State of Connecticut

Department of Developmental Services

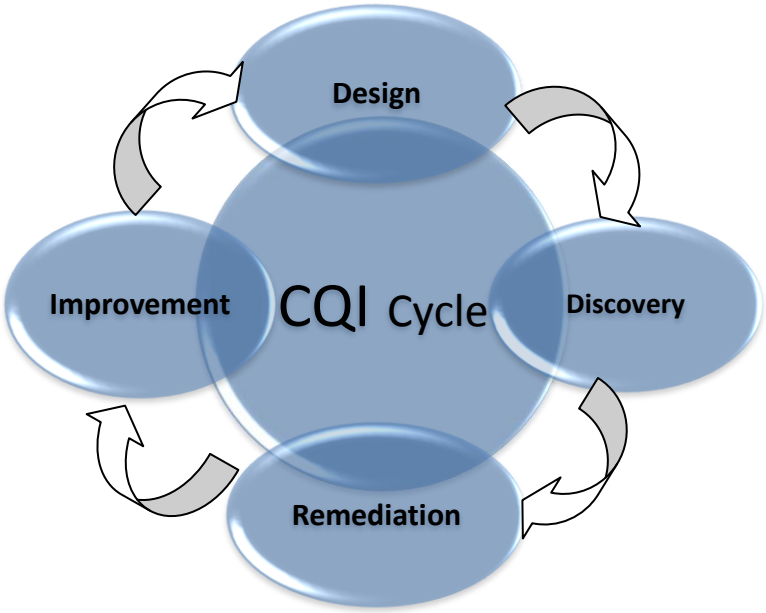
Individual and Family Support

Independence Plus Home and Community-Based Services Waiver

CMS Control Number 0426-R01-IP

February 1, 2008 – January 1, 2011

Evidence of Implementation of Quality Management and Improvement Strategy



STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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April 21, 2011

Mr. Richard McGreal, Associate Regional Administrator
Department of Health and Human Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

Dear Mr. McGreal:

Attached please find Connecticut's response to the Center for Medicare and Medicaid Services (CMS) request for evidence regarding the State's quality management and improvement strategy for the HCBS Waiver control number 0426.R01-IP. This waiver provides services to individuals who meet the State's criteria for care in an intermediate care facility for mental retardation (ICF/MR).

The enclosed notebook outlines the steps the state has implemented regarding oversight activities of its quality management and improvement strategy. We look forward to discussing the evidence package with your staff and provide any follow up information that may be required.

Please contact Debra Duval at 860-418-6149 or Kathy Bruni at 860-424-5177 with any questions related to the evidence package.

Sincerely,

Roderick L. Bremby
Commissioner

RLB:KB:scs

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www.ct.gov/dss

State of Connecticut, Department of Developmental Services
Individual and Family Support
Independence Plus Home and Community-Based Services Waiver
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IFS, Evidence Report:

February 1, 2008 – January 1, 2011

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State of Connecticut and the Government Structure

www.CT.gov

Within its compact borders, Connecticut has forested hills, new urban skylines, shoreline beaches, white-steeple colonial churches, and historic village greens. There are classic Ivy League schools, modern expressways, great corporate offices, and small farms. Connecticut is a small but beautiful state and a vacation destination for many. It is both a New England state, and a suburb to New York City.

Name of State: Connecticut

Statehood: January 9, 1788 (5th state)

Nickname/Official Designation: "The Constitution State" was adopted by Act of the Legislature, 1959.

Name Origin/Indian: *Quinnehtukqut* -- Mohegan for "Long River Place" or "Beside the Long Tidal River"

Capitol: Hartford, the sole Capital City since 1875

Governor: Dannel P. Malloy

State Motto: *Qui Transtulit Sustinet* -- "He Who Transplanted Still Sustains"

Population: The population of Connecticut was 3,405,565 according to the 2000 U.S. Official Census. The most recent population estimate from the Connecticut Department of Public Health is 3,409,549 as of July 1, 2000.

Cities with largest population (2000):

1. Bridgeport 139,529
2. New Haven 123,626
3. Hartford 121,578
4. Stamford 117,083
5. Waterbury 107,271

Connecticut is just about 5,018 square miles, has eight counties, 169 towns, 21 cities and nine boroughs. Connecticut has no county government. Below the state level, governing units are either cities or towns.

State government in Connecticut has three branches: executive, legislative, and judicial. Voters elect six state officers: Governor, Lieutenant Governor, Secretary of State, Treasurer, Comptroller and Attorney General. All have four year terms. Connecticut voters also elect two U.S. Senators and five U.S. Representatives.

The General Assembly or legislature has a Senate and a House of Representatives. Members of both houses represent districts based strictly on population. Currently, there are 36 state senators and 151 state representatives.

The Judicial Department is composed of the Superior, Appellate and Supreme courts. Except for probate judges, who are elected by the voters of the town or district they serve, all judges are nominated by the governor and appointed by the General Assembly.

DDS, as other state agencies, serves the people of Connecticut through a regional structure (North, South and West) that reflects population density. The Commissioner of DDS serves at the pleasure of the Governor.

Connecticut Department of Developmental Services Overview

History: www.ct.gov/dds

The Department of Developmental Services (DDS) has a long history in the State of Connecticut. As early as 1917, services for individuals with mental retardation were largely provided at the Mansfield Training School until 1940 when the Southbury Training School was opened. Eventually these facilities, along with "Regional Centers" established in the 1960's, were overseen by the Office of Mental Retardation, a division of the State Department of Health.

In 1975 the Connecticut General Assembly established an independent Department of Mental Retardation (P.A. No. 75-638). The department has been a department in the executive branch, headed by a Commissioner appointed by the Governor, since that time. Although DDS continues to directly operate both congregate and community-based services and supports, the department's focus has largely become community-based relying upon a public/private partnership.

The result is a statewide system which provides support and services to persons with intellectual disabilities who reside in family homes, independently, in state-operated facilities, in licensed "community training homes" and in over 830 licensed/certified "community living arrangements." Since 1987, most services and supports provided by DDS have been subject to federal reimbursement under Home and Community Based Waivers (Medicaid) which are approved by the Center for Medicaid and Medicare Services (CMS).

In 2007, the department changed its name from the Department of Mental Retardation to the Department of Developmental Services. This change reflects the mission and commitment of the department to serve individuals eligible for services with the utmost respect and dignity.

The Department's Mission

The mission of DDS is to join with others to create the conditions under which all people with mental retardation experience:

- presence and participation in Connecticut town life;
- opportunities to develop and exercise competence;
- opportunities to make choices in the pursuit of a personal future;
- good relationships with family members and friends;
- respect and dignity.

In addition the department: respects the individual and values personal initiative; fosters partnerships among individuals, families and communities; promotes full employment and access to quality health care and desirable housing; recognizes the importance of families and supports them; contributes to the social and economic future of Connecticut and supports individuals served by DDS to do the same; creates a work culture where teamwork and collaboration prevail; supports the capacity of communities to include all their residents.

Services and Trends

The department provides services to Connecticut citizens with intellectual disabilities resulting in an IQ below 70 or Prader-Willi syndrome, participants in the Autism Pilot and to infants and toddlers with significant developmental delays who are enrolled in the Birth to Three program. Persons with intellectual disabilities have much in common with non-disabled citizens in Connecticut, although individuals who have intellectual disabilities often need lifelong support to exercise their rights and to become full and contributing members of their communities. As of June 30, 2010, the Department of Developmental Services was serving 20,761 persons, including those enrolled in the Birth to Three program. DDS also operates a pilot program for adults with autism spectrum disorder but not mental retardation as a result of Section 37 of Public Act 06-188. This pilot served 35 individuals with autism in the greater New Haven area and 30 in the Hartford area in SFY10.

PEOPLE SERVED BY DDS (as of June 2010)				
Age Range	**In Home**	**Out of Home**	**Total**	**Pct of Total by Age**
Birth to Three (0 – 2)	5,273	0	5,273	**25%**
Children (3 – 17)	2,481	181 **(7%)**	2,662	**13%**
Young Adults (18 – 21)	1,234	292 **(19%)**	1,526	**7%**
Adults (22 and older)	4,092	7,190 **(63%)**	11,282	**55%**
Total	13,097	7,664 **(37%)**	20,761	**100%**
Percent of total by Location	**63 %**	**37 %**	**100%**	

Most traditional services and all new development of residential supports are contracted though private providers. DDS continues its closure of admissions to public day and residential services as a result of budget reductions. The public sector continues to provide support to its remaining consumers focusing on individuals with significant medical or behavioral needs and the provision of respite and in-home family supports for individuals still living with their families (over 60% of those served by DDS public services).

DDS currently operates two Home and Community Based Services (HCBS) Waivers serving approximately 8600 people. DDS has just received approval from CMS for an additional waiver designed to serve individuals whose needs can be met with a smaller package of supports than what is offered in the other two waivers with a focus on employment.

Key Councils and Committees

The Council on Developmental Services was established to advise and consult on issues affecting the department of Developmental Services (DDS) its programs and services for Connecticut residents with "intellectual disabilities" and their families. In consultation with the Commissioner of Developmental Services, the Council recommends to the Governor and the Connecticut General Assembly legislation that would enhance and improve the quality of the programs and services provided by the department. The Council, with input from the public, advocates for all persons with intellectual disabilities in Connecticut and provides input on quality improvement issues.

The Council is comprised of thirteen members appointed as follows: "eight members are appointed by the Governor including a doctor of medicine, a person with intellectual disabilities receiving services from the department, and at least two people who are parents or guardians of persons with intellectual disabilities. Four members are appointed by the General Assembly, one a parent or guardian appointed by the speaker of the House, one appointed by the minority leader of the House, one appointed by the president pro tempore of the Senate and one a parent or guardian appointed by the minority leader of the Senate". These members are appointed to serve for two-year terms. Finally, one appointment to the council is required to be a member of the board of trustees of the Southbury Training School and is appointed by the board for a term of one year. The Commissioner of the Department of Developmental Services is an ex-officio member of the Council without a vote and attends the monthly meetings.

The Regional Advisory and Planning Councils (RACs) are responsible for consulting and advising the Regional Director on the needs of persons with intellectual disabilities within the region. The councils engage in education and advocacy and foster communication between advisory groups, individuals, family members, local citizens and organizations. Members include parents, consumers, and individuals designated by the local association for persons with intellectual disabilities. The RACs review quality data and provide input on service delivery programs and strategies.

The Private Provider Council's membership includes DDS Administrators and Managers Provider Executive Managers and Trade Association staffs. The purpose of this council is to review proposed changes in DDS policy, program, and practice in order to assess the impact that the changes will have on the DDS provider community and serve as the official communication channel between DDS and it Community Partners. This includes a routine administrative review of key organizational and programmatic issues and data trends

associated with the department's quality management system. The Private Provider Council recommendations are shared with the DDS Systems Design Team for any further actions, as appropriate.

DSS/DDS Joint Committee is comprised of Department of Social Services (DSS) and Department of Developmental Services (DDS) Medicaid Operations and Waiver Policy and Planning Managers. The purpose of this joint committee is for DSS to assure that DDS meets federal quality requirements and expectations for the operation of its two HCBS Waivers. DSS monitors DDS's activities and performance according to the Memorandum of Understanding between the two agencies and associated requirements found in the Administrative Authority assurance.

DDS System Design Committee consists of DDS Central Office and Regional Executive Team Managers. The purpose of this committee is to monitor compliance with the six HCBS Waiver assurances and other federal, state, and agency requirements. Their responsibilities include a routine administrative review of key organizational and programmatic issues and data trends associated with the department's quality improvement systems in order to determine and/or recommend changes in agency policy, program, infrastructure, and funding levels. The System Design Committee ensures that all changes in programs and practices are appropriately reflected in the agency policy, procedure, and operations manuals and communicated to stakeholders. This group works in conjunction with regional and central office Executive Management Teams to make final decisions on improvement and implementation strategies and new systems design development to advance the HCBS Waivers. They are informed by the following department functional units: Audit, Billing and Rate Setting, Waiver Policy and Enrollment, Quality Improvement, Quality Management, Provider Operations, Case Management, Legal Services and Regional Operations.

DDS Waiver Assurance Reporting Committee has the following membership: DDS Central Office and Regional staff representatives from Provider Operations, Quality Management, Quality Improvement, Information Technology, and Waiver Policy and Enrollment, Planning and Resource Allocation Team, Health Services, and Case Management. This Committee continues the key functions of the former Quality Systems Improvements Committee.

The purpose of this committee is to develop and/or enhance DDS systems to collect, analyze and report data critical to the department's continuous quality improvement system. This includes the developing and enhancing data collection tools / processes, interpreting quality review findings, identifying data trends and patterns and developing improvement recommendations and tracking system improvement efforts. The Waiver Assurance Reporting Committee works collaboratively with Information Technology and other DDS business units, and provides status reports to the System Design Team.

DDS Quality Improvement Task Group (QI Task Group) serves as the implementation arm of the Waiver Assurance Reporting Committee. Its membership includes representation from major operational units in DDS Central Office and the Regions. When quality issues are identified this group is charged to develop and implement quality improvement strategies to remediate such systemic issues.

One of its early charges (April, 2010) was to identify quality improvement activities to address the identified trends in Quality Service Reviews (QSR) results indicating a disparity between data obtained from Provider on-site records and DDS case management records. The QI Task Group identified six system wide quality improvement activities addressing the following practices or functions:

- Revise and reissue the QSR Interpretive Guidelines
- Develop and issue a Case Management QSR handbook for conducting QSRs
- Develop and add a "Documentation Review" process for Regional Provider Performance Reviews,
- Streamline and reissue a DDS Provider Documentation Guide
- QSR Tools Revision Initiative, and
- Improve "My QSR's" Aggregate Reports Function

The first three QI Activities listed above have already been implemented and results are being gathered to gauge their effectiveness. The second three items are in various stages of development or implementation at the current time (April, 2011).

Regional Waiver Implementation Committees play a key role in the implementation of quality improvement strategies and serve as a two-way communication vehicle between Central Office and Regions. Issues, concerns and best practices are often identified addressed and implemented as a result of these communication forums. These committees are comprised of the Regional Executive Team members, case management supervisors and resource management administrators.

In addition to the councils and committees highlighted above, DDS has numerous other unit, content committees or task groups that contribute to effective multilevel communication and consistency in the implementation of practice standards, policies or procedures across functional units, regions and settings

[*Samples of DDS Table of Organization and Regional Table of Organization were inserted here.]*

Waiver Quality Improvement Strategy

The Connecticut Department of Developmental Services (DDS) as the waiver operating agency is responsible to assure that it meets the federal requirements and expectations for the quality operation of DDS HCBS waiver programs. The Department of Social Services (DSS) monitors the activities of DDS per the Memorandum of Understanding and associated responsibilities per the requirements found in the Administrative Authority assurance. DDS has in place long-standing policy, procedures and practices to assure the health and welfare of individuals supported by the department. However, reduction in the workforce has and will continue to influence the manner in which these assurances are met.

DDS has structured its quality system to address all requirements identified in the six Waiver Assurances and strives to meet the goals of the HCBS Quality Framework. DDS Regional Offices assume the responsibility for overall service access, planning and delivery (Level of Care and Service Planning), and for substantial elements of the quality system through the provision of Targeted Case Management, system safeguards evaluation and analysis of data related to provider performance, and the maintenance of state administrative functions. DDS Central Office maintains responsibility for the Division of Investigations, oversight of TCM, Provider Licensure activities, Provider Qualifications functions, and for systemic oversight, system safeguards, fiscal accountability, administrative authority and quality improvement. The regions and central office collaborate on the Provider Certifications activities.

The department developed a data system to support QI functions through a CMS Systems Change Grant awarded in 2003. That system, called "My QSR" data application, is utilized to automate the monitoring that occurs as a function of the DDS Quality Service Review activities carried out by central office Quality Review staff and by Case Managers, Case Management Supervisors and other staff as appropriate. An overview of the QSR System is included here as it became fully operational after the IFS Waiver Application was submitted to CMS.

Quality Service Review (QSR) and "My QSR"

The QSR uses a set of quality indicators to review public and private service providers. The QSR uses ongoing quality review activities to collect data on a wide variety of measures such as personal outcomes, environmental safety, rights and responsibilities, health and safety risks and safeguards, and satisfaction. The QSR collects data for DDS and providers to evaluate the quality of services and the effectiveness of their quality improvement systems.

The QSR measures both: individuals' experiences with services and supports and the provider and DDS systems' effectiveness in supporting individuals to achieve positive personal outcomes. Information is collected using consumer interviews, support person interviews, document and record reviews, and observations. Once data is collected service patterns and trends can be identified to evaluate provider performance.

The QSR is designed around seven general focus areas. The focus areas were selected based on the department's mission, principles of self-determination, and discussions with individuals, family members and support persons about what is important in their lives and quality means to them. A broad principle statement defines each of the seven focus areas. These focus areas are:

- Planning and Personal Achievement
- Relationships and Community Inclusion
- Choice and Control
- Rights, Respect and Dignity
- Safety
- Health and Wellness, and
- Satisfaction

Each of the above listed focus areas has a set of personal outcomes and support expectations that serve as a basis for quality review ratings. The personal outcomes and support expectations are used to gather information about the individual's experience relative to achieving the outcome and how well the provider assists the individual to achieve the outcome.

Several methods are used to collect data in order to determine if the QSR personal outcomes, support expectations and quality indicators are achieved. Reviewers use quality indicator data collection tools to conduct the review process. The quality indicators identify required

items for verification and provide guidance for quality reviewers assuring consistency across reviewers and review settings.

Beginning with the State Fiscal Year 2011 upon guidance from CMS, a representative random sample for IFS Waiver Participants was drawn to be used by reviewers during that fiscal year. Prior to this sampling method DDS drew a sample of participants based on service type and location.

"My QSR" is a web-based application and permits authorized DDS employees and service providers access to quality data for individual personal outcomes, provider performance and systemic quality oversight and improvement. In this manner the DDS assures follow-up on individual ratings and can identify systemic trends.

DDS maintains separate LAN linked system to collect data on abuse or neglect incidents, program review activities, Human Rights reviews, deaths and other critical incidents, and vacancies. The CT Automated Consumer Information System (eCAMRIS) continues to be the data system to maintain individuals' information and supports many of the other applications.

