

QUESTIONS ON THE 2011 QUALITY MANAGEMENT SELF-ASSESSMENT PROCESS

Question categories that makeup these frequently asked questions include:

- general
- policies and procedures
- self-assessment standards
- provider reviews and evidence that providers meet required standards

GENERAL QUESTIONS

1. If our agency completed the 2010 Self-Assessment will we need to complete the 2011 Self-Assessment?

Yes. The completion of the self-assessment will be an annual requirement for each provider of the applicable services. The submission due date for the submission of the 2011 Provider Quality Management Self-Assessment is November 1, 2011.

2. Will feedback be provided to providers on the self-assessment after the November 1, 2011 submission?

Yes. The provider will receive acknowledgement that the self-assessment has been received and routed to the regional HCBS specialist. The HCBS specialist will send email correspondence to providers that the self-assessment has been accepted OR if the self-assessment indicates non-compliance with current Iowa Administrative Code (IAC) standards and an acceptable corrective action plan was not identified, if the provider selected no as a response and did not identify an acceptable corrective action plan or if additional information is needed.

3. Is there a license requirement for the staff responsible for QI plan? For example: if a paraprofessional is interested in extra duties, would that person be able to manage the QI plan or does it require an RN?

There are no minimum qualifications or licensing requirements for staff responsible for the development or oversight of the provider's Quality Improvement (QI) plan.

4. Is the state going to use the information it gathers in this process in its dealings with the Centers for Medicaid and Medicare Services (CMS)?

The State of Iowa will be using data gathered through its oversight process as evidence of the State's efforts to meet the expectations of CMS' Quality Framework.

5. If an agency only has Habilitation services, will Chapter 24 continue to accredit for services since they are not reviewing the files?

The self-assessment process is not a replacement for accreditation of services. Rather, the self-assessment looks at quality issues of a provider. If the agency is enrolled to provide services by meeting the standards under IAC 441-Chapter 24, it is anticipated that the accreditation process for those services will continue.

6. We would love to see more information/examples on documentation – specifically looking for QA techniques in reference to documentation requirements.

Available resources are the self-assessment and IAC 441-Chapter 79.3 which identifies the standards for documentation. You may also wish to contact your provider association for assistance in this area. You can also access the IME documentation training at: www.ime.state.ia.us/Providers/TrainingSchedule.html

You may also check the HCBS FAQ at:

http://www.ime.state.ia.us/HCBS/HCBS_FAQs.html

In addition, resources are available at: www.hcbs.org

7. Are there any provider meetings occurring where people are brainstorming/sharing how they are doing QA/QI in their agencies? We would be very interested in this.
It is recommended you contact your provider association regarding this topic. Information on quality improvement activities is also available at www.hcbs.org
8. Do accountability levels (thresholds) need to be submitted to HCBS for approval?
It will be the provider's responsibility to provide evidence of their Quality Improvement (QI) activities upon request. The HCBS program will not be involved in "approving" provider-established thresholds.
9. Will the accreditation requirement for prevocational and day habilitation be removed with the implementation of this process?
As mentioned above, the self-assessment process is for addressing quality issues of the provider, and is not intended to replace accreditation requirements. There are no plans at this time to change provider enrollment criteria for these services.
10. Are we talking fiscal or annual year in reference to the 2011 Self-Assessment?
The 2011 Self-Assessment pertains to the calendar year.
11. What do we record when some of the required policies and procedures do not apply? For example, we don't use restraints, we have no policy (we don't need one) and we don't do behavioral plans.
The provider policy should reflect that the agency does not engage in the practice/process that the self-assessment requirement addresses.
12. Does the CARF accreditation process still apply to enrollment/certification for day habilitation, etc.?
See # 5 and #9 above. There are no changes being made in the enrollment criteria at this time for services requiring the completion of the self-assessment.
13. Regarding the QI plan – how are timelines determined for remediation and improvement?
The provider develops and identifies the timelines through the establishment of their quality improvement plan.
14. Will the 2011 timeline be the same as the 2010?
The 2011 Self-Assessment will be available on August 1, 2011 and the required submission date will be November 1, 2011.
15. Will providers still do an annual SA - no matter where they are in the onsite review cycle?
Yes, as the completion of the self-assessment will be an annual requirement for each provider enrolled in the applicable services.
16. Can providers use the same QI reporting format to Waiver as they do to CARF?
The HCBS program has not identified a "reporting format" that must be used. The self-assessment does identify the mandatory areas for review that must be included in the provider's QI Plan.

