y3 (FY 24-25)

Note: Questions 14, 15 and 18 are not included in this table because they are demographic questions.

CYCLE 2, YEAR 3 (FY 24-25): 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 100% for this question.	16	25	64%	1	3	33%	6	6	100%	5	9	56%	4	7	57%
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 99% for this question.	16	25	64%	1	3	33%	6	6	100%	5	9	56%	4	7	57%
Q3. The SCO engages in activities, or has a written policy, to improve racial equity performance. (NS)	22	25	88%	2	3	67%	6	6	100%	9	9	100%	5	7	71%
Q4. *The SCO's staff completed annual training core courses as required in the training year. (# of staff reviewed)	142	153	93%	13	15	87%	37	40	93%	59	61	97%	33	37	89%
Q5. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days	21	24	88%	2	2	100%	6	6	100%	7	9	78%	6	7	86%
Q6. SCO staff completed the required number of training hours in the training year.	21	25	84%	3	3	100%	5	6	83%	7	9	78%	6	7	86%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	23	25	92%	3	3	100%	6	6	100%	7	9	78%	7	7	100%

* 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 3 (FY 24-25): 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**	**%**
Q8. The SCO maintains written documentation of any delegated or purchased function related to incident management. Note: Self-Assessment data reflects 94% for this question.	5	8	63%	0	2	0%	2	2	100%	3	4	75%	0	0	N/A
Q9. The SCO completes monitoring of delegated or purchased incident management function(s). Note: Self-Assessment data reflects 89% for this question.	2	8	25%	0	2	0%	1	2	50%	1	4	25%	0	0	N/A
Q10. The SCO has a written policy that supports the release of the incident information upon request. Note: Self-Assessment data reflects 97% for this question.	14	25	56%	2	3	67%	4	6	67%	5	9	56%	3	7	43%
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 96% for this question.	15	25	60%	1	3	33%	5	6	83%	5	9	56%	4	7	57%
Q12. The SCO completes monthly individual incident data monitoring. Note: Self-Assessment data reflects 90% for this question.	12	25	48%	0	3	0%	5	6	83%	2	9	22%	5	7	71%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months. Note: Self-Assessment data reflects 88% for this question.	7	25	28%	0	3	0%	3	6	50%	2	9	22%	2	7	29%

CYCLE 2, YEAR 3 (FY 24-25): 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.	371	378	98%	53	53	100%	71	71	100%	183	190	96%	64	64	100%
Q17. The SC offers information about services and resources to the family.	208	257	81%	29	48	60%	44	61	72%	102	114	89%	33	34	97%
Q19. *The individual's ISP was updated when a change in need was identified.	135	139	97%	15	15	100%	37	38	97%	62	65	95%	21	21	100%
Q20. The Service Notes (SNs) met quality standards.	330	378	87%	40	53	75%	71	71	100%	157	190	83%	62	64	97%
Q21. If there were identified issues, the SC followed up on the issues.	169	199	85%	26	33	79%	46	50	92%	68	85	80%	29	31	94%
Q22. *The SC documented a risk assessment.	377	378	100%	53	53	100%	71	71	100%	189	190	99%	64	64	100%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	333	346	96%	29	29	100%	71	71	100%	170	183	93%	63	63	100%
Q24. *The SC developed a person-centered ISP to address all assessed needs.	340	378	90%	52	53	98%	63	71	89%	164	190	86%	61	64	95%
Q25. *An ISP was developed that supports the outcomes/objectives throughout the entire plan.	372	378	98%	52	53	98%	71	71	100%	187	190	98%	62	64	97%
Q26. The SC conducted all monitorings at the required frequency.	283	378	75%	36	53	68%	52	71	73%	133	190	70	62	64	97%
Q27. The SC conducted all monitoring at the required location.	290	378	77%	43	53	81%	63	71	89%	134	190	71%	50	64	78%
Q28. The Individual Monitoring Tools met quality standards.	330	378	87%	50	53	94%	67	71	94%	160	190	84%	53	64	83%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP.	320	378	85%	44	53	83%	56	71	79%	166	190	87%	54	64	84%
Q30. The SC provided due process rights information at the annual ISP meeting.	357	378	94%	52	53	98%	67	71	94%	177	190	93%	61	64	95%
Q31. *Choice of Providers was offered to the individual/family.	364	378	96%	53	53	100%	69	71	97%	178	190	94%	64	64	100%
Q32. *Choice of services was offered to the individual/family.	364	378	96%	53	53	100%	69	71	97%	178	190	94%	64	64	100%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	363	378	96%	52	53	98%	69	71	97%	178	190	94%	64	64	100%
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.	357	375	95%	53	53	100%	69	71	97%	173	189	92%	62	62	100%
Q35. The SC follows ODP's PUNS policy based on the individual's current need(s).	364	378	96%	45	53	85%	71	71	100%	184	190	97%	64	64	100%
Q36. If the individual has Limited English Proficiency, the SCO has staff or contractors/language services who are trained to communicate with the individual.	24	25	96%	2	2	100%	3	3	100%	12	13	92%	7	7	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.	377	378	100%	53	53	100%	71	71	100%	189	190	99%	64	64	100%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
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.	124	130	95%	15	15	100%	11	13	85%	70	73	96%	28	29	97%
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").	343	359	96%	52	53	98%	69	71	97%	159	171	93%	63	64	98%
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.	11	11	100%	9	9	100%	0	0	NA	1	1	100%	1	1	100%
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	95	97	98%	14	14	100%	4	5	80%	54	55	98%	23	23	100%
Q42. *The individual's identified physical and mental health care needs are addressed. Note: Self-Assessment data reflects 98% for this question.	291	378	77%	43	53	81%	48	71	68%	138	190	73%	62	64	97%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
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.	7	9	78%	1	1	100%	0	0	NA	3	5	60%	3	3	100%
Q44. The ISP includes all identified medical personnel seen during the review period.	366	378	97%	53	53	100%	71	71	100%	179	190	94%	63	64	98%
Q45. The individual's preferences for wellness activities are documented in the ISP.	378	378	100%	53	53	100%	71	71	100%	190	190	100%	64	64	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	143	143	100%	16	16	100%	58	58	100%	54	54	100%	15	15	100%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	126	143	88%	19	23	83%	17	20	85%	59	67	88%	31	33	94%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (*NS*)	40	43	93%	1	1	100%	2	2	100%	25	27	93%	12	13	92%
Q49. The SCO identified and took action for issues identified upon review of initial incident reports in EIM.	39	43	91%	0	0	NA	0	0	NA	24	28	86%	15	15	100%
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	35	36	97%	0	0	NA	0	0	NA	23	24	96%	12	12	100%