Case Management monitors the service delivery and satisfaction for each participant on a quarterly basis through TCM activities. Case Management Supervisors complete structured record reviews each quarter, selected randomly, that includes assessment of adherence to DDS policies and procedures related to level of care, service planning and delivery, abuse, neglect and exploitation and consumer rights.

DDS Central Office Waiver Policy and Enrollment Unit; Audit, Billing and Rate Setting Unit, Quality Management Unit, Quality Improvement Director and the Administration Divisions implement additional quality assurance and improvement activities. The Single State Medicaid Agency, DSS, further supports the quality management system through its own record audits, review of DDS reports, management of the MMIS system and management of the Fair Hearing process. Those activities are outlined under each of the assurance areas described below.

1. Level of Care:

Discovery:

- The Central Office Waiver Policy and Enrollment Unit verify that all newly enrolled individuals have a completed Level of Care determination, and that each one makes a choice between ICF/MR and waiver services.
- The Central Office Audit, Billing and Rate Setting Unit conducts a quarterly chart audit of 10 records per quarter per Region inclusive of verification of timely and appropriate Level of Care determination.
- The Case Manager Supervisor conducts a sample review of each case manager's caseload each quarter including a review of Level of Care determination timeliness and appropriate determinations.
- The DSS waiver manager reviews 10 records per quarter to verify that DDS follows policies and procedures regarding Level of Care determinations.

Remediation:

- The CO Waiver Policy and Enrollment Unit notifies the Regional Case Management Supervisor of findings from individual initial enrollment reviews and record audits. Corrective actions are completed in the Regional Offices and reported back to the CO Waiver Policy and Enrollment Unit.
- The Case Manager Supervisor ensures remediation of any individual or case manager specific issues identified in the LOC determination review.

2. Service Planning and Delivery

- The Region assures the completion of assessments and review of Level of Need and Risk Assessment screenings, and follows a person-centered planning process in assisting individuals and their families/legal representatives in the development of individual plans.
- The Region provides information and support for individuals to self-direct to the extent he/she desires.
- The Region informs the individual and family/legal representative of all qualified providers of services and supports outlined in the individual plan, and provides assistance as requested in the selection of qualified providers.

- The Region and Central Office monitor the qualifications of direct hire support staff through oversight of the Fiscal Intermediaries.
- The Region assures the case manager/support broker coordinates and monitors the provision/delivery of waiver and non-waiver services and supports;
- The Region assures the case manager/support broker assists individuals in accessing non-waiver services as appropriate.
- The Region follows policies and procedures for the allocation of waiver openings and assigns funding based on Level of Need results.
- The Region conducts Quality Reviews, monitors contract provider performance, and participates in the development of Provider Quality Improvement plans.

Discovery:

- Each quarter Case Management supervisors review a sample of each case manager's caseload to review compliance with Individual Plan (IP) policies and procedures. These include reviews to assure the plan addresses all identified needs, preferences and risks; that plans identify generic, state plan and waiver services; that participants were informed of and made choices regarding service delivery methods and service providers; that services are being implemented; and that changes are made to the plan based on participant circumstances.
- Case Managers receive monthly reports from the Fiscal Intermediaries regarding services delivered and billed against the approved Individual Plan for monitoring to assure services are delivered as described in the IP and to monitor for over or under utilization.
- Case Managers implement quarterly monitoring of each participant to verify implementation of the Individual Plan through in person or telephone contact and review of each service provider's written, six-months report of progress on the specific service.
- The QSR includes indicators to assess service planning, provider choice and service delivery. Findings are for analysis of performance trends.
- The Central Office Audit, Billing and Rate Setting Unit performs 10 record audits in each of the three Regions per quarter inclusive of review of the timely development of the plan, choice of service delivery type and provider, and plan outcomes and prescribed services address participants needs, preferences and risks.
- DSS conducts quarterly record reviews of 10 participants per quarter. Findings are reported back to DDS for corrective action.

Remediation:

- Individual specific findings are entered into the "My QSR" data application and communicated to the service provider or case manager as appropriate for corrective action on an individual basis. The CM Supervisor monitors case management follow-up.
- Provider systemic findings are presented and monitored for corrective action by the Regional Resource Management Unit during provider performance review meetings.
- DDS system wide data is presented to the DDS Systems Design Committee. QI plans may be developed that address case management, service providers and system issues depending on the findings.
- DSS meets with DDS managers on a quarterly basis to discuss findings and make recommendations for system improvement.

3. Qualified Providers

- The Central Office Operations Center processes all provider enrollment applications. Service Providers may apply to participate in the DDS waiver program at any time. The initial enrollment process assures that all providers meet waiver requirements for licensure, insurance and certification as appropriate, have policies and procedures in place that reflect understanding and process to meet DDS policy in all areas of provider qualifications, service implementation, participant rights, and participant safeguards and agree to Medicaid requirements. The enrollment package and Medicaid Provider Agreement is maintained in the DDS office.
- The Central Office Operations Center works in conjunction with Regional Resource Management Units to monitor the adequacy of the provider network to assure access to waiver services across the state. When problems with access are noted, the CO Operations Center will work with Regional Offices to develop targeted recruitment and provider development initiatives. This includes targeted recruitment of culturally diverse vendors and recruitment for specific service needs in geographic areas of the state.
- The Fiscal Intermediary is responsible for ensuring that all provider qualifications for pre-employment and staff training requirements are met when participants self-direct services and hire their own staff.
- On-going performance of service providers and compliance with waiver provider qualifications and required training is monitored by case managers for individual participants, by the Regional Resource Management Units, and by Quality Review staff as described below.

Discovery:

- Case Managers report to the Regional Resource Management Unit problems with access when participants have difficulty with accessing preferred services or providers in specific areas of the state.
- Case Managers review provider quarterly or bi-annual progress reports, monthly and quarterly Reports on service utilization, and conduct quarterly contacts through TCM to monitor provider performance on behalf of each participant.
- Quality Reviewers conduct annual visits to all facility based day and vocational service locations as part of a comprehensive system of oversight. Quality Review staffs also conduct a review for a 10% sample of participants who live in their own home and receive in-home supports. This sample is stratified by service provider.
- Regional Resource Management Units collect summary performance data related to contracts, quality reviews, case management oversight, and adherence to policies and procedures related to participant safeguards, and meet with day/vocational and residential service providers two times per year as part of a continuous quality improvement cycle.
- The Commissioner issues Certification to a Qualified Provider to deliver support services to individuals. Certification is achieved and maintained by the qualified provider by participating in and meeting the expectations of the department's quality systems in the area of level of care determinations, individual plans and service delivery, outcome achievement, provider qualifications, individual's health and welfare, compliance with financial requirements, and implementing plans to address issues identified by the department's staff or the provider organization.
- The agencies are audited on an annual basis to evaluate compliance with assuring provider qualifications prior to employment and with staff training requirements for participants who self-direct services.

Remediation:

- Provider performance data is entered into "My QSR" data application. Providers must enter online corrective action plans in response to "not met" findings. These corrective action plans are reviewed and accepted by the Regional Resource Manager for privately operated services or by the Quality Review Specialist Supervisor for publically operated services.
- Systemic Provider performance concerns may result in targeted technical assistance provided by the DDS Regional Office or enhanced monitoring.
- The Quality Improvement Director prepares summary reports for the DDS Systems Design Committee waiver assurance data and trends for formulation of remediation and/or improvement plans pertaining to the system at large.

4. Health and Welfare

Discovery and Remediation:

- The Region operates the Program Review Committee and Human Rights Committee, and monitors compliance with the safeguards established for the use of behavioral medications, restrictive behavioral interventions and other restrictions on the rights of individuals.
- The Region implements Abuse/Neglect and Incident Management systems by monitoring the completion and quality of investigations and implementation of all follow-up recommendations by the private providers.
- The Region monitors Medication Management practices, Nursing Delegation and End of Life decisions according to policies and procedures.
- The Region completes a Mortality Review for all reportable deaths. The Central Office coordinates the Independent Mortality Review Board; a committee comprised medical professionals, MR/DD professionals, and private citizens that review a sample of regional mortality reviews for quality control and make recommendations for systemic improvement. The Central Office Director of Health and Clinical Services is a member of the State Fatality Review Board that conducts separate Fatality Reviews of select cases.
- The Central Office Division of Investigations conducts abuse and neglect investigations of all suspicious deaths, completes a medical desk review of all deaths, and directly investigates other selected cases of reported abuse and neglect in the public and private sectors. This Division monitors the completion of reports, coordinates and evaluates the training of investigators in the public and private sectors, and reviews select investigative reports completed by private and public sector investigators.
- The Central Office Division of Quality Management Services monitors incidents, concerns and recommendations for individual and provider follow-up and intervention.
- Quality Management Services issues Safety Alerts to private, public service providers and DDS staff to apprise them of potential health concerns and safety hazards.
- The Central Office Director of Health and Clinical Services holds routine meetings with department wide nursing personnel, serves as a liaison for private sector medical personnel, develops best practice guides and training curriculums, and monitors the state-wide medication administration program.
- The Regions prepare annual summary reports of compliance with and performance in the areas of critical incidents, abuse and neglect investigations, PRC and HRC reviews and Quality Review results for day/vocational and residential providers for

review and discussion with the Resource Management during the provider performance review meetings.

- The Regions monitor the timely reporting and follow-up of all critical incidents, and completion of and follow-up to abuse and neglect investigation reports.
- The Regions monitor the completion of Immediate Protective Service Plans as directed by the Office of Protection and Advocacy in response to allegations of abuse or neglect for participants.
- The Central Office Waiver Policy and Enrollment Unit prepares summary reports of critical incidents and abuse and neglect allegations and findings for analysis regarding trends on a regional and statewide basis for review by Systems Design Committee as requested.

5. Administrative Authority

- DSS receives and evaluates DDS summary reports completed by the DDS Audit, Billing and Rate Setting Unit, and summaries prepared by the DDS Waiver Policy and Enrollment Unit for performance reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity and consumer satisfaction.
- DDS participates in DDS/DSS meetings with key waiver management staff to discuss performance and operational concerns on a quarterly basis.
- DSS conducts the Fair Hearing process and provides instruction to DDS on the implementation of utilization review criteria.
- DSS conducts 40 individual record reviews per year to evaluate Level of Care and Plan of Care requirements.

6. Financial Accountability

- The Regional Office samples day/vocational billing at each facility location during annual review visits. This review includes verification of program documentation on each day service is billed.
- The Administration Division conducts sample audits of provider billing records based on reports of potential irregularities.
- The Fiscal Intermediary only accepts billing for self-directed services if signed by the participant or the participant's legal representative.

- The DDS requires audits of the providers to meet contract requirements for verification of billing and making payments on behalf of the state for waiver claims on an annual basis.
- DSS reviews billing submitted by DDS via the Department of Administrative Services for waiver participant eligibility and authorization for services on a quarterly basis.

DDS Published Reports and Documents

DDS prepares a number of reports and documents for internal use and analysis and for public review.

Management Information Report (MIR)

Prepared quarterly by the DDS Waiver Policy and Enrollment Unit, includes: demographics; DDS referral and eligibility; service utilization; placement/access to services; waiting list data; waiver enrollment; incident data; abuse/neglect data; worker's compensation data; revenue; referrals to the Abuse/Neglect Registry; and psychiatric hospitalization utilization. Ad hoc reports are prepared and included as available. This report is posted on the DDS website.

Business Plan Reports

Annual business plans are developed by each CO Division within the Department in conjunction with regional staff. Goals and objectives are prepared each year to support department goals generated internally or through external direction. Extensive quality improvement information is included in these plans. Quarterly progress reports are prepared and shared with all Divisions for review

Mortality Review Report

Mortality data and analysis is compiled on an annual basis to report causes of death, trends regarding mortality of individuals supported by DDS, and recommendations for systemic DDS and health care system improvement.

Advanced Planning Document

State operation of HCBS Waivers requires the state to have an approved Quality Improvement Strategy for which the state identifies performance measures to meet Waiver Assurances. CT DDS has 30 such performance measures. As DDS began preparing the IFS Waiver Evidentiary Report in 2011, it realized that the current IT applications provide limited electronic reporting, applications are not integrated, systems lack features for automated notification, remediation and follow-up verification.

DSS in conjunction with DDS is in the process of submitting a Planning APD (Advance Planning Document) to enhance DDS's IT systems that support its HCBS Waiver operation. The department's Integrated Application Suite For HCBS Waiver Coordinated Consumer Services seeks to build a Web-accessible integrated application suite and consolidated HCBS Waiver data store for collecting, updating, and organizing the data needed throughout the waiver operation process workflow.

The APD supported IT project will address developing an information architecture beginning with a data model as requirements basis for sourcing and implementing a consolidated data store. The logical scope and physical implementation of the data model must be adequate to populating the set of application services required to support timely, effective, and complete service coordination, for the department's consumers, including discovery and remediation of non-compliance with Waiver Assurances.

The integrated application suite will also ensure any enhancements to the Title XIX billing interface to DSS, as the single state Medicaid agency (SSMA), conform to applicable Medicaid data exchange standards, as they may evolve. Further, the project seeks to replace existing HCBS Waiver production applications that are functionally limited, as well as source new production applications for core-mission business services which are currently lacking applications to support them.

Overall Benefits of APD—Information Technology System Enhancement Project to HCBS Waiver Operation:

- Increased staff efficiency through ease of report generation and one-time data entry
- Increased reliability/accuracy of data through one-time data entry into integrated data warehouse and implementation of applications that support and enhance business work flow
- Ability to link and integrate data from various business areas resulting in improved management of Medicaid billing, consumer outcomes, management of qualified providers
- Improved ability to manage all aspects of waiver operation through integrated application suite, allowing notifications to primary and supervisor users for scheduling activities, identifying areas of non-compliance, creating appropriate remediation and follow-up verification loops, aggregation of data. Automation of these functions will improve remediation activities at both the individual and systemic levels
- Improved ability to produce relevant reports based on integrated data that better meet federal requirements
- Improved intra and interagency collaboration and collaboration with providers, consumers and their families.

- Ensure continued HCBS Waiver FFP and reduce risk of non compliance with report or procedural requirements for Waiver operation.

Estimated Time Frame for APD**:**

- Submit Planning APD to CMS—March 2011
- If PAPD approved Submit IAPD to CMS—September 2011
- Release RFP for Technical Vendor—October 2011
- Secure Technical Vendor for Implementation of DDS Integrated Application Suite For HCBS Waiver Coordinated Consumer Services-- January 2012 through at least 2013

[*QI Action Plan from the QI Task Group was inserted here.]*

State of Connecticut

Department of Developmental services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance I: Level of Care - The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's Level of Care (LOC) consistent with care provided in a hospital, NF, or ICF/MR.

Sub-Assurance Ia: An evaluation for level of care is provided to all participants for whom there is reasonable indication that services may be needed in the future.

Performance Measure Iai: Number and percent of new enrollees who had a LOC indicating a need for ICF/MR prior to receipt of services.

ASSURANCE I: **Level of Care** -The State demonstrates that it implements the processes and instruments(s) specified in its approved waiver for evaluating/reevaluating an applicant's/ waiver participant's level of care provided in a hospital, NF, or ICF/MR.

Sub-Assurance Ia: An evaluation for level of care is provided to all participants for whom there is reasonable indication that services may be needed in the future.

Performance Measure Iai: Number and percent of new enrollees who had a LOC indicating a need for ICF/MR prior to receipt of services.

System Monitoring Processes

The State of Connecticut has been in the process of refining the DDS Waiver Enrollment Processes since 2008. Changes in the DDS Waiver Enrollment process were made to streamline Medicaid processes, reduce paperwork and augment the DSS Waiver Enrollment Process. A one page, self-populated referral form was created through our existing DDS Database, eCAMRIS (electronic Connecticut's Automated Mental Retardation Information System.) This referral is known as the DDS 219e. The form was piloted in spring of 2009 and introduced as a procedure by the summer of 2009. DDS Case Management Trainings across the State occurred during the winter months of 2009 and 2010. Currently, trainings are being offered, at minimum, annually across the state.

In brief, Regional DDS Staff review the individual's Level of Need and determine Level of Care. When an individual meet the Level of Care requirement and receives a funding allocation to meet their support needs, they are referred to DDS Central Office for DDS Waiver Enrollment. Once the Regional referral form is submitted and approved by DDS Central Office, the recommendation for DDS Waiver Enrollment is made to the Department of Social Services, the Single State Medicaid Agency. DSS reviews the recommendation for Waiver Enrollment and determine eligibility.

Within the form of the DDS 219e, there is a section for the DDS Case Manager to read and sign that as a professional Qualified Mental Retardation Professional, *"There is a reasonable indication that the person, but for the provision of waiver services, would need services in an ICF/MR or NF. (42CFR441.302(c)). The Person requires assistance due to having at least one of the following: Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily living functions; Has deficits in self-care and daily living skills requiring habilitative training; Has maladaptive social and/or interpersonal behavior patterns to the extent that they he/she is incapable of conducting self-care or activities of daily living without habilitative training. This determination was made through an interdisciplinary team process based on comprehensive professional assessments, evaluations and/or reports that are on file in the case record."* The DDS Regional Planning and Resource Allocation Team (PRAT) Coordinators review this form to ensure that it is signed by a Regional DDS Staff person, most often the DDS Case Manager, a Case Manager Supervisor or Program Manager. DDS

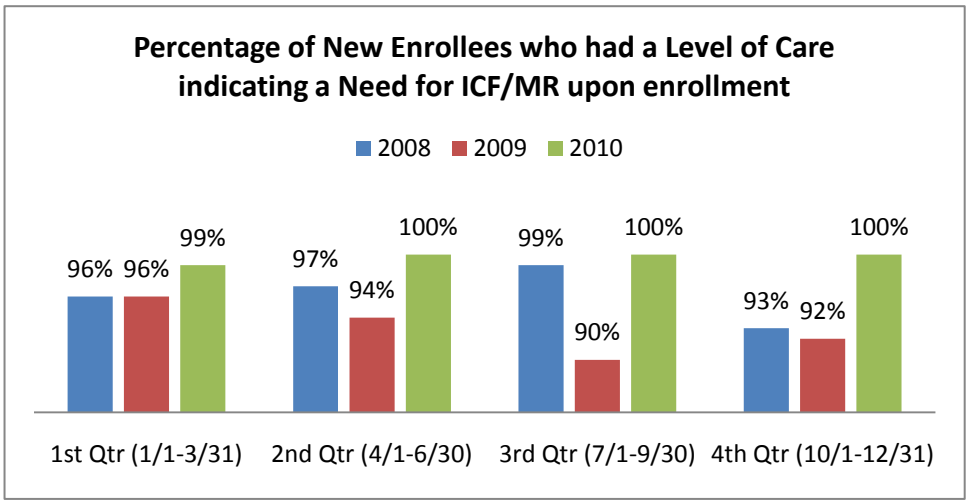
CO Waiver Policy and Enrollment Unit review this form to ensure that it is signed by Regional DDS Staff person. The numbers of applications that are processed at DDS CO are tracked. The number and percent of these applications that are in compliance with 42CFR441.302(c) is then recorded. These statistics are used to measure the performance measure for this sub-assurance.