17. How soon after November 1, 2011 will providers hear back from the IME whether they are eligible to provide services?

The self-assessment will only impact a provider's "eligibility" if they do not comply with requests to submit a completed self-assessment or there is evidence of the provider's refusal to be in compliance with the Iowa Administrative Code (IAC) standards.

Providers who submit a completed self-assessment will receive acknowledgement of its receipt. Based on the volume of self-assessments that will be received, providers should not expect to be notified by their regional HCBS specialist unless the self-assessment indicates non-compliance with current IAC standards, or if additional information is needed.

18. Will the self-assessment include Elder Group Homes?

If the Elder Group Home is enrolled in any of the services that requires the self-assessment, then yes. The self-assessment focuses on specific services, rather than the settings where the service is provided. A complete listing of the services that the self-assessment applies to can be found in Informational Letter No.1030 and also on our website at www.ime.state.ia.us/HCBS/ReviewTools.html using the "applicable services" link.

19. What is that email address for QI questions?

hcbsqi@dhs.state.ia.us or contact your area HCBS Specialist
http://www.ime.state.ia.us/docs/HCBS_Specialists.pdf

20. If a Specialist finds something, what is the timeline for our agency to respond?

If the Specialist finds something that the provider needs to address, the correspondence with the provider will identify any required changes and timelines.

21. What are we submitting by November 1, 2011?

The completed 2011 Self-Assessment is to be submitted by November 1, 2011. The self-assessment is considered complete when all sections of the form have been completed in their entirety and the "Guarantee of Accuracy" has been received by the IME. When a provider has identified areas of non-compliance with current IAC standards, the self-assessment must identify a plan of corrective action.

The "Guarantee of Accuracy" statement requires the signature of the agency director as well as the president of the governing body. Factor the time needed to obtain these signatures when developing your submission timeline.

22. Can the "Guarantee of Accuracy" page be scanned and emailed to the IME?

No, it will need to be faxed or mailed.

23. How do I terminate services if I find that my agency is enrolled to for a service that we no longer provide?

When a provider wishes to terminate their enrollment in services, Provider Services requires the provider to submit a written request that identifies:

- NPI number
- Tax ID Number (EIN)
- Explanation of the action they want provider services to take, i.e., specific services and programs they want terminated
- Fax number so that the IME can contact them if additional information is needed

- The provider request must be **signed and dated**.

The provider may submit the request by fax **(515) 725-1155**:

To: IME Provider Services
Subject: changes

24. If our agency intends to disenroll from a service should we do so before we complete the self-assessment?

Yes. If you have requested to terminate a service, notify Provider Services as instructed in the previous response. A few weeks after the request is submitted you may wish to do a follow-up call to Provider Services to ensure the requested termination of services has occurred.

25. When you ask for office sites, do you want us to list service locations (i.e. if our agency has RBSCL sites)?

No, you should only list the locations at which the agency operates a office, i.e., satellite office.

26. How many versions of the 2011 Self-Assessment will be available?

There is only one version of the 2011 Self-Assessment

27. How do HCBS certified providers factor in this process?

HCBS certification is a separate process. The self-assessment is about Quality Improvement, not certification. You should continue to expect involvement from other entities responsible for certification of services.

28. Will the on-site reviews that will occur every five years at a minimum be for each service provision separately?

No. The HCBS on-sight review will look at all of the applicable services the agency is enrolled for.

QUESTIONS RELATED TO POLICIES AND PROCEDURES

29. Is there a standard form or something to help write these policies & procedures?

The HCBS program does not provide templates for the development of policies. It is recommended providers use the self-assessment as a guide when developing the policies as it identifies the minimum components that are to be included in the policies.

**Please review the “Navigation Help” and “Rule References” documents posted on the web site for direction on how to access the IAC in order to determine the current standards for each service. These materials are on our website at:
<http://www.ime.state.ia.us/HCBS/HCBSindex.html>**

30. Are you looking for a separate policy book for waiver services/IME services or could we use policies already in place?

It is not necessary to maintain a separate policy book specific to HCBS services. A provider may use existing policies if these meet the requirements identified on the self-assessment.

31. Is it possible for the provider to put the 12 mandatory QI areas into a multi-year review cycle versus annually? For example: 4 areas annually on a three-year cycle (with the exception if incident reporting which would continue to be done annually as we already have a system set up for that).