Appendix C: ID/A Provider Results for QA&I, C2Y3 (FY 24-25)

Note: Some questions are not shown in this table. Questions 8, 25 and 26 collected demographic information.

CYCLE 2, YEAR 3 (FY 24-25): 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 Quality Management Plan (QMP) and its Action Plan.	303	373	81%	53	65	82%	36	46	78%	129	156	83%	85	106	80%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	289	373	77%	51	65	78%	32	46	70%	123	156	79%	83	106	78%
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance.	373	431	87%	68	77	88%	48	57	84%	159	182	87%	98	115	85%
Q4. The Therapy Provider renders the service in a home and community location.	4	4	100%	0	0	NA	1	1	100%	1	1	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.	39	43	91%	16	17	94%	7	10	70%	1	1	100%	15	15	100%

CYCLE 2, YEAR 3 (FY 24-25): 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.	72	85	85%	20	23	87%	9	12	75%	21	26	81%	22	24	92%
Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service.	69	76	91%	9	11	82%	12	14	86%	25	26	96%	23	25	92%
Q9. The Provider has a written policy regarding individual choice when sharing a bedroom with another individual.	51	57	89%	3	5	60%	10	11	91%	18	20	90%	20	21	95%
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	56	61	92%	4	5	80%	11	11	100%	19	21	90%	22	24	92%
Q11. The Provider shall have a written policy regarding facilitating and making accommodations to assist an individual to visit with whom the individual chooses.	291	340	86%	51	59	86%	35	45	78%	129	149	87%	76	87	87%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	361	431	84%	62	77	81%	44	57	77%	154	182	85%	101	115	88%
Q13. *The Provider's staff completed annual training core courses as required in the training year.	2,747	2,996	92%	48	541	90%	367	405	91%	965	1,079	89%	883	949	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.	217	320	68%	38	53	72%	30	43	70%	84	136	62%	65	88	74%
Q15. Provider staff completed the required number of training hours in the training year.	259	336	77%	48	61	79%	28	39	72%	109	141	77%	74	95	78%
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	393	422	93%	66	73	90%	50	54	93%	172	182	95%	105	113	93%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q17. The Provider has a policy that addresses providing support to individuals with medication administration.	210	269	78%	33	44	75%	30	38	79%	96	122	79%	51	65	78%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).	363	425	85%	65	76	86%	49	57	86%	150	179	84%	99	113	88%
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management.	58	74	78%	14	15	93%	12	16	75%	17	22	77%	15	21	71%
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s).	52	72	72%	11	14	79%	10	16	63%	18	22	82%	13	20	65%
Q21. The Provider has a written policy that supports the release of the incident report information upon request.	304	431	71%	60	77	78%	37	57	65%	127	182	70%	80	115	70%
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 97% for this question.	303	431	70%	56	77	73%	36	57	63%	123	182	68%	88	115	77%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q23. The Provider completes monthly individual incident data monitoring. Note: Self-Assessment data reflects 98% for this question.	189	255	74%	39	51	76%	23	36	64%	66	89	74%	61	79	77%
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months. Note: Self-Assessment data reflects 95% for this question.	196	255	77%	37	51	73%	22	35	63%	71	90	79%	66	79	84%
Q27. **Staff are trained on the individual's communication profile and/or formal communication system. Note: Self-Assessment data reflects 96% for this question.	117	143	82%	29	31	94%	22	27	81%	40	52	77%	26	33	79%
Q28. The Provider maintains a signed statement acknowledging that the individual has received information on individual rights. Note: Self-Assessment data reflects 98% for this question.	984	1,237	80%	207	238	87%	138	169	82%	371	512	72%	268	318	84%