Evidence

The percentage of enrollees who had a Level of Care, indicating a need for ICF/MR upon enrollment, averaged 96%. In an attempt to bring this number closer to 100% and in the spirit of the Paperwork Reduction Act of 1995, the waiver enrollment process was streamlined to a one page self-populated referral form known as the DDS 219e.

At the beginning of SFY 2010, during the development of the DDS 219e, many state employees took advantage of the Retirement Incentive Program. The 2009 data (93%) reflects the transition process from the older waiver referral packets to the 219e. This lower percentage is indicative of three months during which fewer applications were processed due to a shortage of staff. DDS believes that this percentage was actually higher with documentation being available in the individual's regional case file but not included in the waiver application packet. After statewide training that occurred in winter of 2009 and spring of 2010, the average score for this performance measure increased to 99.7%.

Number of New Enrollees Who Had Need for ICF/MR						
	2008		**2009**		**2010**	
	Total	Had	Total	Had	Total	Had
1st Qtr (1/1-3/31)	46	44	293	281	70	69
2nd Qtr (4/1-6/30)	117	113	119	112	131	131
3rd Qtr (7/1-9/30)	157	155	122	110	78	78
4th Qtr (10/1-12/31)	179	166	93	86	103	103
Total	**449**	**478(96%)**	**627**	**589(94%)**	**382**	**381(99.8%)**



Action Plan/Remediation

In an effort to more easily find the Level of Care determination, 42 CFR441.302 (c) was incorporated directly on the self-populated waiver enrollment referral form, the DDS 219e. This began in summer of 2009. Regional staff and Central Office staff ensure that the Regional Signature, most often the DDS Case Manager's, a Case Manager Supervisor's or Program Manager's Signature is present on the form. If the signature is not present on the form, the form is returned to the Region for remediation. Data is collected as waiver enrollment forms are processed at DDS Central Office to ensure a signature is present indicating that the Level of Care was determined prior to receipt of services.

ASSURANCE I: **Level of Care** - The State demonstrates that it implements the processes and instruments(s) specified in its approved waiver for evaluating/reevaluating an applicant's/ waiver participant's level of care provided in a hospital, NF, or ICF/MR.

Sub-Assurance Ib: The level of care of enrolled participants are reevaluated at least annually.

Performance Measure Ibi: Number and percent of LOC determinations that are reevaluated annually.

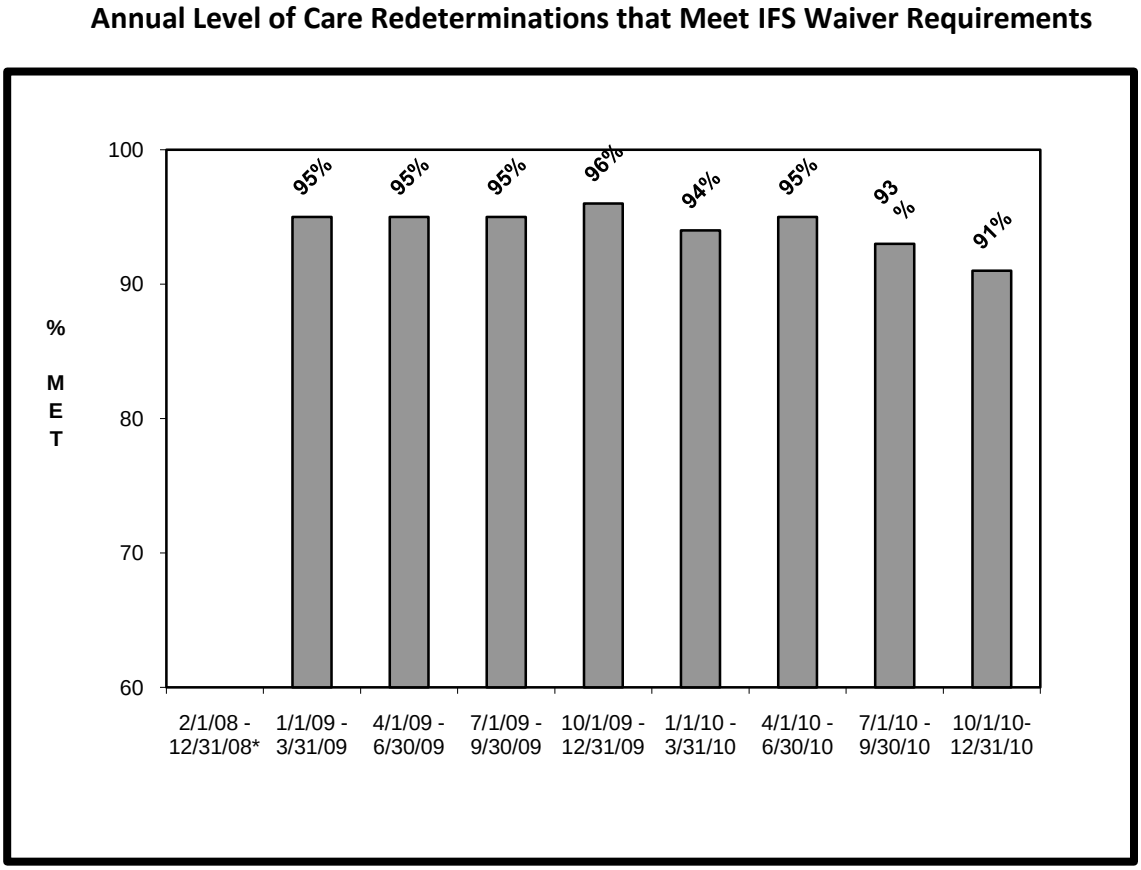
System Monitoring Process

During the planning meeting, the case manager discusses the status of person's Medicaid eligibility and their plans to maintain eligibility. The case manager is responsible for verifying a person's continuing eligibility for Medicaid. During the Case Manager Quality Service Review, the case manager reviews documents to ensure the individual and his or her family or legal representative have submitted required information and may ask to view the person's Medicaid card. Medicaid information is also located in eCAMRIS on the "Client Medicaid Operations" screens. Medicaid information in eCAMRIS is imported directly from Department of Social Services (DSS) data

On an annual basis, during the Individual Planning process, the case manager and the planning and support team complete an HCBS Level of Care Re-determination for continued waiver eligibility. This form is maintained with the Individual Plan form in the master file/individual record and at the provider service location(s). The Level of Care re-determination is completed no more than 365 days from the previous Level of Care determination.

This performance measure is monitored by the DDS Case Management Supervisor's implementation of the QSR. There are two QSR indicators that inform this assurance. One indicator is associated to the Focus Area of Planning and Personal Achievement and the second indicator is associated to Choice and Control. The Case Management Supervisor reviews the DDS Case Management record and verifies if there is complete and current documentation of: application/redetermination for Medicaid Title 19, and DDS Form 219 IFS Redetermination Form.

Evidence



*No QSR data available in 2008 Random sampling for reviews began on 7/1/10

Action Plan/Remediation

The bar graph above reflects the aggregated data collected by Quality Monitors, Case Managers and Case Management Supervisors reviews. Overall the results are above the 90th percentile and we continue to monitor the results as part of the quality improvement activities of the DDS QI Task Group.

Once the QSR Corrective Action Plans (CAPs) are created in the "My QSR" data application for all "Not Met" indicators requiring follow-up the providers are notified electronically and are required to respond. Within fifteen business days CAPs are to be completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements as appropriate.

The provider develops and submits a Continuous Quality Improvement Plan (CQIP) based on QSR and other data. Resource Management reviews and approves the CQIP at the provider's "Annual Performance Review" as needed. The provider's performance and progress with the CQIP is monitored through ongoing review activities by Resource Management.

Systems improvement activities also were implemented as a result of DDS' concerns that quality indicators related to documentation, whether service providers or Case Managers, did not reflect practice as accurately as anticipated.

In 2010 revised Interpretive Guidelines were incorporated into the "My QSR" data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent understanding, implementation and rating of QSR quality indicators across all reviewer roles and service types.

To improve documentation by Case managers, an Individual Plan Training Tool was developed in October of 2010. This tool addresses the re-determination process. Supervisors of Case Management trained their Case Managers on the use of this tool and how to integrate it in their usual workflows. This tool was reviewed with Resources Management, DDS private providers, and Quality Monitoring staff so that everyone was aware of the expectations surrounding the individual planning processes. The central office Waiver Unit also provided training to all case management staff on waiver expectations related to individual planning. In May 2010 a Case Management QSR Handbook was developed for case management. As a result of these systems improvement activities we expect even better results in future reviews.

ASSURANCE I: **Level of Care** - The State demonstrates that it implements the processes and instruments(s) specified in its approved waiver for evaluating/reevaluating an applicant's/ waiver participant's level of care provided in a hospital, NF, or ICF/MR.

Sub-Assurance Ic: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measure Ici: Number and percent of initial Level of Care determinations that have been verified by a Qualified Mental Retardation Professional (QMRP) qualified staff.

System Monitoring Processes

The current procedure for reviewing QMRP signature status is occurring prior to processing the waiver enrollment referral. A State-wide Master List of DDS Case Managers, Supervisors of Case Management and other Professional Staff is kept on file at DDS Central Office. Each Region has their Regional List of QMRP qualified staff. The DDS Professional's signature is compared to this list(s) to determine if the professional is QMRP qualified.

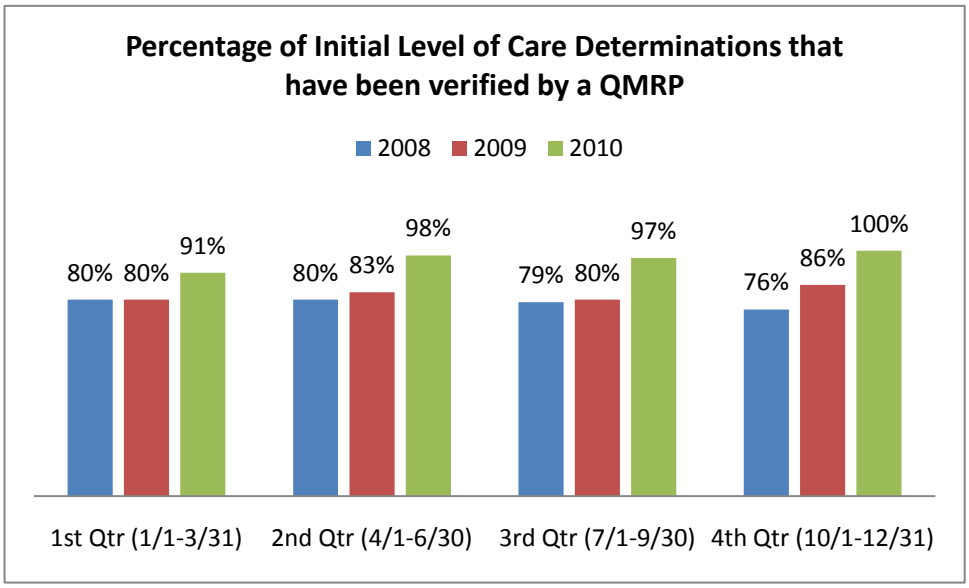
Within the referral form of the DDS 219e, there is a section for the DDS Case Manager to read and sign it as a professional Qualified Mental Retardation Professional, *"There is a reasonable indication that the person, but for the provision of waiver services, would need services in an ICF/MR or NF. (42CFR441.302(c)). The Person requires assistance due to having at least one of the following: Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily living functions; Has deficits in self-care and daily living skills requiring habilitative training; Has maladaptive social and/or interpersonal behavior patterns to the extent that they he/she is incapable of conducting self-care or activities of daily living without habilitative training. This determination was made through an interdisciplinary team process based on comprehensive professional assessments, evaluations and/or reports that are on file in the case record."* The DDS Regional Planning and Resource Allocation Team (PRAT) Coordinators review this referral to ensure that it is signed by a QMRP qualified person, most often the DDS Case Manager, a CM Supervisor or Program Manager. DDS CO Waiver Policy and Enrollment Unit staff also reviews this referral to ensure that it is signed by a QMRP qualified person. The numbers of referrals/applications that are processed at DDS CO are tracked. The percentage of these applications that are in compliance with 42CFR441.302(c) is then recorded, to obtain the data for this performance measure.

Evidence

The average percentage of Level of Care Determinations that was verified by a QMRP in 2008 was 78.8%. This number was partially affected by a system wide review of QMRP qualifications. From 2008 to 2009, DDS Central Office Administrators worked with DDS

Case Managers and Labor Union Representatives to review the definition of a Qualified Mental Retardation Professional and verify the of lists of qualified employees. The updated lists of QMRP qualified staff were disseminated to designated Administrators by summer of 2009. During this process of confirming "Q" qualifications in 2009, the percentage of LOC's verified by a Q increased to 82%. With the verification of the list and implementation of strategies to not process waiver referrals unless a QMRP signs the DDS 219e, the percentage of LOC Determination that has been verified by a QMRP increases to 96.5% and currently hovers around 100%.

Initial LOCs Verified by QMRPs						
	2008		**2009**		**2010**	
	Total	Verified	Total	Verified	Total	Verified
1st Qtr (1/1-3/31)	55	44	351	281	76	69
2nd Qtr (4/1-6/30)	141	113	135	112	134	131
3rd Qtr (7/1-9/30)	196	155	138	110	80	78
4th Qtr (10/1-12/31)	218	166	100	86	103	103
Total	**610**	**478(78%)**	**724**	**589(81%)**	**393**	**381(97%)**



Action Plan/Remediation

In an effort to more easily find the Level of Care determination, 42 CFR441.302 (c) was incorporated directly on the Waiver Enrollment Referral Form, the 219e. This began in summer of 2009. Regional Staff and Central Office Staff ensure that a Qualified Mental

Retardation Professional's Signature is present on the form. If the signature is not QMRP qualified, the referral form is returned to the Region for remediation. A staff person who is Q qualified reviews and verifies that the LOC determination is correct, if a case manager is not QMRP qualified,. Data is collected for Waiver Assurance purposes as waiver enrollment referral forms are processed at DDS Central Office to ensure the signature is not only present indicating that a Level of Care was determined but that the professional staff is QMRP qualified. The procedure for reviewing QMRP status was changed in October 2010 from reviewing the referral forms/applications after they were processed to reviewing them before processing. This maintains a percentage closer to 100% of QMRP compliance.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance II: Service Plans – The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIa: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

Performance Measure IIai: Number and percent of completed quality indicators scored "met" on indicators related to assessments, identified needs and personal goals that were incorporated into the IP.

ASSURANCE II: **Service Plan** - The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIa: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

Performance Measure IIai: Number and percent of quality indicators scored 'met" on indicators related to assessments, identified needs and personal goals that were incorporated into the IP.

System Monitoring Processes

Prior to and during the Individual Plan meeting, the individual and his or her Planning and Support Team (PST) review all recent assessments, screenings, evaluations and reports to gather additional information about the individual that will inform the planning process. The assessments section of the Individual Plan (IP.4), lists the current assessments, screenings, evaluations, and reports that are available or needed by the individual. Any assessments or reviews identified as needed must be referenced in the Action Plan (IP.5), as part of the assessment review, the individual and his or her planning and support team review the Level of Need Assessment and Screening Tool (LON) and the LON Summary Report to ensure they address all the areas of support needed by the individual. The Assessment Summary section of the LON Summary Report will show the results in each area assessed by the tool. Those areas with higher results, relative to the maximum, are areas in which the person more likely requires an increasing level of support. Those support needs are considered in the development of the Individual Plan.

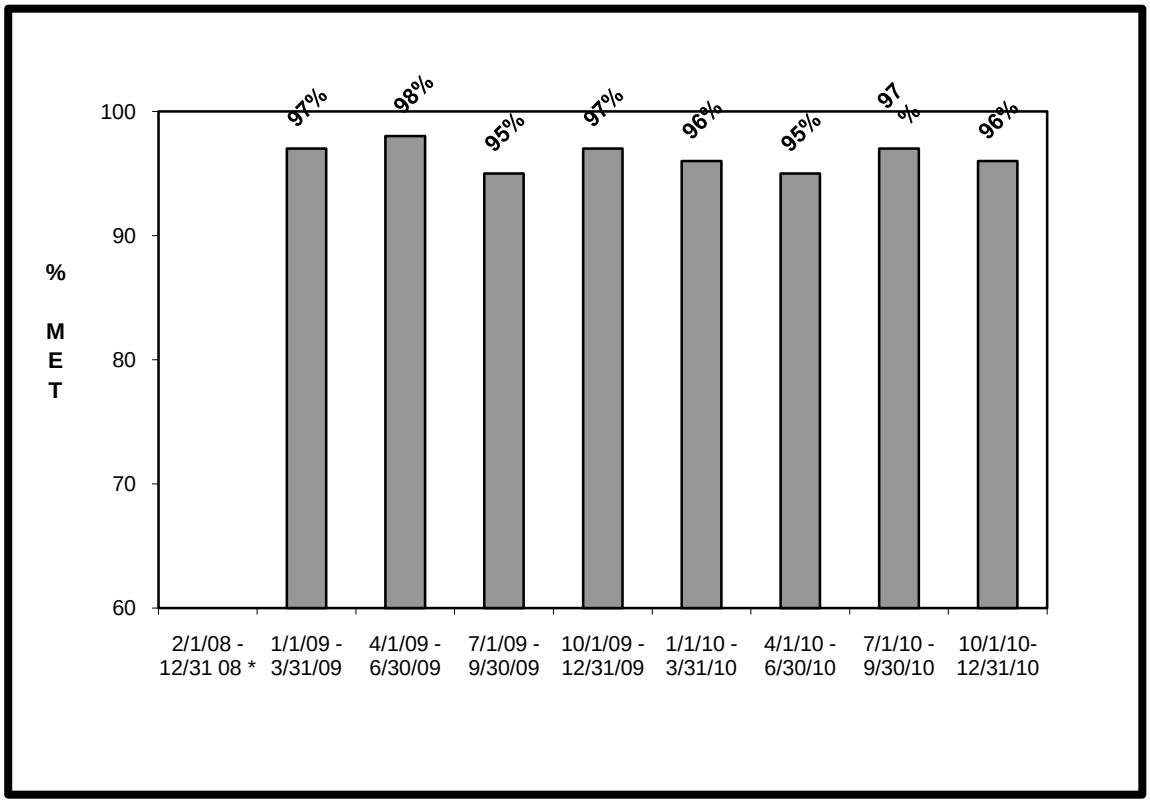
This performance measure is monitored by the DDS Case Management Supervisor's implementation of the QSR. There are four QSR indicators that inform this assurance. All indicators are associated to the Focus Area of Planning and Personal Achievement. The Case Management Supervisor reviews the DDS Case Management record and verifies if there is complete and current documentation of:

a. The individual's personal preferences and goals are identified in the IP.
b. Health, safety and programmatic assessments, screenings, evaluations, report and/or profiles.