The requirement identified in the self-assessment is that each of the 12 areas will be reviewed at least annually.

32. When should the policy and procedure book be completed and part of our compliance process?

The provider's policies and procedures are expected to be completed by the dates identified in your responses on the self-assessment.

33. Do we need to attach our policy and procedures at the time the assessment is due?

Providers should not submit any policies or procedures unless they receive a specific request for this information from the HCBS program.

34. Do we need to formally address mandatory QI subjects for things that don't relate to our agency?

The provider should review the policy developed for each of the requirements on an annual basis to ensure the policy and procedures have not undergone changes.

35. Our agency has a lot of informal procedures currently identified on the checklist. Do we need formal policies?

It is necessary to develop written policies and/or procedures to support each of the requirements identified on the self-assessment. Informal procedures should be incorporated into the agency's written policies.

36. Our agency has written procedures, but not policies (because they require board approval). Is that acceptable?

Yes, so long as they are documented in writing, are consistent with IAC and self-assessment requirements, and the agency is committed to following them. Section E of the self-assessment requires the signature of the Executive Director and Chairperson of the Board of Directors on the "Guarantee of Accuracy." Their signatures assure the information on the self-assessment is accurate and verifiable.

37. If a policy or procedure is not currently supported by rule what do we put as an explanation?

It is acceptable to identify that your agency will come into full compliance by the date in which the Iowa Administrative Code supports a proposed standard.

QUESTIONS RELATED TO SELF-ASSESSMENT STANDARDS

38. **Section D, Area II:** Providers are required to meet the following training requirements. It talks about full and part time employees. How does this effect on-call status employees and independent contractors?

Part-time employees will continue to include anyone not meeting the definition of a full-time staff. The provider is responsible for ensuring independent contractors also meet these training requirements.

39. **Section D, Area II:** Providers are required to meet the following training requirements. It talks about during the first year and every year thereafter. Does this mean calendar year or employment year?

The Residential Based Supported Community Living (RBSCL) service and Children's Mental Health (CMH) waiver have specific staff training requirements that are to be completed during the individual staff's first year and each ongoing year. For all other staff training, the requirements, as identified in the instructions for the self-assessment, are to be met each calendar year.

Section D, Area III Requirement C: Services Plans. For providers is this the Individualized Treatment Plan (ITP) or does this mean the Case manager's service plan?

The self-assessment reflects the requirements that have been established for providers of the applicable services. This reference to service plans would refer to the provider's plan.

40. Each of the service areas that we have – HCBS and Habilitation- all have unique NPI numbers. On the self-assessment where it asks for the NPI number, do you want me to put all of them on the one line or how would you like me to handle this?

For each location you indicate in Section C, include all the NPI numbers related to that location. That would be sufficiently clear for us, and keep you from having to type the same location over and over again.

41. Do I need to complete Section C for each of our 24-hour HCBS sites? Do I need to do anything for clients who receive hourly services?

The intent of this section is to capture the location of offices that a provider has. If there is an agency (satellite) office located at each of the service sites, that information should be noted in this section. This section was not designed to capture consumer specific information.

42. **Section D, Requirement I** Providers are required to establish & maintain fiscal accountability. At a minimum there will be evidence of documentation to support planning and tracking the use of consumer items (specific to SCL & RBSCL, home based habilitation and family and community support services service). Since tied to finances - how specifically? Rate setting establishment based upon individual needs? Tied to the compensatory? \$1570?

The requirement that there is evidence of documentation to support planning and tracking the use of consumer items is specific to Supported Community Living, Residential Based Supported Community Living services, Home-based habilitation and Family and Community Support services. The documentation is required for the specific expenditures that are determined necessary by the consumer's interdisciplinary team and authorized in the targeted case manager's service plan. The total costs of these items cannot exceed \$1570 per consumer per year (\$1500 for CMH waiver), and must be supported by costs allocated to lines 3290, 3520, and 4320 on the Schedule Ds.

43. We need assistance understanding some terminology in the self-assessment. For instance:

- What do the acronyms SCL and RBSCL stand for (so we'll know how to respond)?

A key explaining acronyms used in the self-assessment is located on our website at www.ime.state.ia.us/HCBS/ReviewTools.html and will identify, in part that:

SCL = Supported Community Living; RBSCL = Residential-Based Supported Community Living.

As identified on the acronym key, IDT = Interdisciplinary Team. The requirement for reviewing the presence of due process is specific to the consumers served.