Q29. The individual has a current signed Department-approved room and board residency agreement on file.	468	496	94%	38	43	88%	60	62	97%	190	196	97%	180	195	92%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q30. The Department-approved room and board residency agreement is completed at least annually.	439	473	93%	36	40	90%	56	57	98%	180	184	98%	167	192	87%
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.	1,249	1,363	92%	202	218	93%	151	174	87%	522	563	93%	374	408	92%
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.	1,085	1,182	92%	224	236	95%	115	133	86%	463	513	90%	283	300	94%
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 98% for this question.	605	918	66%	118	170	69%	81	126	64%	213	329	65%	193	293	66%
Q34. The Provider delivered services in the type, scope, amount, frequency, and duration specified in the individual's ISP.	1,431	1,666	86%	282	306	92%	201	219	92%	550	665	83%	398	476	84%

CYCLE 2, YEAR 3 (FY 24-25): 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	%
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP. Note: Self-Assessment data reflects 98% for this question.	172	242	71%	48	85	56%	37	37	100%	27	52	52%	60	68	88%
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 95% for this question.	20	36	56%	8	10	80%	0	0	NA	11	23	48%	1	3	33%
Q37. **The Provider implements communication supports and services as specified in the individual's ISP to ensure effective communication. Note: Self-Assessment data reflects 100% for this question.	146	171	85%	35	36	97%	27	31	87%	48	59	81%	36	45	80%
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.	83	88	94%	17	18	94%	11	11	100%	28	30	93%	27	29	93%
Q39. The individual's ISP includes a competitive integrated employment outcome/objective(s).	104	113	92%	22	23	96%	21	21	100%	22	26	85%	39	43	91%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q40. The individual was supported to make progress towards the outcome of competitive integrated employment.	99	106	93%	20	21	95%	17	17	100%	15	19	79%	47	49	96%
Q41. The individual is supported in exploring competitive integrated employment opportunities.	106	112	95%	27	28	96%	17	17	100%	23	26	88%	39	41	95%
Q42. The Provider supports the individual in obtaining competitive integrated employment. (*NS*)	73	84	87%	28	30	93%	11	11	100%	12	19	63%	22	24	92%
Q43. The Provider supports the individual in maintaining employment.	118	120	98%	43	44	98%	12	12	100%	27	27	100%	36	37	97%
Q44. The Provider supports the individual to maintain competitive integrated employment by facilitating transportation.	49	50	98%	10	10	100%	2	2	100%	16	17	94%	21	21	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*)	13	13	100%	10	10	100%	0	0	NA	3	3	100%	0	0	NA

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
Q46. There is documentation of a fading plan or fading schedule for the individual's ongoing use as part of Supported Employment.	69	87	79%	30	35	86%	3	3	100%	22	31	71%	14	18	78%
Q47. The Provider ensures the individual completes all health care appointments, screenings, and follow-up as prescribed.	240	244	98%	29	29	100%	37	37	100%	96	98	98%	78	80	98%
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan. (*NS*)	1,359	1,457	93%	257	271	95%	172	190	91%	536	577	93%	394	419	94%
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.	37	43	86%	21	21	100%	6	6	100%	4	9	44%	6	7	86%
Q50. The Provider ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	419	454	92%	62	69	90%	89	90	99%	115	131	88%	153	164	93%
Q51. The Provider educates individuals based on the circumstances of incidents for which the Provider is required to file in EIM. (*NS*)	364	396	92%	55	64	86%	78	85	92%	87	96	91%	144	151	95%