Based upon findings, the Case Management Supervisor rates these four QSR indicators and enters the data into "My QSR" application. The bar graph below indicates the aggregated results of these reviews.

Evidence

Participant Assessments and Identified Needs Incorporated into the IP



*No QSR data available in 2008 Random sampling for reviews began on 7/1/10

Action Plan/Remediation

Corrective Action Plans (CAPs) are created in the My QSR data application for all "Not Met" indicators requiring follow-up. Within fifteen business days CAPs are to be completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements.

The provider develops and submits a Continuous Quality Improvement Plan (CQIP) based on QSR and other data. Resource Management reviews and approves the CQIP at the providers Annual Performance Review and as needed. The provider's performance and progress with the CQIP is monitored through ongoing review activities.

Overall the data is above 95% of compliance over 2 years. We continue to monitor as part of the quality improvement activities of the DDS QI Task Group.

Systems improvement activities were implemented throughout DDS to achieve potential gains toward 100% compliance. In 2010 revised Interpretive Guidelines were incorporated into the "My QSR" data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent understanding, implementation and rating of QSR indicators across all reviewer roles and service types.

DDS developed an Individual Plan Training tool in October of 2010 that helps address all participants' assessed needs (including health and safety factors) and personal goals in the IP. Supervisors of Case Management trained their Case Managers in the use of this tool and how to best incorporate it in the usual CM workflows. Training tool was reviewed with Resources Management, DDS private providers, and Quality Monitoring staff to assure common understanding of expectations and each other's roles. .In May 2010 a Case Management QSR Handbook was developed for case managers. We anticipate even better results in future reviews.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance II: Service Plans – The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurance IIb: The state monitors service plan development in accordance with its policies and procedures

Performance Measure IIbi: Number and percent of waiver participants who have had an IP developed within one year of the previous IP.

Performance Measure IIbii: Number and percent of "met" quality indicators related to giving individuals information on, and assistance with selecting qualified providers.

ASSURANCE II: **Service Plan** - The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

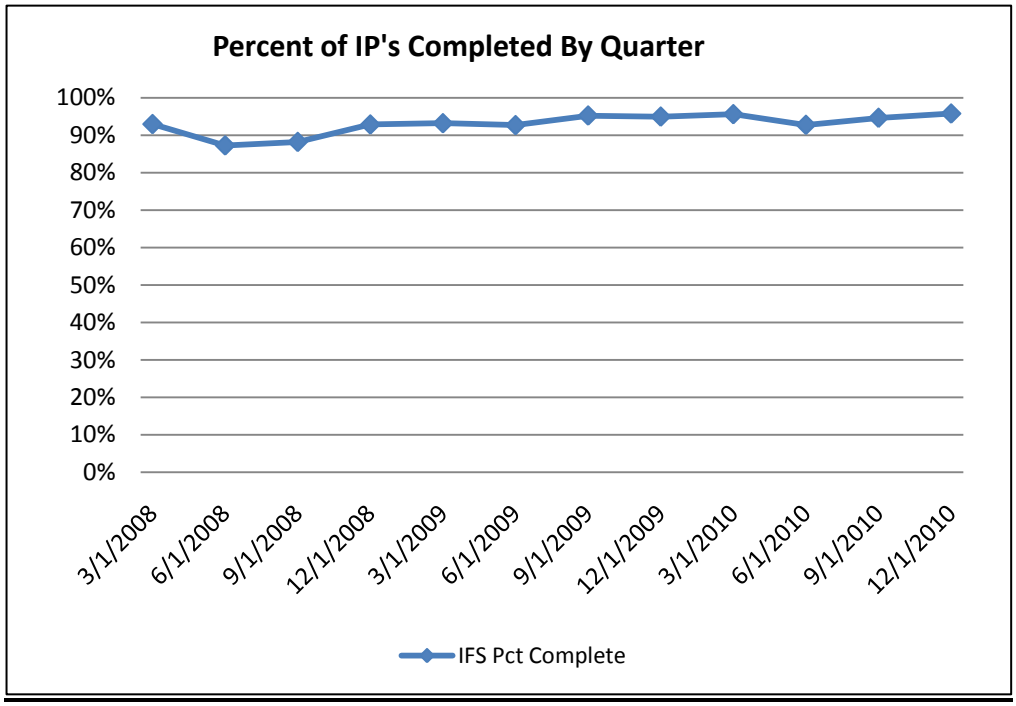
Sub-Assurance IIb: The state monitors service plan development in accordance with its policies and procedures.

Performance Measure IIbi: Number and percent of waiver participants who have had an IP developed within one year of the previous IP.

System Monitoring Processes

The case manager and Planning and Support Team (PST) at a minimum, review or update the Individual Plans on a yearly basis for persons enrolled in a waiver. The plan is renewed within 365 days of the prior plan date. For individuals newly determined eligible for DDS services, the case manager develops an initial Individual Plan within 60 days of the initial visit. Data is entered into eCAMRIS by case managers and case manager supervisors. Aggregate reports are produced for tracking and follow-up purposes.

Evidence



Action Plan/Remediation

In 2010, as part of systems improvement activities, an "Individual Plan Training Tool" was developed. This tool addresses service plan development. Supervisors of case management trained their case managers in the use of this tool and how to integrate this process in their usual workflows. The training tool was also reviewed with resources management, DDS private providers, and quality monitoring staff to assure common understanding of the DDS expectations around these processes and the roles of all involved. Waiver unit staff also provided training for all case management staff regarding the waiver documentation requirements.

Overall the data is above the 90th percentile and we continue to monitor as part of the quality improvement activities of the DDS QI Task Group. We anticipate even better results in future reviews as a result of the trainings provided.

ASSURANCE II: **Service Plan -** The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIb: The state monitors service plan development in accordance with its policies and procedures.

Performance Measure IIbii: Number and percent of 'met" quality indicators related to giving individuals information on assistance with selecting qualified providers.

System Monitoring Processes

After review with the individual, and/or the guardian the case manager documents in the Information Profile section of the Individual Plan information shared with the individual and his or her family or guardian during the meeting including the choice of service options and support providers. The case manager ensures the individual has been offered a choice of supports, service options, and providers and that the plan represents the individual's preferences

This performance measure is monitored through the implementation of the QSR. There are four QSR indicators that inform this assurance. These four indicators are reviewed by both DDS Case Management Supervisors and Quality Management staff. All indicators are associated to the Focus Area of Planning and Personal Achievement. The Case Management Supervisor reviews the DDS Case Management record. The Quality Reviewer reviews the individual's record at the provider service location. Both verify if there is complete and current documentation that the following are included in the individual's IP:

a. Choice of service options and supports.
b. The DDS Case Manager informed and supported the individual regarding choices in: service options, provider options and degree of self-direction and management.
c. Necessary notifications.
d. Responsiveness to individual's request to make changes in supports, services or providers.

Based upon findings, these four QSR indicators are rated and data is entered into "My QSR" by each reviewer.

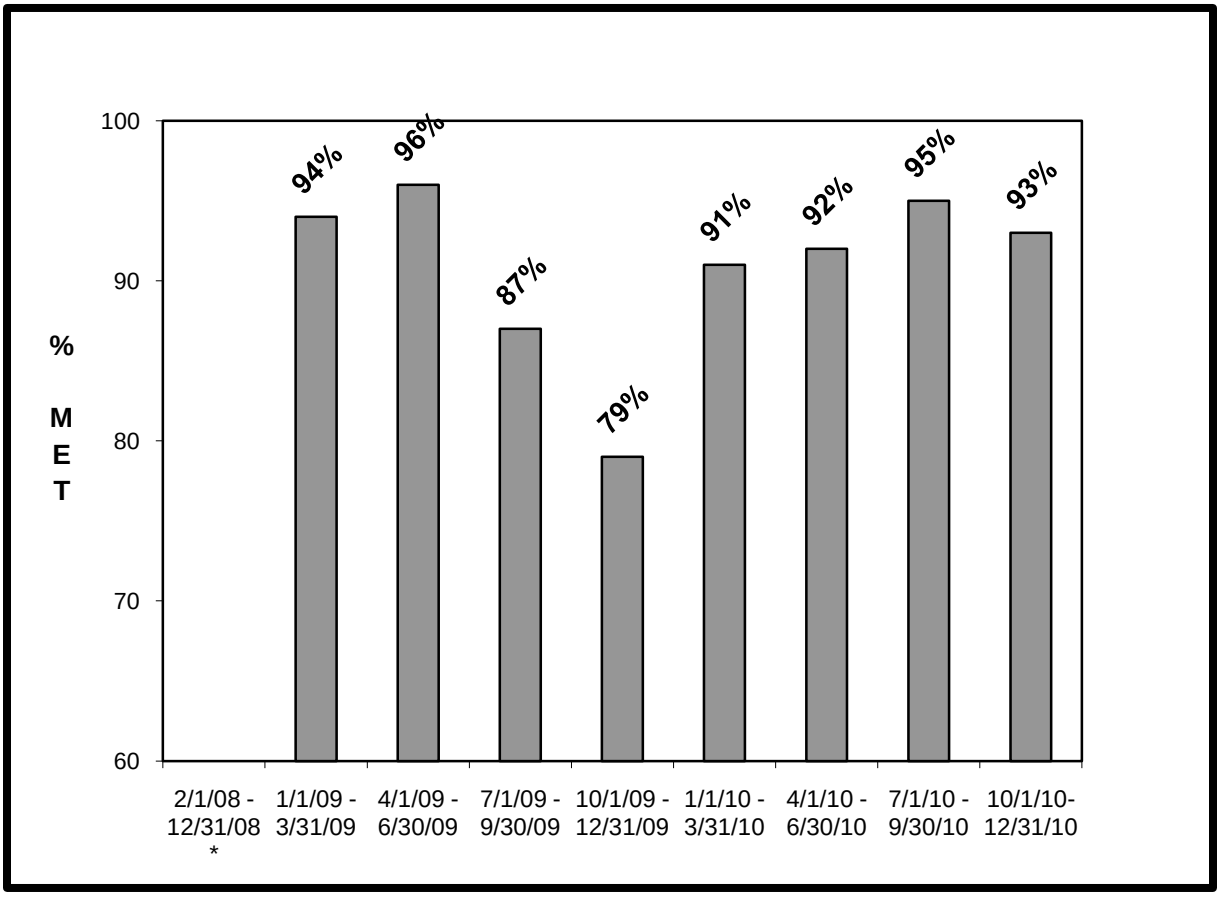
Evidence

Overall the data averages 90% over two years. There was a drop in the data in 10/1/2009 and that is when the department was in the process of hiring and training new case managers due to a retirement incentive program.

The 2009 3rd and 4th quarter QSR data shows decrease in "Met" findings. In addition to the loss of case managers to a retirement incentive there are two more events that influenced these results:

- Beginning in July 2009, a greater number of supported employment and individual supports were reviewed. A significant number of these providers had minimal experience with the QSR and lacked reinforcement of requirements.

Information and Assistance Given to Participants in Selecting Qualified Providers



*No QSR Data Available in 2008. Random sampling began on 7/1/10.

Action Plan/Remediation

Two system wide improvements were instituted addressing the results of this performance measure. First, an "Individual Plan Training Tool" was developed in October of 2010. The

tool addresses the process for giving individuals information or assistance with selecting qualified providers. Supervisors of Case Management trained their case managers on the use of this tool and ways to integrate it into their usual workflows. The Training Tool was also reviewed with resources management, DDS private providers and quality monitoring staff to ensure a consistent understanding of these processes and DDS expectations.

Second, in 2010 revised Interpretive Guidelines for quality indicators were incorporated into the "My QSR" data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent understanding, implementation and rating of QSR indicators across all reviewer roles and service types.

Per the QSR process, corrective action plans (CAPs) are created in the "My QSR" data application for all "Not Met" indicators requiring follow-up. Within fifteen business days CAPs are completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements as appropriate.

Additionally the provider develops and submits a Continuous Quality Improvement Plan (CQIP) based on QSR and other data. Resource Management reviews and approves the CQIP at the providers annual performance review and as needed. The provider's performance and progress with the CQIP is monitored through ongoing review activities.

As a result of these improvement activities we anticipate better results in future review. We continue to monitor this performance measure as part of the Quality Improvement Activities of the DDS QI Task Group.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance II: Service Plans – The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIc: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure IIci: Number and percent of "met" quality indicators showing that Individual Plans are updated/revised annually or when warranted by changes in the waiver participant's needs.

ASSURANCE II: **Service Plan -** The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIc: Service Plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure IIci: Number and percent of 'met" quality indicators showing that Individual Plans are updated/revised annually or when warranted by changes in the waiver participant's needs.

System Monitoring Processes

The case manager along with the Planning and Support Team (PST) update the Individual Plan (IP) at least annually and when warranted by changes in the waiver participant's needs. The case manager monitors progress of the action plan on an ongoing basis through contacts, site visits, review of individual progress reviews (every six months), review of provider documentation, and Quality Service Reviews (QSRs).

This performance measure is monitored by DDS Case Management Supervisor's implementation of the QSR. There are two QSR indicators that inform this performance measure. Both indicators are associated to the Focus Area of Planning and Personal Achievement. The Case Management Supervisor reviews the DDS Case Management record and verifies if there is complete and current documentation that:

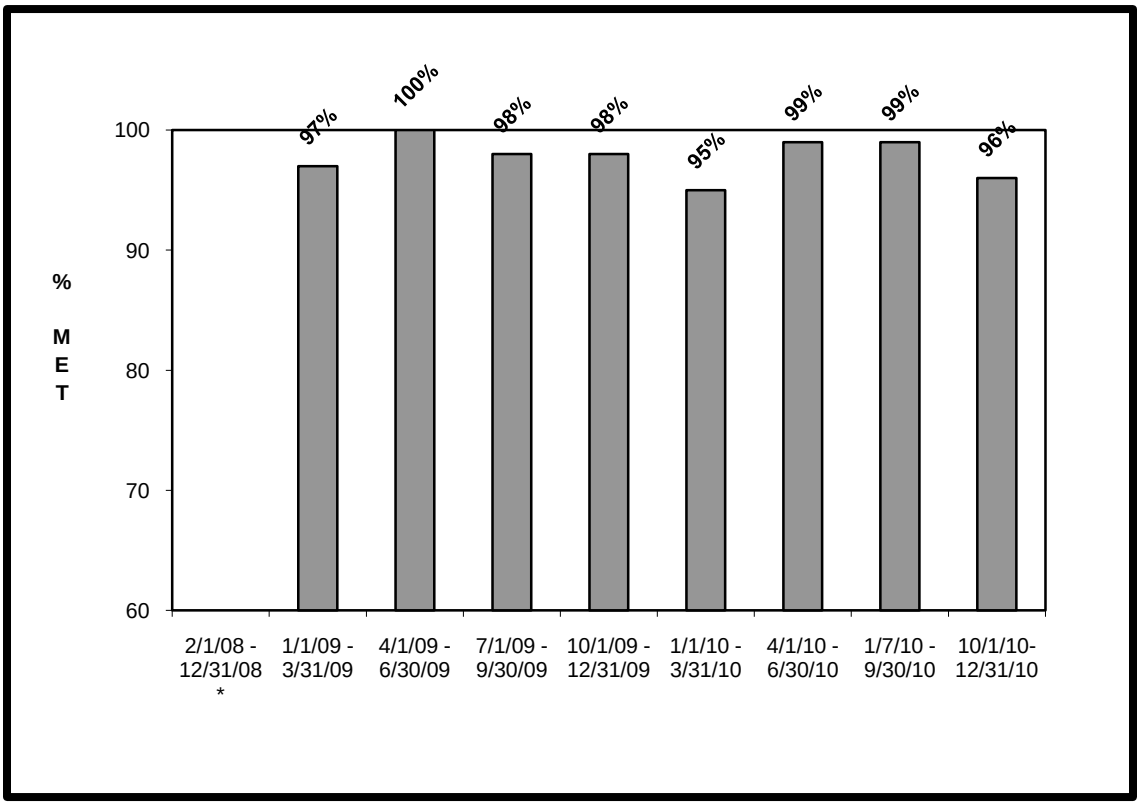
a. The IP was developed on a timely basis.
b. The IP was modified based on changes in the individual's goals, circumstances or preferences.

Based upon findings, the Case Management Supervisor rates these two QSR indicators and enters data in "My QSR".

Evidence

Overall the ratings on this performance measure are above the 95th percentile.