CYCLE 2, YEAR 3 (FY 24-25): 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**	**%**
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.	272	277	98%	20	23	87%	31	32	97%	80	80	100%	141	142	99%
Q53. The individual has the right to lock their bedroom door.	272	276	99%	19	22	86%	31	31	100%	83	83	100%	139	140	99%
Q54. The individual has privacy in their home when audio and/or visual monitoring systems are used in their home.	135	136	99%	10	10	100%	3	3	100%	66	66	100%	56	57	98%
Q55. The individual chose how to decorate their bedroom and the common areas of their home such as the living room or kitchen.	290	291	100%	24	24	100%	34	34	100%	83	83	100%	149	150	99%

CYCLE 2, YEAR 3 (FY 24-25): 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 = 1/1, Northeast = 1/1, West = 2/2	4	4	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 = 1/1, Northeast = 0/1, West = 2/2 Note: Self-Assessment data reflects 100% for this question.	3	4	75%
Q58. The AWC Provider takes action and documents when the maximum allowable hours of care provided by relatives are exceeded. By region: Central = 1/1, Northeast = 1/1, West = 2/2	4	4	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 = 1/1, Northeast = 1/1, West = 2/2	4	4	100%
Q60. The AWC Provider provides MEs with information about the AWC Provider's roles and responsibilities. By region: Central = 1/1, Northeast = 1/1, West = 2/2	4	4	100%
Q61. The AWC Provider has and implements policies to ensure ME's report incidents to the AWC. region: Central = 1/1, Northeast = 1/1, West = 1/1	4	4	100%
Q62. The AWC Provider has and implements a process for analyzing customer satisfaction responses. By region: Central = 1/1, Northeast = 1/1, West = 2/2	4	4	100%
Q63. The AWC Provider utilizes customer satisfaction findings to improve AWC services. By region: Central = 1/1, Northeast = 1/1, West = 2/2	4	4	100%
Q64. The AWC Provider takes action to fulfill unmet responsibilities of the ME. By region: Central = 1/1, Northeast = 1/1, West = 1/1	3	3	100%
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 = 1/1, Northeast = 1/1, West = 1/2 Note: Self-Assessment data reflects 100% for this question.	3	4	75%

Appendix D: AAW SCO Results for QA&I, C2Y3 (FY 24-25)

Note: Demographic questions 14, 15, and 18 are not included in the following table. For the AAW, these SCO questions also did not apply, or the sample size was 0, so they are not shown in the table: 1-13, 35 and 40. Due to the small sample size for shared SCOs (9 records), some questions might lack statistical significance.

CYCLE 2, YEAR3 (FY 24-25): 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.	3	5	60%	0	0	N/A	1	1	100%	0	1	0%	2	3	67%
Q2. **The SCO uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	2	5	40%	0	0	N/A	1	1	100%	0	1	0%	1	3	33%
Q3. **The SCO engages in activities, or has a written policy, to improve racial equity performance.	8	9	89	0	0	N/A	1	1	100%	5	5	100%	2	3	67%
Q4. *The SCO's staff completed annual training core courses as required in the training year.	2	4	50%	0	0	N/A	0	1	0%	0	0	0%	2	3	67%
Q5. New SC(s) completed the required ODP SC Orientation prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual.	4	4	100%	0	0	N/A	1	1	100%	0	0	0%	3	3	100%
Q6. SCO staff completed the required number of training hours in the training year.	4	4	100%	0	0	N/A	1	1	100%	0	0	0%	3	3	100%

CYCLE 2, YEAR3 (FY 24-25): 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	%
Q7. The SCO has an Incident Management (IM) Representative that is a Certified Investigator (CI).	9	9	100%	0	0	N/A	1	1	100%	5	5	100%	3	3	100%
Q10. The SCO has a written policy that supports the release of the incident information upon request.	6	9	67%	0	0	N/A	0	1	0%	4	5	80%	2	3	67%
Q11. The SCO has a policy to monitor EIM incident reports, including but not limited to, restraint and medication error reports in order to ensure proper procedures are followed and detect abuse and neglect.	6	9	67%	0	0	N/A	0	1	0%	4	5	80%	2	3	67%
Q12. The SCO completes monthly individual incident data monitoring.	2	4	50%	0	0	N/A	0	1	0%	0	0	N/A	2	3	67%
Q13. The SCO conducts and documents a trend analysis of all incident categories at least every 3 months.	1	4	25%	0	0	N/A	0	1	0%	0	0	N/A	1	3	33%
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 100% for this question.	59	62	95%	20	20	100%	7	7	100%	14	17	82%	18	18	100%
Q17. The SC offers information about services and resources to the family.	46	48	96%	12	12	100%	5	5	100%	14	16	88%	15	15	100%
Q19. *The individual's ISP was updated when a change in need was identified.	53	56	95%	19	19	100%	5	5	100%	14	15	93%	15	17	88%

CYCLE 2, YEAR3 (FY 24-25): 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	62	89%	18	20	90%	7	7	100%	14	17	82%	16	18	89%
Q21. If there were identified issues, the SC followed up on the issues.	57	57	100%	18	18	100%	7	7	100%	15	15	100%	17	17	100%
Q22. *The SC documented a risk assessment.	62	62	100%	20	20	100%	7	7	100%	17	17	100%	18	18	100%
Q23. *The SC incorporated risk mitigation strategies into the ISP.	62	62	100%	20	20	100%	7	7	100%	17	17	100%	18	18	100%
Q24. *The SC developed a person-centered ISP to address all assessed needs.	61	62	98%	20	20	100%	7	7	100%	16	17	94%	18	18	100%
Q25. *An ISP was developed that supports the outcomes/objectives throughout the entire plan. Note: Self-Assessment data reflects 100% for this question.	57	62	92%	19	20	95%	7	7	100%	13	17	76%	18	18	100%
Q26. The SC conducted all monitorings at the required frequency. Note: Self-Assessment data reflects 87% for this question.	54	62	87%	18	20	90%	7	7	100%	11	17	65%	18	18	100%
Q27. The SC conducted all monitoring at the required location.	55	62	89%	18	20	90%	7	7	100%	13	17	76%	17	18	94%
Q28. The Individual Monitoring Tools met quality standards. Note: Self-Assessment data reflects 97% for this question.	59	62	95%	20	20	100%	7	7	100%	15	17	88%	17	18	94%

CYCLE 2, YEAR3 (FY 24-25): 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	%
Q29. *The individual received services in type, scope, amount, duration, and frequency as defined in the ISP. Note: Self-Assessment data reflects 90% for this question.	61	62	98%	20	20	100%	7	7	100%	16	17	94%	18	18	100%
Q30. The SC provided due process rights information at the annual ISP meeting. Note: Self-Assessment data reflects 100% for this question.	60	62	97%	20	20	100%	7	7	100%	15	17	88%	18	18	100%
Q31. *Choice of Providers was offered to the individual/family.	60	62	97%	20	20	100%	7	7	100%	15	17	88%	18	18	100%
Q32. *Choice of services was offered to the individual/family.	60	62	97%	20	20	100%	7	7	100%	15	17	88%	18	18	100%
Q33. *The SC provided the individual information on participant directed services (PDS) options annually.	59	62	95%	20	20	100%	7	7	100%	14	17	82%	18	18	100%
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.	2	2	100%	2	2	100%	0	0	NA	0	0	NA	0	0	N/A
Q36. If the individual has Limited English Proficiency, the SCO has staff or contractors/language services who are trained to communicate with the individual.	62	62	100%	20	20	100%	7	7	100%	17	17	100%	18	18	100%

CYCLE 2, YEAR 3(FY 24-25): 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**	**%**
Q37. **The ISP includes information about how the individual communicates and the communication supports and services the individual may need to assure effective communication.	27	29	93%	11	11	100%	1	1	100%	10	11	91%	5	6	83%
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.	61	62	98%	20	20	100%	7	7	100%	16	17	94%	18	18	100%
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").	2	2	100%	2	2	100%	0	0	NA	0	0	NA	0	0	N/A
Q41. The Employment/Volunteer section of the individual's ISP indicates that the individual has an employment goal.	19	20	95%	7	8	88%	1	1	100%	7	7	100%	4	4	100%
Q42. *The individual's identified physical and mental health care needs are addressed.	61	62	98%	20	20	100%	7	7	100%	16	17	94%	18	18	100%