Individual Plans are Updated/Revised at Least Annually or when Participant's Needs Change



*No QSR data available in 2008. Random sampling began on 7/1/10

Action Plan/Remediation

Even though DDS is pleased with the high ratings on this performance measure we believe that the system wide improvement initiatives of the "Individual Plan Training Tools" and the revision and distribution of the "Interpretive Guidelines" for the QSR quality indicators will help to maintain and hopefully raise our compliance with this requirement. The "Corrective Action Plan" (CAPs) process imbedded in the DDS, QSR activities assures continual review and remediation of each "not met" finding.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance II: Service Plans – The State demonstrates it has designed and implemented an effective system for reviewing adequacy of service plans for waiver participants.

Sub-Assurance IId: Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency, specified in the service plan.

Performance Measure IIdi: Number and percent of FI service billings that match the service authorizations.

Performance Measure IIdii: Number and percent of "met" quality indicators related to delivery of services in accordance with the service plan including type, scope, amount and frequency.

ASSURANCE II: **Service Plan** - The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IId: Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

Performance Measure IIdi: Number and percent of FI service billings that match the service authorizations.

System Monitoring Processes

The services of a Fiscal Intermediary (FI) are required for individuals who self-direct their services and supports. The FI assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in individual budgets.

DDS conducts an Annual Performance review on each FI. Areas reviewed include employee record audit, vendor audit, accurate and timely submission of expenditure reports, workers compensation policies for employees who work 26 hours or more, accurate and timely submission of annual report and agreed upon procedure audit, and customer service and satisfaction.

DDS also requires The FI to submit annual Agreed upon Procedure Audits to ensure that the FI is complying with DDS Cost Standards and Business Rules.

Evidence

The FI does not make a payment unless it matches the authorization based on cost standards and business rules. DDS reviews FI performance annually.

In addition, each FI submits an annual audit of Agreed upon Procedures to ensure that they are within the Cost Guidelines and Business Rules set forth by DDS.

A sample of completed performance reviews and agreed upon procedure audits are attached.

Action Plan/Remediation

If there are any performance issues identified, DDS meets with the FI to address the issues and the FI develops a plan to correct the issues. If issues remain unresolved a formal letter will be sent to the FI to suspend or terminate services.

Prior to 2008 DDS terminated contracts with one fiscal intermediary due to performance issues, a second fiscal intermediary was terminated in FY2008 and a third fiscal intermediary had new admission suspended until they could complete action plan to address issues they were having.

If a FI or DDS become aware of issues with billing they are reported and investigated through the DDS False Claims procedure.

DDS is developing a reporting tool with the FIs to capture data related to staff training, annual reporting requirements and agreed upon procedures, and billing. Once completed this tool will be put into effect and tracked. The target date for implementation of this additional content is State Fiscal Year 2012.

[Samples of actual Fiscal Intermediary Performance Reviews were attached here]

ASSURANCE II: **Service Plan** - The State demonstrates it has implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IId: Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

Performance Measure IIdii: Number and percent of "met" quality indicators related to delivery of services in accordance with the service plan including type, scope, amount and frequency.

System Monitoring Processes

The case manager ensures that the Individual Plan (IP6), supports and services section, includes the type, scope, amount, and frequency of services and supports needed to address the person's needs. HCBS waiver services, DDS state funded supports, Medicaid state plan services and generic or informal supports are tailored to the individual's needs and provided as specified in the IP. The information documented in the plan includes the agency or individual who will provide support, the type of service or support, frequency, scope and the amount of service or support. Individual plans that include waiver services also specify which waiver service(s) are to be provided.

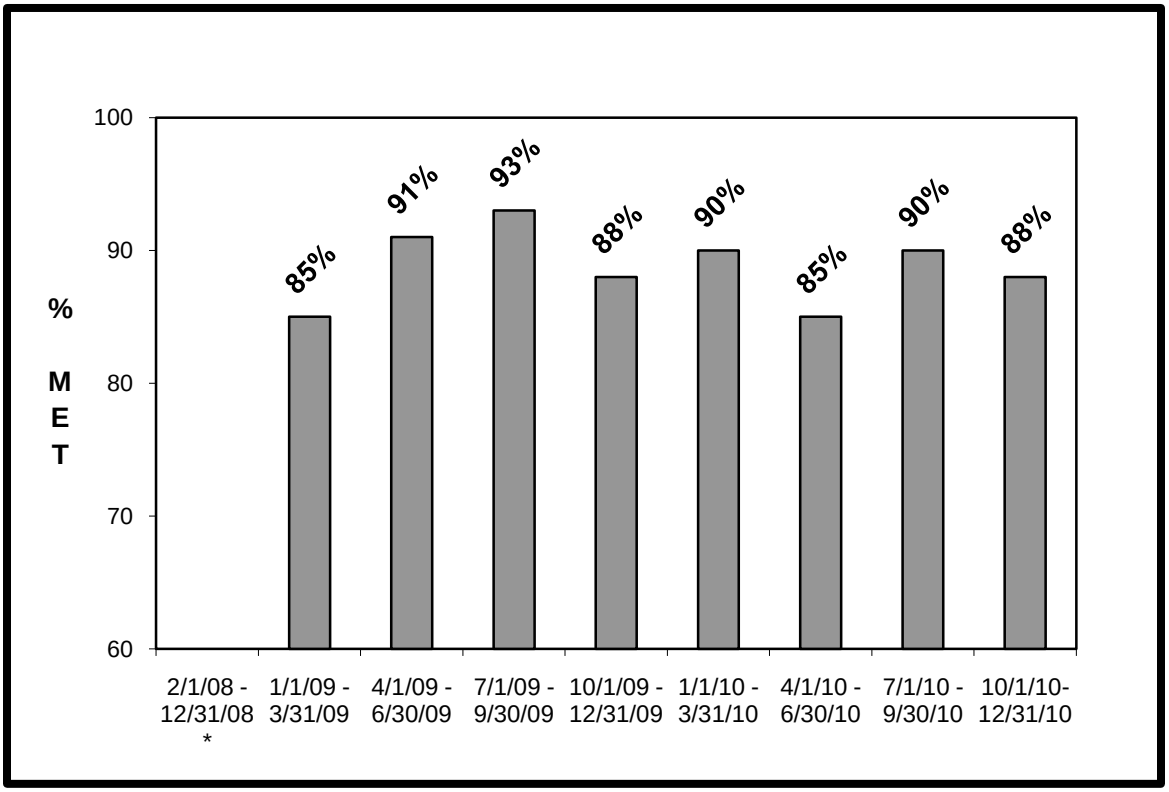
This performance measure is monitored through the implementation of the QSR. There are nine quality indicators that inform this assurance. Quality Monitors review seven QSR indicators. DDS Case Managers review two indicators. Seven indicators are associated to the Focus Area of Planning and Personal Achievement. Two indicators are associated to the Focus Area of Health and Wellness. The Quality Monitors reviews the individual's record at the provider service location and verifies if there is complete and current documentation of:

- Health, Safety and Programmatic assessments, screenings, evaluations, report and/or profiles.
- Required medical assessments and appointments.
- Required oral/dental assessments and appointments.
- Progress reviews identifying that needed services and supports, as identified in the Individual Plan, are received. Attention is given to the documented type, scope, amount duration and frequency of such services.
- After IP development, assessments, screenings, evaluations, reports and/or profiles are obtained.

Evidence

On the graph below results average 88.8% for the two year period. We continue to monitor this performance measure as part of the quality improvement activities of the DDS, QI Task Group.

Services are Delivered in Accordance with Service Plan Including Type, Scope, Amount and Frequency



*No QSR data available in 2008. Random sampling began on 7/1/10.

Action Plan/Remediation

There were two systems wide improvement activities instituted to address the results of this performance measure. First an "Individual Plan Training Tool" was developed in October of 2010. This Tool helps case managers address the type, scope, amount and frequency of services that is specified in the service plan. Supervisors of Case Management trained their case managers on the use of this Tool and ways to integrate it into their usual workflows. Also, the Training Tool was reviewed with resources management, DDS private providers and quality monitoring staff to ensure a common understanding of DDS expectations around these processes.

In 2010 revised Interpretive Guidelines were incorporated into the “My QSR” data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent understanding, implementation and rating of QSR indicators across all reviewer roles and service types.

Corrective Action Plans (CAPs) are created in the My QSR data application for all "Not Met” indicators requiring follow-up. Within fifteen business days CAPs are to be completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements.

The provider develops and submits a Continuous Quality Improvement Plan (CQIP) based on QSR and other data. Resource Management reviews and approves the CQIP at the providers Annual Performance Review and as needed. The provider’s performance and progress with the CQIP is monitored through ongoing review activities.

As a result of these improvement projects and QSR processes DDS anticipates even better results in future review.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance II: Service Plans – The State demonstrates it has designed and implemented an effective system of reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIe: Participants are afforded choice:

1) Between waiver services and institutional care; and

> **Performance Measure IIei: Number and percent of new applications showing that each new enrollee makes a choice between waiver services and institutional care.**

2) Between/among waivers services and providers.

> **Performance Measure IIeii: Number and percent of "met" quality indicators showing that individuals are given a choice between/among waiver service providers.**

ASSURANCE II: **Service Plan** - The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of **service plans** for waiver participants.

Sub-Assurance IIe: Participants are afforded choice between waiver services and institutional care.

Performance Measure IIei: The number and percent of new applications showing that each new enrollee makes a choice between waiver services and institutional care at the time of waiver enrollment.

System Monitoring Processes

The purpose of the DDS 222 Form is to document that when a recipient is determined to be likely to require the Level of Care provided in an ICF/MR, the recipient or his or her legal representative will be informed of any feasible alternatives under the Home and Community Based Services Waiver and given a choice of either institutional or home and community based services. Prior to, during or after the onset of services, Participants have a choice between waiver Services and institutional care. Participants, their guardians, or DDS Regional Directors *(on behalf of the individual)* will mark the choice as indicated by the box checked on the DDS 222 Form and sign the form.

Once this form is completed, the choice is reflected on the Waiver Enrollment Referral Form, the DDS 219e. DDS Professional staff filling out the DDS 219e will document the date and the name of the individual, their guardian or Regional Director who signed the DDS 222 form.

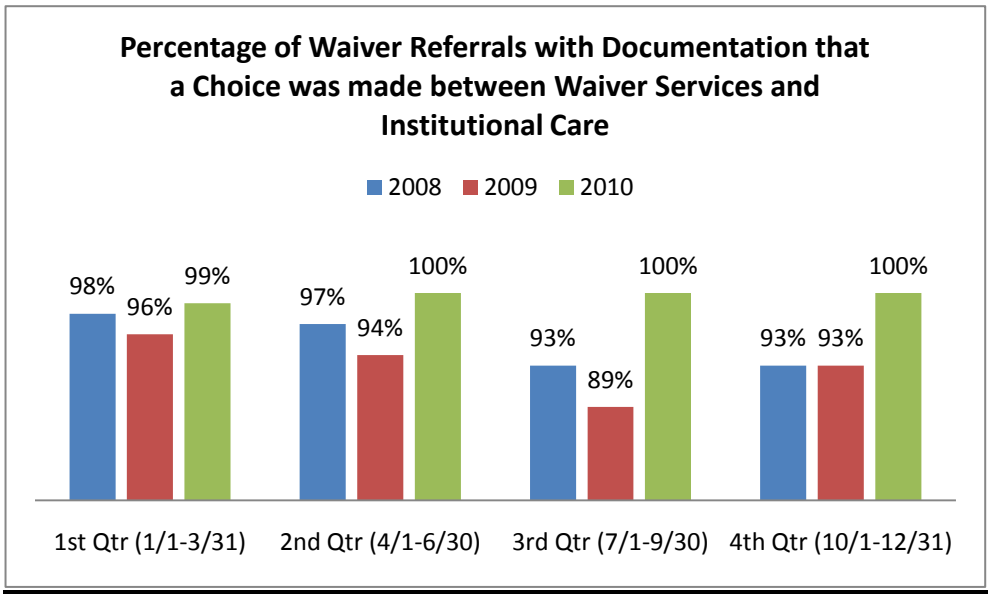
The current procedure for reviewing choice by the participant between waiver services and institutional care is occurring prior to processing the Waiver Enrollment Referral. Data is collected for Waiver Assurance purposes as Waiver Enrollment Referral Forms are processed at DDS Central Office to ensure the choice was made between Home and Community Based Services & Institutional Care.

Evidence

In 2008, the percentage of waiver referrals with documentations that a choice was made between waiver services and institutional care was 95.3%. In an effort to increase this percentage, the waiver enrollment process was reconstructed from a multi page document to a one page self-populated referral form known as the DDS 219e. Information from DDS 222 Form was incorporated into the DDS 219e. During the development of the DDS 219e in 2009, many state employees took advantage of a Retirement Incentive Program and left state service. The percentage of waiver referrals with the DDS 222 information dropped to 93%. This percentage reflects the transition process from the older waiver referrals packets to the

DDS 219e. This percentage is also indicative of a 3 month lag in processing/enrolling individuals due to a loss of staff as a result of the retirement incentive program. DDS also believes that this percentage was actually higher with documentation being available within the region case file of the Individual but not included in the waiver application packet. A review of the process/data also revealed the need to have individuals sign the form again after an institutional stay or appointment/of/or a change in guardianship. After statewide training occurred in winter of 2009 and spring of 2010, this metric jumped to 99.75%.

Waiver Referrals with Choice between Waiver Services and Institutional Care						
	2008		2009		2010	
	Choice	Total	Choice	Total	Choice	Total
1st Qtr (1/1-3/31)	44	45	281	293	69	70
2nd Qtr (4/1-6/30)	113	117	112	119	131	131
3rd Qtr (7/1-9/30)	155	167	110	124	78	78
4th Qtr (10/1-12/31)	166	179	86	93	103	103
Total	**478(94%)**	**508**	**589(94%)**	**629**	**380(99.7%)**	**380**



Action Plan/Remediation

Regional Staff and Central Office Staff ensure that the Individual's Choice is present on the Waiver Enrollment Referral Form, the DDS 219e. If the section showing that a choice was made is not complete, the Waiver Enrollment Referral Form the DDS 219e is returned to the Region. If the Waiver Enrollment form was processed and subsequently there are questions about the DDS 222 form and who signed it, remediation occurs. A formal DDS policy and procedure will be written on this new waiver enrollment process to institutionalize DDS' practices.

ASSURANCE II: **Service Plan** - The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurance IIe: Participants are afforded choice between waiver services and institutional care: and between/among waiver services and providers.

Performance Measure IIeii: The number and percent of "met" quality indicators showing that individuals are given choice between/among waiver services and providers.

System Monitoring Processes

The Case Manager ensures that the individual, guardian and family members are offered choices of qualified providers and are fully informed of their right to freely select among qualified providers. The case manager ensures that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers. Case managers provide the DDS guide, "Making Good Choices about Your DDS Supports and Services" with individuals and families to share information about self-directing, agency with choice, and qualified provider options. When individuals request supports and services from agencies, case managers refer them to the directory of qualified providers within that region. The directory is located in the case manager's desktop, "Table of Contents", and on the DDS Intranet under Qualified Providers.

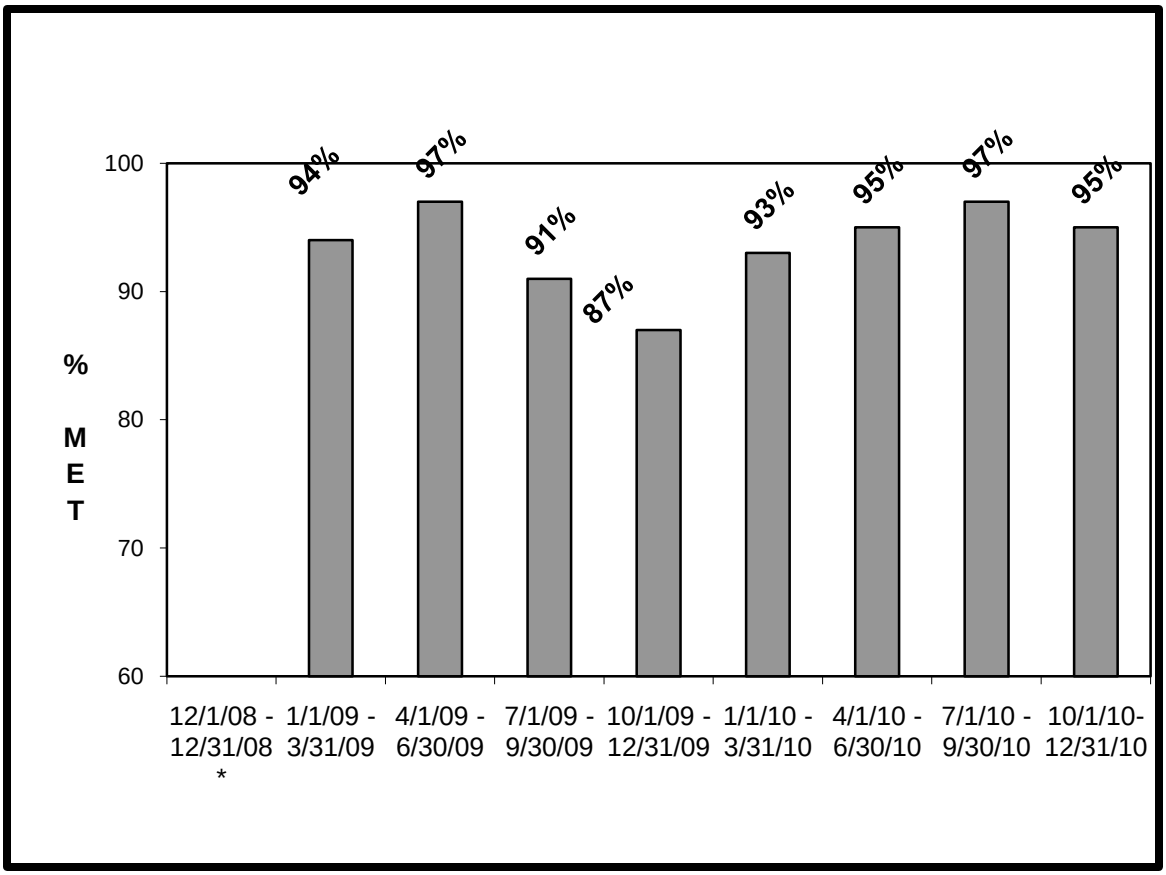
This performance measure is monitored by the DDS Case Management Supervisor's implementation of the QSR. There are four QSR indicators that inform this assurance. All indicators are associated to the Focus Area of Planning and Personal Achievement. The Case Management Supervisor reviews the DDS case management record and verifies if there is complete and current documentation of:

a. Choice of service options and supports.
b. The DDS Case Manager informed and supported the individual regarding choices in: service options, provider options and degree of self-direction and management.
c. Necessary notifications.
d. Responsiveness to individual's request to make changes in supports, services or providers.

Evidence

The data entered below reflects the aggregated data gathered by, Case Management Supervisors. Overall the data averages 94% over two years and we continue to monitor this performance measure as part of the quality improvement activities of the DDS QI Task Group.

Participants are Given a Choice between/among Waiver Services and Providers



*No QSR data available in 2008. Random sampling began on 7/1/10

Action Plan/Remediation

In order to support the continued improvement in this performance measure DDS instituted three system wide improvement activities. First, in October of 2010, an "Individual Plan Training Tool" was developed. This Tool addresses the re-determination process. Supervisors of Case Management trained their case managers on the use of this tool and ways to incorporate it into their usual workflows. Further the Training Tool was reviewed with resources management, DDS private providers and quality monitoring staff to ensure common understanding of DDS expectations and each other's roles. The Waiver Unit provided training to all case management staff.

Second, in May 2010 a QSR Handbook was developed for case management to improve the consistency among quality reviews. Thirdly, in 2010 the revised Interpretive Guidelines were incorporated into the "My QSR" data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent

understanding, implementation and rating of QSR indicators across all reviewer roles and service types.

In addition, Corrective Action Plans (CAPs) are created in the "My QSR" data application for all "Not Met" indicators requiring follow-up. Within fifteen business days CAPs are completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements.

Finally, providers develop and submit a Continuous Quality Improvement Plan (CQIP) based on QSR and other data to DDS. Resource Management reviews and approves the CQIP at the providers Annual Performance Review and as needed. The provider's performance and progress with the CQIP is monitored through ongoing review activities.

We anticipate that as a result of these redundant follow up and monitoring processes DDS will attain even better results in future reviews.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance III: Qualified Providers – The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

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

Performance Measure IIIai: Number and percent of new provider applicants qualified per DDS procedure.

Performance Measure IIIaii: Number and percent of professionals who submit licensure or certification documentation annually.

Performance Measure IIIaiii: Number and percent of providers certified per DDS certification process.

ASSURANCE III: **Qualified Provider -** The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

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

Performance Measure IIIai: Number and percent of new provider applicants qualified per DDS procedure.

System Monitoring Processes

A provider must submit to the Operations Center a complete enrollment packet with all components meeting DDS standards. Application requirements are posted on the DDS Website. The Operations Center reviews the enrollment packet for content and completeness. Any missing or unacceptable items will be detailed in an email to the provider. The application will not be processed until all items have been received.

An agency applicant must submit the following documents as part of their application packet: Provider Application, Assurance Agreement, Provider Agreement, incorporation papers, mission statement, Board of Directors/Advisory Board, experience and qualifications, table of organization, financial audit or evidence of line of credit, certificate of insurance, Strategic Plan or Business Plan, resume and letters of support or reference for either the Principal of the Entity, Connecticut Administrator or principals of a partnership. The agency applicant is also required to submit policies/procedures that meet DDS requirements.

The following policies are required: HIPAA, Drug-Free Workplace, Non-Smoking, Client Funds Management, Medication Administration, Transporting Individuals, Criminal Background Checks, DDS Abuse and Neglect Registry Verification, CT Sexual Offender Registry Verification, Motor Vehicle License Checks, Prevention and Reporting Abuse and Neglect and Prevention of Sexual Abuse, Incident Reporting, Human Rights, Confidentiality, Capacity to Respond to All Emergency Situations and Staffs Ability to Follow All Emergency Procedures, Handling Fire and Other Emergencies, Knowledge of Approved and Prohibited Physical Management Techniques, Anti-Discrimination, Bathing and Personal Care, Water Safety, Infection Control, Training of Direct Service Staff, Supervision of Staff, Backup

Staffing, Observing, Reporting and Responding to Changes that Affect Individuals, Training of Professional Staff in Clinical Disciplines, Training of Professional Staff in Procedures Critical to their Clinical Role, Continuity of Operations Plan (COOP), and a Quality Improvement Plan.

An agency applicant's policies and procedures are reviewed by the Operations Center and Department staff with expertise in the area. Providers are notified via email of procedures that do not meet DDS requirements and are required to submit revisions until policy and procedures are acceptable.

New provider agencies who want to provide Clinical Behavioral Support or Healthcare Coordination must complete all the requirements for a new qualified provider as specified above in addition to the following for each clinician who will provide the service: resume or curriculum vita and university diploma, copy of current professional clinical license or certificate (as applicable), three current letters of reference and contact information, and for Clinical Behavioral Support - a sample of recent work (two sample functional analyses or assessments and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors).

The Qualified Provider Interview Committee reviews an agency applicant's application documents and interviews agency representatives. Based on the agency's qualifications and experience, the Committee may recommend denying or limiting the requested services until the agency proves that they have gained the experience/qualifications necessary to adequately provide the waiver service. The Interview Committee forwards its recommendation of either approval or denial to the Director of the Operations Center for a final decision

Individual Practitioners who wish to become qualified providers of Clinical Behavioral Support or Healthcare Coordination must meet the qualifications for this service and submit the following: Provider Application, Assurance Agreement, Provider Agreement, Confidentiality and HIPAA Assurance Agreement, incorporation papers (as applicable), letter of intent, resume or curriculum vita and university diploma, copy of current professional clinical license or certificate (as applicable), three current letters of reference , certificate of insurance, and for Clinical Behavioral Support Services only - a sample of recent work (two samples of functional analyses or assessments and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors).

Interviews for the Individual Practitioner are at the discretion of the Operations Center's clinical designee. After a review of the application, the clinical designee will recommend approval/denial of an applicant to the Director of the Operations Center.

If provider doesn't complete the application process they are not forwarded for interview and are not included in the data below.

Evidence

	7/1/09-9/30/09	10/1/09-12/31/09	1/1/10-3/31/10	4/1/10-6/30/10	7/1/10-9/30/10	10/1/10-12/31/10
Number of Submitted Applications Qualified	0	8	9	5	20	6
Percent of Submitted Applications Qualified	0%	89%	100%	100%	100%	100%
Number of Submitted Applications Denied	0	1	0	0	0	0
Percent of Submitted Applications Denied	0	11%	0	0	0%	0%

Action Plan/Remediation

Qualified Providers are assigned a Regional Resource Manager and meet with them annually around quality and fiscal management issues. At the annual quality meeting the agency reviews their Continuous Quality Improvement Plan. If data demonstrates a need for improvement in a particular area the Provider will be asked to develop a goal to address that area in their Continuous Quality Improvement Plan. If significant progress is not demonstrated the region notifies the Provider in writing that they are on Enhanced Monitoring following the DDS Enhanced Monitoring Procedure.

HOW TO APPLY TO BECOME A
QUALIFIED PROVIDER FOR AGENCY
THE DEPARTMENT OF DEVELOPMENTAL SERVICES

Qualified providers must meet the standards established in the Department of Developmental Services (DDS) HCBS Waiver Manual. All providers must be incorporated in the United States. Providers must have a working email address to receive communication from the Department. It is highly encouraged for all applicants to read the HCBS manual that can be found on the DDS website (http://www.ct.gov/dds). Click on the link *For Providers* and then *How To Become A Qualified Provider*. There will be a link for the HCBS Waiver Manual.

To become a qualified provider complete the Application for Qualified Providers, the Assurance Agreement, the Provider Agreement and submit all necessary documents outlined in the Components of a Complete Enrollment Packet below. **All documents submitted in the packet must be clearly labeled with item number and description of the item. Documents not properly labeled will be considered unacceptable**. The application packet should be sent to the Operations Center where it is reviewed for content and completeness. Any missing or unacceptable items will be detailed in an email to the provider. Once the provider has submitted a complete packet and the Department has accepted it, the credentials of the organization, the Principal of the Entity and the Connecticut Administrator will be verified by DDS. After the credentials have been verified, the agency representatives will be interviewed by a Qualified Provider Committee. The Qualified Provider Committee, consisting of DDS staff, will either accept the application, will approve the application for all requested services, accept the application for a limited amount of services or deny qualified provider status. The decision of the Committee will be deemed final. Providers may submit a new application one year from the date of notification of the denial.

Once a provider is qualified, supports to individuals cannot begin until the Connecticut Administrator and/or the owners have completed DDS training. Training will be performed in the regional offices on a rotating basis. Please remember that being placed on the qualified providers list does not guarantee individuals of the Department will choose to contract with a provider.

COMPONENTS OF A COMPLETE ENROLLMENT PACKET
The Provider must submit the following information for the packet to be considered complete.
All documents submitted in the enrollment packet must be clearly labeled with item number and description of the item. Documents not properly labeled will be considered incomplete.

1. Provider Application
http://www.ct.gov/dds/lib/dds/operations_center/application_for_qualified_providers.pdf
2. Assurance Agreement
http://www.ct.gov/dds/lib/dds/operations_center/agency_assurance_agreement.pdf
3. Provider Agreement
http://www.ct.gov/dds/lib/dds/operations_center/providers/provider_agreement.pdf
HOW TO APPLY TO BECOME A QUALIFIED PROVIDER 2 *10/1/09 mp*
4. Corporate Documents
a. A copy of the incorporation papers.
b. Mission statement or philosophy of the organization on providing supports to individuals with intellectual disabilities.

c. Board composition that includes their title, profession, and length of terms. If the organization is not required to have a Board of Directors, the agency must establish an Advisory Board that should include representation by at least oneself advocate or a parent of a child with intellectual disabilities. A list of members of the Advisory Board that includes their title, profession and relationship to the organization.

d. A description of the Agency/organization's experience and qualifications that directly impact the ability to provide the desired service or services.
e. Table of organization or current structure.
f. Submit a financial audit or evidence of credit to demonstrate financial stability.
g. Submit a certificate of insurance or certificate of insurability to demonstrate that the organization has or is able to acquire sufficient general liability insurance.
h. For existing organizations, a Strategic Plan must be submitted that demonstrates how DDS supports fit into the existing organization.
i. If this is a new entity, the organization must submit a Business Plan that details the goals of the organization and how they are to be attained. At a minimum, the plan should include a narrative describing the new entity, goals and objectives, a three year timeline, and a budget based on growth projections.

5. Principal and Administrator Documentation
a. Principal of the entity's resume highlighting the individual's entire professional experience and the qualifications that directly impacts their ability to provide the desired service.
b. Connecticut Administrator's resume, if different than the Principal of the entity, highlighting the individual's entire professional experience and the qualifications that directly impacts their ability to provide the desired service.
c. If the entity is a partnership or a Limited Liability Corporation (LLC), all the principals must submit a copy of their resume highlighting each individual's entire professional experience and the qualifications that directly impacts their ability to provide the desired service.
d. Letters of support or references from current or past individuals or entities for which the organization, the Connecticut Administrator, and/or the principal(s) of the entity has conducted similar services. There must be three (3) letters each for the organization, the Connecticut Administrator, and/or the principal(s) that clearly identifies who the reference is for and the name, phone number and address of the individual supplying the reference. Please be aware that it is a requirement of the Department to verify the reference.
HOW TO APPLY TO BECOME A QUALIFIED PROVIDER 3
10/1/09 mp

6. Policies and Procedures
All policies/procedures must comply with DDS requirements; however, they must be specific to you agency and the services you plan to offer. Each must be a separate document and include the date of the procedure and the date of last revision.
a. Submit HIPAA Policy to demonstrate that the agency will protect the confidentiality of the individual and family's information.
b. Submit Drug-Free.

c. Submit Non-Smoking Policy.
d. Submit Client Fund Policy and Procedure.
e. Submit Medication Administration Policy and Procedure.
f. Submit policies and procedures regarding transporting individuals supported by the agency.
g. Submit policies and procedures on criminal background checks.
h. Submit policies and procedures on verifying names on the DDS Abuse and Neglect Registry.
i. Submit policies and procedures on checking the CT Sexual Offender Registry before hiring.
j. Submit policies and procedures on motor vehicle license checks.
k. Submit policies and procedures on prevention and reporting abuse and neglect.
l. Submit policies and procedures on incident reporting.
m. Submit policies and procedures on human rights.
n. Submit policies and procedures on confidentiality.
o. Submit policies and procedures that demonstrates the capacity to respond to all emergency situations and that staff are able to follow all emergency procedures.
p. Submit policies and procedures on handling fire and other emergencies.
q. Submit policies and procedures on prevention of sexual abuse.
r. Submit policies and procedures on and knowledge of approved and prohibited physical management techniques.
s. Submit policies and procedures on Anti-Discrimination Policy that demonstrates the organization will not discriminate against any employee, applicant for employment or participant because of race, age, color, religion, sex, handicap, national origin or sexual orientation.
t. Submit policies and procedures on Bathing and Personal Care.
u. Submit policies and procedures on Water Safety.
v. Submit policies and procedures on Infection Control.
w. Submit policies and procedures on training of direct service staff in required areas.
x. Submit policies and procedures explaining supervision of staff while working in a home setting or community.
y. Submit policies and procedures on back up staffing if lack of immediate care threatens individual's health and welfare.
z. Submit policies and procedures that demonstrate the organization will participate in individual's person-centered planning.
aa. Submit policies and procedures on observing, reporting and responding to changes that affect individual.
bb) Submit policies and procedures on training of professional staff in clinical disciplines
cc) Submit policies and procedures on training of professional staff in procedures critical to their clinical role.
dd) Submit all other required DDS policies and procedures as they apply to the services.
ee) Submit a Continuity of Operations Plan.
ff) Submit a Quality Improvement Plan.

For more information contact:
Maureen Prewitt at Maureen.Prewitt@ct.gov

State of Connecticut
Department of Developmental Services
QUALIFIED PROVIDER INTERVIEW COMMITTEE
RECOMMENDATION FORM
AGENCY: Opportunity Works Connecticut, Inc.
AGENCY REPRESENTATIVES: William Paluska, President
I. Rene Lambert, Executive Director
Roberto Marquez, Program Manager
SERVICES APPLYING FOR: Adult Companion
Group Day
Individualized Day Support
Individualized Home Support
Personal Support
Supported Employment
Respite Care – Individual
Transportation
Interpreter
DATE OF INTERVIEW: January 10, 2011
INTERVIEW COMMITTEE: Peter Mason, Deb Duval, Sheryl Kemp, Pat Dillon, Leah Clark, Maureen Prewitt

Opportunity Works Connecticut, Inc. has applied to become an Agency Qualified Provider for the Department of Developmental Services (DDS). After a review of this provider's completed Enrollment Packet, the agency's representatives met with the Qualified Provider Interview Committee to provide additional information on the agency's ability to deliver services and supports to individuals with intellectual disabilities in accordance with the polices and procedures for the Department of Developmental Services. The following areas were discussed during the interview: mission, organizational structure, experience in the field, support strategies, and business plan.

The president of Opportunity Works Connecticut, Inc. brings years of experience managing various businesses and is using his community connections to assist in fundraising, securing equipment and potential work once they are qualified. The executive director and program manager have years of experience working both in residential and day programs. Based on this interview, the Interview Committee recommends the following:

Approval as a qualified provider for a limited number of services - The Interview Committee recommends Opportunity Works Connecticut, Inc. be qualified to provide Adult Companion, Group Day, Individualized Day Supports, Respite – Individual, and Transportation. It is recommended they not be approved for Individualized Home Supports, Supported Employment or Personal Supports at this time.

Opportunity Works Connecticut, Inc. 2 January 10, 2011
The reasons for a Limited number of services: The Committee decided to limit the number of services to allow the agency time to establish their programs, begin hiring staff, etc.
Individual Home Supports

Individual Home Supports did not fit with the other types of services Opportunity Works Connecticut, Inc. was requesting. Agency representatives shared that Individual Home Supports was included on the application, however, it was a long term goal and that at this time their primary interest was in day services. As this service is outside the supports found in a typical day program, the committee has denied the agency's request to provide this service at this time.
Supported Employment

Agency representatives did not demonstrate a thorough job placement history or employment strategy, which includes job development, job coaching, and how they planned to transition individuals to real work.
Personal Supports

Personal Support did not fit with the other types of services they were requesting. However, if the Personal Support service is needed for transportation, DDS may approve this service based on a written request and documentation of need submitted by the agency.
The Committee has determined the following areas must be addressed before Opportunity Works Connecticut, Inc. will be eligible to apply for additional supports.
Agency is limited to 17 participants until they have received a positive regional contract review.

Agency administration should attend upcoming supported employment trainings to increase their knowledge of supported employment programs, specifically job development and development of a career plan. Documentation at such trainings must be provided to DDS before this service can be added.

Agency can request Personal Supports if it is required for transportation. Agency must submit a request to add this service as well as documentation of need.

To be completed by DDS Operations Center Director
AGREE WITH THE RECOMMENDATIONS OF THE INTERVIEW COMMITTEE
DISAGREE WITH THE RECOMMENDATIONS OF THE INTERVIEW COMMITTEE.
Comments:_____
_____
_____
_____
_____ _____
Joseph W. Drexler, Operations Center Director Date

DDS OPERATION CENTER

INDIVIDUAL PRACTITIONER QUALIFIED PROVIDER
CLINICAL BACKGROUND REVIEW FORM
HEALHCARE COORDINATION
APPLICANT: Chrystal Giumentaro
ADDRESS: 142 Mountain Road, Windsor, CT 06095
DATE: July 19, 2010
ATTACHMENTS:
Some of the following background is provided for your information: application; resume; university diploma; clinical license or certificate; letters of reference.

INTERVIEW: (Optional - Interview will be at the discretion of the Operation Center's clinical designee).
Date interview conducted: _____.