CYCLE 2, YEAR 3(FY 24-25): 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	%
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.	7	7	100%	1	1	100%	1	1	100%	2	2	100%	3	3	100%
Q44. The ISP includes all identified medical personnel seen during the review period.	58	62	94%	20	20	100%	6	7	86%	15	17	88%	17	18	94%
Q45. The individual's preferences for wellness activities are documented in the ISP.	62	62	100%	20	20	100%	7	7	100%	17	17	100%	18	18	100%
Q46. **If the individual has complex needs, the SC ensured there are strategies for supports in place to address those needs.	57	57	100%	18	18	100%	7	7	100%	15	15	100%	17	17	100%
Q47. The SCO ensures all reportable incidents are documented in the Enterprise Incident Management (EIM) system as required.	18	19	95%	2	3	67%	1	1	100%	7	7	100%	8	8	100%
Q48. The SCO educates individual based on the circumstances of incidents for which the SCO is required to file in EIM. (NS)	6	7	86%	1	2	50%	0	0	NA	2	2	100%	3	3	100%
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.	5	6	83%	1	2	50%	1	1	100%	1	1	100%	2	2	100%

CYCLE 2, YEAR 3(FY 24-25): 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**	**%**
Q50. The SCO identified and took action for issues identified upon review of final incident reports in EIM.	4	5	80%	1	2	50%	1	1	100%	1	1	100%	1	1	100%

Appendix E: AAW With Shared Provider Results for QA&I, C2Y3 (FY 24-25)

Note: Demographic questions 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, 25-30, 36-47, 49-55.

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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 Quality Management Plan (QMP) and its Action Plan.	40	45	89%	7	8	88%	7	7	100%	15	18	83%	12	12	100%
Q2. **The Provider uses data to assess progress towards achieving identified person-centered Quality Management Plan (QMP) goals and its Action Plan target objectives.	40	45	89%	7	8	88%	6	7	86%	15	18	83%	12	12	100%
Q3. **The Provider engages in activities, or has a written policy, to improve racial equity performance.	42	45	93%	8	8	100%	6	7	86%	18	18	100%	10	12	83%
Q5. The transportation trip Provider has a policy to ensure that there is an aide in the vehicle when transporting more than six individuals.	5	5	100%	2	2	100%	0	0	NA	0	0	0%	3	3	100%
Q6. The Provider issued written notice to all required parties within the required time frames when transitioning an individual to another service Provider.	7	7	100%	2	2	100%	0	0	NA	3	3	100%	2	2	100%

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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**	**%**
Q7. The Provider continued to provide the authorized service(s) during the transition period to ensure continuity of service.	6	6	100%	1	1	100%	0	0	NA	3	3	100%	2	2	100%
Q8. Enter the number of individuals who have transitioned from prevocational services to competitive integrated employment during the review period. Enter N/A for AAW only Providers or if the Provider did not render the applicable service(s) during the review period.	3	3	100%	0	0	N/A	0	0	NA	2	2	100%	1	1	100%
Q9. The Provider has a written policy regarding individual choice when sharing a bedroom with another individual.	9	9	100%	0	0	NA	1	1	100%	4	4	100%	4	4	100%
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.	10	10	100%	0	0	NA	1	1	100%	5	5	100%	4	4	100%

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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.	42	44	95%	8	8	100%	7	7	100%	18	18	100%	9	11	82%
Q12. The Provider shall have written procedures to receive, document, manage, and respond to complaints regarding the delivery of a service.	36	45	80%	4	8	50%	7	7	100%	14	18	78%	11	12	92%
Q13. *The Provider's staff completed annual training core courses as required in the training year.	28	43	65%	6	8	75%	7	9	78%	8	14	57%	7	12	58%
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.	23	40	58%	4	6	67%	5	7	71%	8	15	53%	6	12	50%
Q15. Provider staff completed the required number of training hours in the training year.	31	35	89%	6	6	100%	6	6	100%	10	13	77%	9	10	90%
Q16. The Provider has a policy on sexual health, personal relationships, and sexuality consistent with the guidelines.	44	45	98%	7	7	100%	7	7	100%	18	18	100%	11	12	92%

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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**	**%**
Q17. The Provider has a policy that addresses providing support to individuals with medication administration.	33	38	87%	5	7	71%	5	7	71%	15	15	100%	8	9	89%
Q18. The Provider has an Incident Management (IM) Representative that is a Certified Investigator (CI).	44	46	96%	7	8	88%	6	6	100%	17	18	94%	12	12	100%
Q19. The Provider maintains written documentation of any delegated or purchased function related to incident management.	8	8	100%	2	2	100%	3	3	100%	3	3	100%	0	0	NA
Q20. The Provider completes monitoring of delegated or purchased incident management (IM) function(s).	8	8	100%	2	2	100%	3	3	100%	3	3	100%	0	0	NA
Q21. The Provider has a written policy that supports the release of the incident report information upon request. Note: Self-Assessment data reflects 100% for this question.	29	44	64%	4	8	50%	6	7	60%	11	18	61%	8	11	73%
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 99% for this question.	30	45	67%	3	8	38%	6	7	86%	11	18	61%	10	12	83%

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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	%
Q23. The Provider completes monthly individual incident data monitoring. Note: Self-Assessment data reflects 99% for this question.	21	32	66%	3	6	50%	4	7	57%	7	8	88%	7	11	64%
Q24. The Provider conducts and documents a trend analysis of all incident categories at least every 3 months. Note: Self-Assessment data reflects 99% for this question.	22	32	69%	3	5	60%	4	6	67%	8	10	80%	7	11	64%
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.	2	2	100%	0	0	NA	1	1	100%	0	0	NA	1	1	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.	2	2	100%	0	0	NA	1	1	100%	0	0	NA	1	1	100%
Q33. The progress notes indicate how progress will be addressed if there was a lack of progress on a desired outcome. (C2Y3 AAW only Providers=2 record reviews, and both were NA for this question)	0	0	0%	0	0	NA	0	0	NA	0	0	NA	0	0	NA
Q34. The Provider delivered services in the type scope amount frequency and duration specified in the individual's ISP.	2	2	100%	0	0	NA	1	1	100%	0	0	NA	1	1	100%

CYCLE 2, YEAR 3 (FY 24-25): AAW With Shared 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**	**%**
Q35. The Provider implemented the individual's back-up/contingency plan as specified in the ISP.	1	1	100%	0	0	NA	0	0	NA	0	0	NA	1	1	100%
Q48. The Provider has ensured that the individual is able to pursue their preferred wellness activities as identified in the Individual Plan.	2	2	100%	0	0	NA	1	1	100%	0	0	NA	1	1	100%

Appendix F: Variation Responses for QA&I, C2Y3 (FY 24-25)

C2Y3 VARIATION RESPONSES: ADMINISTRATIVE ENTITIES	#	%
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	94%
(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.	1	6%
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.	14	88%
(No) The AE has a policy, however, one or more of the identified requirements were not satisfied.	2	12%
(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.	13	93%
(No) The AE has a protocol but one or more of the requirements is not met.	1	7%
(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.	16	100%
(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.	0	0%
Q24. The AE has a protocol for supporting individuals and families to resolve issues with SCOs and/or Providers. (NS)		
(Yes) The AE has a protocol.	15	94%
(No) The AE has a protocol, but it does not include the areas identified.	1	6%
(No) The AE does not have a protocol.	0	0%

C2Y3 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.	15	94%
(No) The documentation provided does not demonstrate that the AE completed a quality review of auto approved and authorized ISPs.	0	0%
(No) The AE does not have a protocol to complete a quality review of auto approved and authorized ISPs.	1	6%
Q26. The AE evaluates trends in ISP disapprovals and engages in technical assistance based on trend analysis. (NS)		
(Yes) The AE evaluates trends in ISP disapprovals and engages in TA as needed to improve the quality of ISPs.	8	50%
(No) The AE evaluated trends in ISP disapprovals and did not engage in TA as needed to improve the quality of ISPs.	5	31%
(No) The AE did not evaluate trends in ISP disapprovals and did not engage in TA as needed to improve the quality of ISPs.	3	19%
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.	15	94%
(No) The information reviewed does not demonstrate sufficient activities by the AE to expand and build the capacity of the Provider network.	1	6%
(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.	4	25%
(Yes) The AE used person-centered performance data to develop the QMP and its Action Plan.	9	56%
(No) The AE does not have a QMP and its Action Plan.	3	19%
(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.	8	50%
(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.	3	19%
(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%

C2Y3 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.	13	81%
(No) The documentation provided does not sufficiently demonstrate training attendance.	2	13%
(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 prior to the ARUD.	142	83%
(No) The AE did not approve the ISP prior to ARUD.	25	15%
(No) There is not an Annual ISP (Annual Review Update) approved for the individual.	3	2%
Q54. The DP 251 form is complete. [For reevaluations only.]		
(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.	351	95%
(No) The DP 251 is missing either the signature or date.	20	5%
(No) The DP 251 is not in the individual's file.	0	0%
Q55. The DP 251 is timely. [For reevaluations only.]		
(Yes) The DP 251 is timely.	362	98%
(No) The DP 251 is not timely.	3	0.8%
(No) The DP 251 is not in the individual's file.	6	0.2%
Q56. The medical evaluation includes a recommendation for an ICF/ID or ICF/ORC LOC. [For reevaluations only.]		
(Yes) The LOC recommendation is indicated on the medical evaluation.	2	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. [For reevaluations only.]		
(Yes) The medical evaluation is dated within 365 days prior to the QDDP signature.	2	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.	371	100%
(No) There is no annual reevaluation date in HCSIS.	0	0%
(No) The annual reevaluation date is incorrect (old).	2	0.5%