X RECOMMEND **APPROVAL** TO BECOME A QUALIFIED PROVIDER

RECOMMEND **DENIAL** TO BECOME A QUALIFIED PROVIDER
REASON FOR APPROVAL/DENIAL:

Ms. Giumentaro has experience working with persons with intellectual disabilities as a nurse with a private agency as well as experience in long term care and a substance abuse program. She would bring the assessment, counseling, and community referral skills she has acquired in all of these settings to the role of healthcare coordinator.

Reviewer: Dory McGrath, MN, RN Date: July 19, 2010
Title: Director of Health& Clinical Services
Department of Developmental Services
Please email or fax completed form to: Maureen Prewitt - 860-622-2738

ASSURANCE III: **Qualified Providers** - The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

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

Performance Measure IIIaii: Number and percent of professionals who submit licensure or certification documentation annually.

System Monitoring Processes

For those waiver services requiring a licensed or certified provider, applicants must submit copy of their current professional clinical license or certificate as part of their application packet. Licenses and certificates are verified on the Connecticut Department of Public Health or the Behavior Analyst Certification Board websites. Expiration dates are entered into the Qualified Provider database. Database is reviewed monthly for those licenses/certificates that are due to expire. Copies of current license/certification and verification documentation are filed in agency/individual practitioner file.

If a copy of the renewal has not been received by the Operations Center, the agency/individual practitioner is emailed requesting that a copy be submitted. Websites are verified, database is updated and copies of documentation are filed in agency/individual practitioner file.

Evidence

	7/1/09-9/30/09	10/1/09-12/31/09	1/1/10-3/31/10	4/1/10-6/30/10	7/1/10-9/30/10	10/1/10-12/31/10
Number of professionals requiring annual documentation	0	7	1	3	3	9
Percent of professionals requiring annual documentation	0%	100%	100%	100%	100%	100%
Number of professionals with annual documentation submitted	0	7	1	3	3	9
Percent of professionals with annual documentation submitted	0%	100%	100%	100%	100%	100%

Action Plan/Remediation

If updated licenses are not renewed and on file with DDS the provider is removed from the drop down for that service so that they cannot get selected as a service provider. Also the Provider Profile is updated to show that they are not qualified to provide the service.

For Clinical Behavioral Supports, DDS ensures that certification is current where applicable and/or each individual practitioner has a Master's Degree. If these requirements are not met they do not become qualified for the service.

When a qualified provider is not complying with statutes, regulations, policies, procedures, directives, provisions of the Purchase of Service Contract or the Provider Assurance Agreement and such non-compliance is negatively impacting supports to consumers, DDS and the provider shall follow the process outlined in the Enhanced Monitoring Procedure. This will assure that a consistent methodology for resolution, termination, non-renewal or disqualification of provider status is used consistently across cases.

DDS OPERATION CENTER

INDIVIDUAL PRACTITIONER QUALIFIED PROVIDER
CLINICAL BACKGROUND REVIEW FORM
HEALHCARE COORDINATION
APPLICANT: Chrystal Giumentaro
ADDRESS: 142 Mountain Road, Windsor, CT 06095
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Date interview conducted: _____.

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ASSURANCE III: **Qualified Providers**, The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

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

Performance Measure IIIaiii: Number and percent of providers certified per DDS certification process.

System Monitoring Processes

Provider Certification is defined as the written authorization issued by the Commissioner to a Qualified Provider to deliver support services to individuals. Certification is achieved and maintained by the qualified provider by participating in and meeting the expectations of the department's quality system in the area of level of care determinations, individual plans and service delivery, outcome achievement, provider qualifications, individual's health and welfare, compliance with financial requirements, and implementing quality improvement plans to address issues identified by department staff or the provider organization.

To phase in the Provider Certification Process, the Department determined that effective 7-1-10, Initial Certification would be issued to all Qualified Providers who provide the following services; Day Support Option, Sheltered Employment, Individual Supported Employment, Group Supported Employment, Community Living Arrangements, Respite, Continuous Residential Support, Individualized Home Supports (Supported Living, Independent Living) and Individualized Supports.

This initial Certification was valid until the provider's next Regional Provider Performance Review, at which time a recommendation regarding Certification renewal would be made by Regional Resource Management to Quality Management Services.

At the time of Certification renewal, Resource Management recommends one or two-year Certification. This determination is based upon two performance components. A one-year Certification is issued if a provider has a Licensed Community Living Arrangement (CLA) on an annual licensure status or if the provider is on Enhanced Monitoring. All other providers are issued a two-year Certification. Resource Management then sends the recommendations to Quality Management Services in DDS central office. Quality Management Services reviews and make recommendations regarding Certification to the Commissioner of the DDS for final authorization. Providers are notified in writing of Certification status.

Evidence

The Provider Certification Process began in July 2010. Since then one, "one-year" and 15, "two-year" certifications have been issued.

Action Plan/Remediation

Once Certification was implemented, the impact of Enhanced Monitoring and One Year CLA regulatory licensing status upon Certification required further clarification and definition. These issues were identified and will be addressed through the work of the System Design Committee.

To further define the Provider Performance Review components on which a certification recommendation is made, DDS Systems Design Committee directed Quality Management to convene a Certification Benchmarks Committee in October 2010. Members of the Committee represent Quality Management, Quality Improvement, Operations Center, Regional Resource Administration, Regional Public and Private Administration and Case Management. The Certification Benchmarks Committee has made much progress to date, however, their work is not yet finished. Once Provider input is obtained and the work is completed, the recommendations from this group will be presented to the Systems Design Committee for implementation or further direction.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance III: Qualified Providers – The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-assurance IIIb: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure IIIbi: Number and percent of staff newly hired by participants who are qualified to provide services.

ASSURANCE III: **Qualified Providers** - The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance IIIb: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure IIIbi: Number and percent of staff newly hired by participants who are qualified to provide services.

System Monitoring Processes

The Fiscal Intermediary (FI) reviews each application against the job requirements according to service definition that they are provided by DDS. Each staff is expected to meet or exceed the requirement as outlined the DDS information. If an applicant does not meet the required standard, the FI notifies the employer that the applicant is not eligible to be an employee.

Evidence

	FY 11 Qrt 1	FY 11 Qrt 2	FY 11 Qrt 3	FY 11 Qrt 4
How many new hires for the quarter	249	185		
Number of new self-hired staff qualified to start working	215	184		
Percent of self-hired qualified to work	86.35%	99.46%		

Fiscal Intermediaries have always reviewed this data, but no formal documentation was kept on this until this fiscal year.

Action Plan/Remediation

If employees do not meet requirements they are not allowed to work with individuals and FIs are not able to issue payment. The DDS will continue to track and document applicants and their qualifications to work.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance III: Qualified Providers – The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance IIIc: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure IIIci: Number and percent of "met" quality indicators that relate to support person training.

Performance Measure IIIcii: Number and percent of direct hire staff who have received required training.

ASSURANCE III: **Qualified Providers** - The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance IIIc: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure IIIci: Number and percent of "met" quality indicators that relate to support person training.

System Monitoring Processes

DDS Quality Monitors conduct Quality Service Reviews which are designed to measure both: individuals' experiences with services and supports and the provider and DDS systems' effectiveness in supporting individuals to achieve positive personal outcomes. Information is collected using consumer interviews, support person interviews, document and record reviews, and observations. Once data is collected service patterns and trends can be identified to evaluate provider performance.

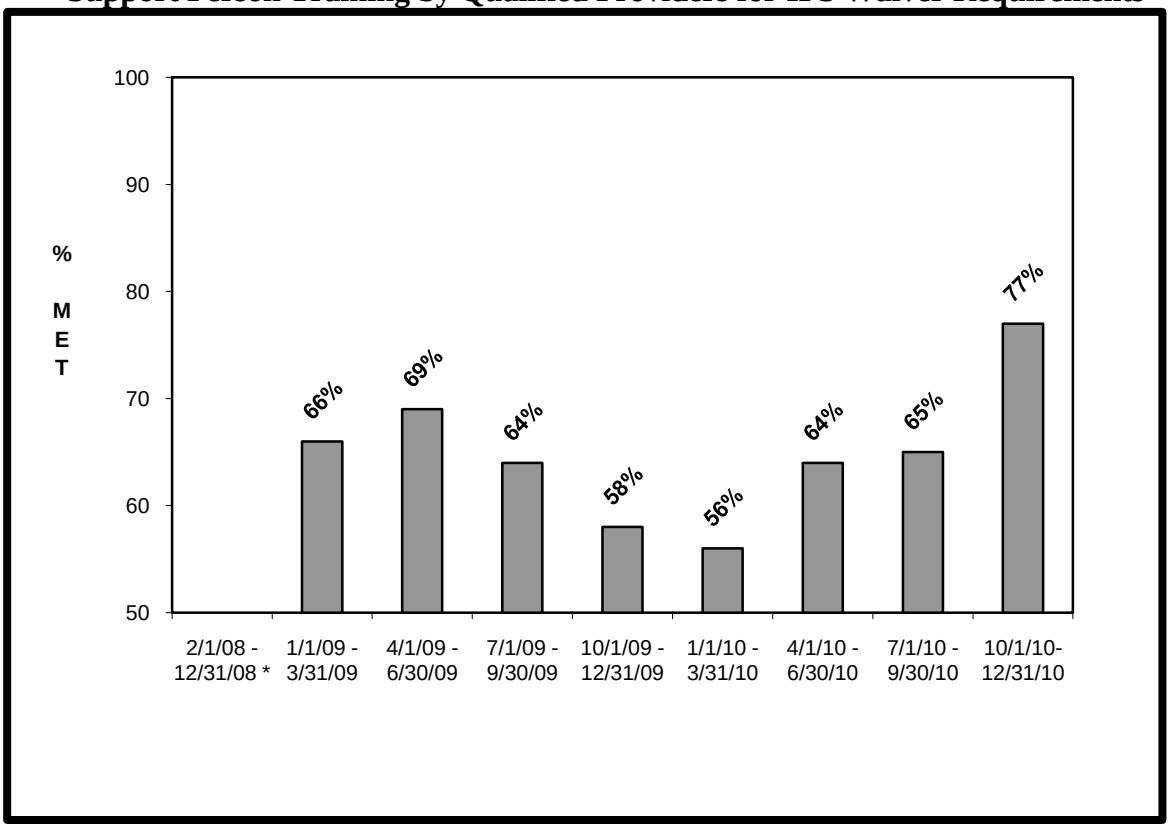
The QSR uses a set of quality indicators to review public and private service providers. The QSR uses ongoing quality review activities to collect data on a wide variety of measures such as personal outcomes, environmental safety, rights and responsibilities, health and safety risks and safeguards, and satisfaction. The QSR collects data for DDS and providers to evaluate the quality of services and the effectiveness of their quality improvement systems.

Six quality indicators are used to provide the data for this Performance Measure. The indicators are:

- IP identifies additional qualifications and training required for staff to adequately support the person.
- Support person training re: health, safety, and plan is documented.
- Documentation that at least one staff on duty per shift is currently trained in CPR.
- Documentation that only licensed/certified personnel administers medication.
- Support person has documented training re: individual rights
- Support person has documented training re: Abuse/Neglect reporting and prevention

Evidence

Support Person Training by Qualified Providers for IFS Waiver Requirements



*No QSR data available in 2008. Random sampling began 7/1/10.

Beginning with the State Fiscal Year 2011 upon guidance from CMS, a representative random sample for IFS Waiver Participants was drawn to be used by reviewers during that fiscal year. Prior to this sampling method DDS drew a sample of participants based on service type and location. The overall performance on this measure has been below 70% until the last quarter.

Action Plan/Remediation

Analysis of the backup data for this performance measure has shown that in most instances when the indicators are marked "Not Met" it is either because the documentation is not available at the site when the review is conducted or because one or more portions of the training on health, safety and the plan have not been completed by the support person. The interpretive guidelines for all of the QSR indicators were revised and posted on the DDS website in July 2010. Providers now know exactly what the Quality Monitors are basing their finding on when they conduct a review. In addition, DDS has drafted a guide for providers on what documentation is required for waiver participants and what must be present at the service location. This guide is currently being reviewed and will be distributed when it is finalized. Each provider's performance is discussed at their annual Performance Review meeting and goals for improvement are included in their Continuous Improvement Plan.

ASSURANCE III: **Qualified Providers** - The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance IIIc: The state implements its policies and procedures for verifying tht provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure IIIcii: Number and percent of direct hire staff who have received required training.

System Monitoring Processes

The Fiscal intermediary oversees and tracks training requirements for all self-directed employees through signed fact sheets, signed Provider Qualifications and Training Verification and completed CDS training as identified below.

"PRIOR TO EMPLOYMENT the following steps need to be completed:

1. Read the following documents.
   - **Individual Planning Fact Sheet**
   - **Incident Reporting Fact sheet**
   - **Physical Management Techniques Fact Sheet**
   - **False Claims Act Procedure**

2. Complete all additional pre-hire training that has been required in the IP.
3. Have your employer sign the Provider Qualifications and Training Verification Record form that you received in your new employee packet. **You cannot begin your employment until your employer has submitted this signed form to their FI.**

"WITHIN 90 DAYS OF YOUR START DATE the following training must be completed:

1. Complete the following 18 College of Direct Support (CDS) on line lessons within the first 90 days of the start of your employment. These 18 lessons are found in the following four online modules:
   - **Direct Support Professionalism (5 lessons)**
   - **Maltreatment of Vulnerable Adults and Children (3 lessons)**
   - **Individual Rights and Choices (4 lessons)**
   - **Safety at Home and in the Community (6 lessons)**

2. Have your employer sign the New Hire E-Learning Verification form when you have completed these lessons. Your employer will then submit this form to their FI to authorize payment of the CDS training stipend to you. Once the FI has checked the CDS system and

verified that the lessons have been completed successfully they will send you a training stipend of $180.00 in your next check. If you do not complete all CDS training requirements within the 90 day period, your employer is not allowed to approve any additional hours of work for you. **The FI will not process payments for any hours worked after the 90 day period, if the CDS training has not been completed."**

The Fiscal Intermediary sends reminder letters to the employee at 60 days to complete the training. A letter is sent at 90 days if the employee has not completed the training notifying that they are not allowed to provide services until completed. If training is not completed within the next 30 days then they are no longer an employee and would be required to start the process from the beginning.

Evidence

Upon review, it was noted that Abuse and Neglect was not included as read and signed prior to direct hire staff beginning employment. Effective May 1, 2011, Abuse and Neglect will be added to the new hire packet and will be required as a read and sign before employment can begin.

	FY 11 Qrt 1	FY 11 Qrt 2	FY 11 Qrt 3	FY 11 Qrt 4
Number of new self-hired staff that have completed CDS training *(This is not exclusive to the quarterly new hires but of all that have finished that quarter)*	146	147		
Grand Total of active self-hires	2408	2430		
Percent of new self-hired staff qualified	98.61%	99.96%		

Although the Fiscal Intermediary has always overseen and completed this process, formal documentation was not occurring prior to State FY11.

Action Plan/Remediation

If the training has not been completed within 90 days the staff can't work with individuals. If the training is not completed within 120 days they are no longer an employee and would have to start the process from the beginning if they wished to provide supports. Beginning with May 1, 2011 the training requirements will include 'abuse and neglect" content areas. FIs will continue to track and document qualifications for work of each candidate.

Date:

(Name and address of Employer)

Regarding: (Name of Employee)

(Address of Employee)

Dear (Name of Employer):

This is to inform you that (Name of Employee) has not completed the CDS training required by the Department of Developmental Services within the required time frame of 120 days.

Your Fiscal Intermediary, Allied Community Resources, has been notified by DDS Self Determination Director, Beth Miller that this employee's **approved provider status** has been **terminated** and he/she can no longer be a provider through the DDS Program, effective (90-day due date) due to non-compliance with CDS Online Training requirements.

At this point, if this employee chooses to become **reapproved** as a provider/employee for you and be paid through the DDS program, he/she must complete the new hire process again.

Sincerely,

Valerie Giannelli

Valerie Giannelli, Supervisor

Provider Applications & Credentialing Department

CC: Beth Miller

State of Connecticut

Department of Developmental Services

M. Jodi Rell
Governor

Peter H. O'Meara
Commissioner

Kathryn du Pree
Deputy Commissioner

Date:

(Name and address of employer)

Regarding: CDS Employee Training for:

(Name of employee)

Dear (Name of Employer):

This is a final notice that (Name of Employee) has not completed the CDS training required by the Department of Developmental Services.

Your Fiscal Intermediary, Allied Community Resources, has been instructed by DDS Self Determination Director, to stop payment for any services after (due date) (Name of Employee) has not completed the CDS training requirements. There will be no retroactive payments made after (due date). Please make sure the employee is using the www.collegeofdirectsupport.com/CT address to access the online training.

If your employee completes the training before (due date) there will be no interruption in payments.

Sincerely,

Valerie Giannelli
FI Representative
CC: (Name of Employee)
SD Director for Region ….

Date:

(**name and address of employer**)

Regarding: Internet Training Update

Dear Employer:

This is a friendly reminder that your employee _____has about 30 days to complete the internet training modules required by the Department of Developmental Services. If your employee does not complete the required Internet training modules by (**90-day due date)**, the employee will no longer get paid and there will be no retro active payments while the employee is completing the training. Please make sure the employee is using the www.collegeofdirectsupport.com/CT address to access the online training. If you have any questions about this notice please contact the Department of Developmental Service representative for your region listed below.

Robin Wood
Self Determination Director North Office
Phone: 860-263-2449
Email: robin.wood@ct.gov
Gregory McMahon
Self Determination Director South Office
Phone: 203-294-5063
Email: gregory.mcmahon@ct.gov
Beth Aura Miller
Self Determination Director West Office
Phone: 203-805-7430
Email: bethaura.miller@ct.gov
Sincerely,
Valerie Giannelli
FI Representative
CC: (**name of employee**)

Attach: "DDS New Employee Paperwork Checklist"
Version 6, updated 7/14/09 VG

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance IV: Health and Welfare – The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

Sub-Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVai: Number and percent of new staff hired by participants who self-direct that received training on identifying abuse and neglect and all statutory reporting requirements.

Performance Measure IVaii: Number and percent of reported instances of abuse and neglect that are investigated.

Performance Measure IVaiii: Number and percent of "met" quality indicators related to the implementation of recommendations resulting from abuse/neglect investigations.