C2Y3 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.	6	24%
(Yes) The SCO used person-centered performance data to develop the QMP and its Action Plan.	10	40%
(No) The SCO does not have a QMP and its Action Plan.	4	16%
(No) The SCO has a QMP and its Action Plan but did not use person-centered performance data to develop it.	5	20%
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.	13	52%
(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.	3	12%
(No) The SCO does not have a QMP and its Action Plan.	3	12%
(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.	5	20%
(No) The SCO has a QMP and its Action Plan but did not use person-centered performance data to develop it.	1	4%
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.	23	92%
(No) There is no evidence that the SCO has an IM Representative.	2	8%
(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.	133	96%
(Yes) The SC documented justification if the ISP was not updated when change(s) in need were identified.	2	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.	4	3%
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.	169	94%
(No) The SC did follow up on identified issues but did not notify the Provider.	7	4%
(No) The SC did not follow up on identified issues.	23	12%

C2Y2 VARIATION RESPONSES: ID/A SCOs *(continued)*	#	%
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.	378	99.7%
(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	0.3%
(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).	291	77%
(No) Any of the identified physical and mental health care needs are not addressed.	60	16%
(No) The SC did not document follow-up on identified physical and mental health care needs.	27	7%

C2Y3 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.	221	60%
(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan.	82	22%
(No) The Provider does not have a QMP and its Action Plan.	34	9%
(No) The Provider has a QMP and its Action Plan but did not use person-centered performance data to develop it.	36	10%
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.	197	53%
(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.	92	25%
(No) The Provider does not have a QMP and its Action Plan.	35	9%
(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.	40	11%
(No) The Provider has not updated the QMP in more than 3 years.	1	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").	8	2%
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.	56	92%
(No) The Provider has a policy; however, one or more of the identified requirements were not satisfied.	3	5%
(No) The Provider does not have a policy.	2	3%
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.	361	84%
(No) The Provider has written procedures however; it does not include all requirements.	62	14%
(No) The Provider does not have written procedures.	8	2%

C2Y2 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.	393	93%
(No) The Provider has a policy; however, it is inconsistent with the guidelines identified in ODP Bulletin 00-18-01.	13	3%
(No) The Provider does not have a policy.	16	4%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. *(NS)*		
(Yes) The Provider has a policy that addresses providing supports to individuals with medication administration.	210	78%
(No) The Provider has a policy; however, one or more of the identified requirements were not met.	31	12%
(No) The Provider does not have a policy.	28	10%
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.	363	85%
(No) There is no evidence that the Provider has an IM Representative.	42	10%
(No) The IM Representative did not have a CI certificate within the required timeframe.	20	5%

C2Y2 VARIATION RESPONSES: AAW SCOs	#	%
Q19. *The individual's ISP was updated <u>when</u> a change in need was identified.		
(Yes) The ISP was updated when change(s) in need were identified.	52	93%
(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.	4	7%
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.	50	88%
(No) The SC did follow up on identified issues but did not notify the Provider.	0	0%
(No) The SC did not follow up on identified issues.	7	12%
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.	62	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).	55	89%
(No) Any of the identified physical and mental health care needs are not addressed.	6	10%
(No) The SC did not document follow-up on identified physical and mental health care needs.	1	2%

C2Y3 VARIATION RESPONSES: PROVIDERS of AAW Services	#	%
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.	25	58%
(Yes) The Provider used person-centered performance data to develop the QMP and its Action Plan.	15	35%
(No) The Provider does not have a QMP and its Action Plan.	1	2%
(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.	26	60%
(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.	13	30%
(No) The Provider does not have a QMP and its Action Plan.	1	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.	3	7%
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.	37	79%
(No) The Provider has written procedures however; it does not include all requirements.	10	21%
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.	45	98%
(No) The Provider has a policy; however, it is inconsistent with the guidelines identified in ODP Bulletin 00-18-01.	1	2%
Q17. The Provider has a policy that addresses providing support to individuals with medication administration. *(NS)*		
(Yes) The Provider has a policy that addresses providing supports to individuals with medication administration.	30	88%
(No) The Provider has a policy; however, one or more of the identified requirements were not met.	3	9%
(No) The Provider does not have a policy.	1	3%

C2Y3 VARIATION RESPONSES: AAW PROVIDERS	#	%
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.	2	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%