Performance Measure IVaiv: Number and percent of Mortality Reviews conducted annually on deaths that meet the DDS policy for mortality reviews.

Performance Measure IVav: Number and percent of staff who have received training in reporting and prevention of abuse and neglect and individual rights.

Performance Measure IVavi: Number and percent of critical incidents where there was follow-up by the region per DDS procedure.

Performance Measure IVavii: Number and percent of substantiations of abuse or neglect.

ASSURANCE IV: **Health and Welfare** - The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub-Assurance IVa: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Performance Measure IVai: Number and percent of new staff hired by participants who self-direct that received training on identifying abuse and neglect and all statutory reporting requirements.

System Monitoring Processes

The Fiscal intermediary oversees and tracks the training requirements for all self-hired employees. Prior to beginning work, the employee is required to read and sign a fact sheet that outlines the definitions and reporting requirements for incidents of suspected abuse and neglect. The employee may not begin work until they have read and signed the fact sheet. The fact sheet is provided by the FI as part of a hiring packet.

The Fiscal Intermediary also monitors training through the College of Direct Support. Abuse and Neglect is covered through the second online module as listed below.

"WITHIN 90 DAYS OF YOUR START DATE the following training must be completed:

"1. Complete the following 18 College of Direct Support (CDS) on line lessons within the first 90 days of the start of your employment. These 18 lessons are found in the following four online modules:

- **Direct Support Professionalism (5 lessons)**
- **Maltreatment of Vulnerable Adults and Children (3 lessons)**
- **Individual Rights and Choices (4 lessons)**
- **Safety at Home and in the Community (6 lessons)**

"2**.** Have your employer sign the New Hire E-Learning Verification form when you have completed these lessons. Your employer will then submit this form to their FI to authorize payment of the CDS training stipend to you. Once the FI has checked the CDS system and verified that the lessons have been completed successfully they will send you a training stipend of $180.00 in your next check. If you do not complete all CDS training requirements within the 90 day period, your employer is not allowed to approve any additional hours of work for you. **The FI will not process payments for any hours worked after the 90 day period, if the CDS training has not been completed."**

The Fiscal Intermediary sends reminder letters to the employee at 60 days to remind them that they need to complete the training. A letter is sent at 90 days if the employee has not completed the training notifying that they are not allowed to provide services until

completed. If training is not completed within the next 30 days then they are no longer an employee and would be required to start the process from the beginning.

Evidence

Upon review, it was noted that Abuse and Neglect was not included as read and sign prior to direct hire staff beginning employment. Effective May 1, 2011, Abuse and Neglect will be added to the new hire packet and will be required as a read and sign before employment can begin. Abuse and neglect training is included in the data below.

	FY 11 Qrt 1	FY 11 Qrt 2	FY 11 Qrt 3	FY 11 Qrt 4
Number of new self-hired staff that have completed CDS training *(This is not exclusive to the quarterly new hires but of all that have finished that quarter)*	146	147		
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Action Plan/Remediation

If the training has not been completed within 90 days the staff can't work with individuals. If the training is not completed within 120 days they are no longer an employee and would have to start the process from the beginning if they wished to provide supports.

Date:

(Name and address of Employer)

Regarding: (Name of Employee)

(Address of Employee)

Dear (Name of Employer):

This is to inform you that (Name of Employee) has not completed the CDS training required by the Department of Developmental Services within the required time frame of 120 days.

Your Fiscal Intermediary, Allied Community Resources, has been notified by DDS Self Determination Director, Beth Miller that this employee's **approved provider status** has been **terminated** and he/she can no longer be a provider through the DDS Program, effective (90-day due date) due to non-compliance with CDS Online Training requirements.

At this point, if this employee chooses to become **reapproved** as a provider/employee for you and be paid through the DDS program, he/she must complete the new hire process again.

Sincerely,

Valerie Giannelli

Valerie Giannelli, Supervisor

Provider Applications & Credentialing Department

CC: Beth Miller

State of Connecticut

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Deputy Commissioner

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Valerie Giannelli
FI Representative
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SD Director for Region ….

Date:

(**name and address of employer**)

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Robin Wood
Self Determination Director North Office
Phone: 860-263-2449
Email: robin.wood@ct.gov
Gregory McMahon
Self Determination Director South Office
Phone: 203-294-5063
Email: gregory.mcmahon@ct.gov
Beth Aura Miller
Self Determination Director West Office
Phone: 203-805-7430
Email: bethaura.miller@ct.gov
Sincerely,
Valerie Giannelli
FI Representative
CC: (**name of employee**)

ASSURANCE IV: Health and Welfare - The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub- Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVaii: Number and percent of reported instances of abuse or neglect that are investigated.

System Monitoring Processes

The CT DDS (Department of Developmental Services) system of reporting and investigating allegations of abuse and neglect of individuals with intellectual disabilities is governed by CT General Statutes.

Allegations of abuse or neglect must be reported to the Department of Children and Families (DCF) if the victim of the suspected abuse or neglect is under 18 years of age, to the Office of Protection and Advocacy for Persons with Disabilities (OPA) if the victim is between the ages of 18 and 59, and to the Department of Social Services if the victims is 60 years or older. If the alleged abuse or neglect occurred in a medical facility or the alleged perpetrator is a service provider licensed by the Department of Public Health (DPH), the allegation is also reported to the DPH. Additionally, local police departments may be notified based on the nature of the allegation. Allegations of financial exploitation, psychological abuse, and verbal abuse, which do not fall under the jurisdiction of another state agency, are conducted by DDS Division of Investigations (DOI) Lead Investigators, DDS pool investigators or DDS Qualified Provider pool investigators. All allegations are documented on forms mandated by the respective state agency. Allegations and the investigatory process are tracked by three DDS regional Abuse and Neglect Liaisons to ensure prescribed time frames are met for the completion of investigations.

All investigations into allegations of abuse and neglect are conducted by trained investigators from the DCF, OPA, DDS and the DDS Qualified Provider community. Investigations conducted by DDS Qualified Provider pool investigators are monitored and reviewed for completeness and accuracy by the DDS Lead Investigators, and by the OPA for those investigations which fall under that agency's statutory authority. Any assistance provided by a DDS Lead Investigator in the completion of a DDS Qualified Provider investigation is noted in the completed investigation report.

In 2004, a CT State statute revision mandated that in cases where there is a death o a person with intellectual disabilities for whom the DDS has direct or oversight responsibility for medical care and there is a suspicion that abuse or neglect contributed to the death, the Commissioner of the DDS must notify the Director of the OPA. The OPA will conduct an investigation into the circumstances surrounding the individual's death. All recommendations contained in the investigation report are addressed by the DDS.

All completed investigation reports result in either the substantiation or the non-substantiation of the allegation (s).

All investigation reports completed by the DDS DOI Lead Investigators, DDS and Qualified Provider pool investigators are reviewed and approved by DDS.

Administrators and are forwarded to the agency having statutory jurisdiction over the investigation process, based on the age of the victim.

Furthermore, the DDS has two agreements with other state agencies related to the abuse and neglect system. Since June of 2005, the DDS and the Office of Protection and Advocacy for Persons with Disabilities Interagency Agreement has governed the abuse and neglect system for individuals between the ages of 18 and 59. Since October of 2005, the DDS and Department of Public Safety Memorandum of Understanding has identified a CT State Trooper as responsible for fulfilling the duties as the Director of the DDS DOI.

Evidence

It is the responsibility of the three DDS regional Abuse and Neglect Liaisons to track allegations of abuse and neglect to ensure the completion of the investigation process within prescribed time frames. Data is enteered and maitained in the DDS eCAMRIS from the time of the initial allegation through the completion of the investigarion process, including whether the allegation was substatuated or not, and recommendations generated from the findings of the investigation, as applicable.

The following table represents a compilation of eCAMRIS abuse and neglect data related to IFS Waiver participants.

	IFS Waiver				
Qtr End Date*	**Nbr Alleg**	**Inv**	**Nbr Subst ****	**Pct Inv**	**Pct Subst**
3/31/2008	28	28	11	100 %	39%
6/30/2008	37	37	17	100 %	46%
9/30/2008	45	45	13	100 %	29%
12/31/2008	45	45	23	100 %	51%
Total 2008	**155**	**155**	**64**	**100 %**	**41%**
3/31/2009	46	46	16	100 %	35%
6/30/2009	45	45	18	100 %	40%
9/30/2009	37	37	17	100 %	46%
12/31/2009	43	43	14	100 %	33%
Total 2009	**171**	**171**	**65**	**100 %**	**38%**
3/31/2010	34	34	12	100 %	35%
6/30/2010	39	39	14	100 %	36%
9/30/2010	53	53	16	100 %	30%
12/31/2010	35	35	9	100 %	26%
Total 2010	**161**	**161**	**51**	**99%**	**32%**

*: allegation made in quarter.

**: allegation made in quarter substantiated. Due to time frames between the reporting of an allegation and the completion of the investigation, substantiation may have occurred in subsequent quarter.

Action Plan/Remediation

If there is a determination that an allegation was not reported, as mandated by CT General Statutes, and/or a timely investigation was not conducted, provisions are in place to initiate the investigation process. Remediation activities would include training in statutory reporting requirements, investigation training, training in the DDS abuse and neglect policy and procedures, enhanced monitoring, or any other areas deemed necessary by the DDS or the agency having statutory jurisdiction over the reporting or investigation process.

Data related to abuse and neglect allegations and investigations is reviewed by the three DDS regional Abuse and Neglect Liaisons at least every 6 months to ensure compliance with applicable DDS procedures.

ASSURANCE IV: **Health and Welfare** -The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

Sub-Assurance IVa: The State, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVaiii: Number and percent of "met" quality indicators related to the implementation of recommendations resulting from abuse/neglect investigations.

System Monitoring Processes

Upon completion of the investigation, recommendations are logged into the DDS Abuse/Neglect System (A/N database). A copy of the recommendation(s) goes to the provider, all appropriate DDS staff: Assistant Regional Director, Regional Director, Case Management Supervisor, Case Manager, Resource Manager and Quality Monitor Supervisor. With these recommendations is a request for documentation of implementation of said recommendations to be submitted within 30 days.

Follow up to ensure compliance, is coordinated jointly with the Regional Abuse Neglect Liaison and Resource Management (if the incident happened at a provider site) and case management. Follow up on implementation of recommendations is done by email, phone call, observation and/or review by the Quality Monitor. The Regional Director receives a quarterly report on the status of recommendations for that period. Proof of implementation is logged into the A/N database. At any given time, a report can be generated showing the status of a recommendation.

Abuse/neglect allegations made in an individual's own home, are investigated by the Office of Protection and Advocacy. When the investigation is completed and recommendations are received by the regional Abuse/neglect Liaison, they are forwarded to the Case Manager for implementation.

Case Management supervisors review responses made by Case managers for timeliness and appropriateness. Approved responses are forwarded to the A/N Liaison to be submitted to OPA and for tracking.

This performance measure is monitored by Quality Monitors through implementation of the QSR. There are four QSR indicators that inform this assurance. All indicators are associated to the Focus Area of Rights, Respect and Dignity. The Quality Reviewer reviews the individual's record at the provider service location and verifies if there is complete and current documentation that:

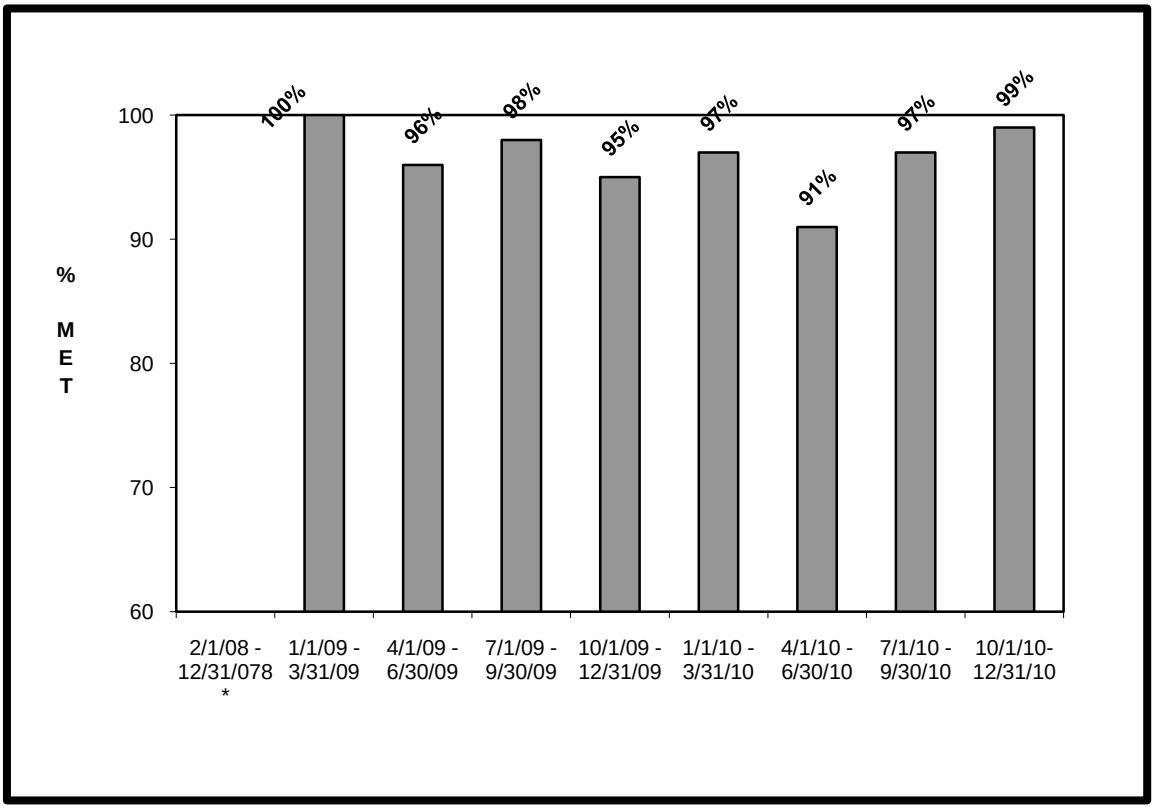
- The individual has not experienced abuse or neglect.

- Individual's accidents/incidents are reported, investigated and followed-up.
- Abuse/Neglect policies and procedures were followed.
- Abuse/Neglect concerns are addressed.

Based upon findings, the Quality Reviewer rates these four QSR indicators and enters data into "My QSR".

Evidence

Met, QSRs Related to the Implementation of Recommendations Resulting from Abuse and Neglect Investigations



*No QSR data available in 2008. Random sampling began 7/1/10.

Action Plan/Remediation

When recommendations are not implemented (rare), this would be discussed with the provider at the annual provider performance review. The provider may submit documentation at the time of the meeting; however, if they have not implemented the

recommendations, DDS can place the agency on “Enhanced Contract Monitoring” to remediate the situation.

To further improve the results on the performance measure revised Interpretive Guidelines were incorporated into the “My QSR” data application and posted on the DDS website for all users and providers to readily access. Interpretive Guidelines are necessary to assure consistent understanding, implementation and rating of QSR indicators across all reviewer roles and service types.

Corrective Action Plans are created in the My QSR data application for all "Not Met” indicators requiring follow-up. Within fifteen business days CAPs are to be completed by the service provider, including DDS Case Management. CAPs are reviewed and approved by Resource Management, Quality Management or the Case Management Supervisor. CAPs include remediation for the individual reviewed and systemic service improvements, as appropriate.

Additionally, the provider develops and submits a Continuous Quality Improvement Plan (CQIP) based on QSR and other data. Resource Management reviews and approves the CQIP at the providers Annual Performance Review and as needed. The provider’s performance and progress with the CQIP is monitored through ongoing review activities.

ASSURANCE IV: Health and Welfare: The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub- Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVaiv: Number and percent of mortality reviews conducted annually on deaths that meet the DDS policy for mortality reviews.

System Monitoring Processes

Connecticut law requires CT DDS to review the death of anyone for whom it has direct or oversight responsibility for medical care. CT DDS has established a two tier mortality review process as part of its quality assurance system to trigger corrective action and reduce future risk for people. The two tier system includes a regional mortality review committee and Independent Mortality Review Board (IMRB). Criteria for review by the regional mortality review committee include any death where the department bears direct or oversight responsibility for medical care. The regional mortality review committee does not review the deaths of individuals who live at home with their families or who were placed by their family/guardian into a licensed nursing facility. The regional committee members are appointed by the DDS Regional Director and include regional Health Service Director or Medical Director, DDS residential manager, DDS and non DDS Registered Nurses, Consumer Advocate, and DDS abuse/neglect liaison. Criteria for review by the IMRB include referrals from the regional mortality committee for medical, health or residential care concerns; suspicion of abuse/neglect and post mortem examinations. Members of the IMRB are appointed by the CT DDS Commissioner and Executive Director of the CT Office of Protection and Advocacy for Persons with Disabilities (OPA) and include DDS Director of Health and Clinical Services, DDS Director Division of Investigations, DDS Director Division of Quality Management, community based physician, representatives from the State Office of Protection and Advocacy and the State Department of Public Health, Executive Director of private provider agency and parent representative. In addition, the mortality process includes a final review of all IMRB cases by the CT DDS Commissioner and Director of Health and Clinical Services. Statewide actions are taken to improve quality of care based on mortality review findings including development of health and safety protocols and guidelines and targeted training programs for private and public agency staff and community health providers. If a death is considered suspicious for abuse or neglect, appropriate authorities such as the CT Dept. of Public Health Facility and Practitioner Units and the CT Office of Protection and Advocacy are notified to ensure the safety of other community-based residents or to initiate an investigation as appropriate. All referrals made through the DDS mortality review system for follow up actions are tracked by the IMRB

chairperson and cases remain open until responses are reviewed and approved by full IMRB committee.

Evidence

Data on deaths is submitted by the regional Health Services Directors to central office for data entry and closure in the eCAMRIS system. The table below represents a compilation of such data related to IFS Waiver participants.

	# of deaths of DDS clients	# of deaths of DDS clients on IFS waiver	# of deaths of DDS clients on IFS waiver meeting criteria for mortality review	% of deaths of IFS waiver clients meeting criteria that were reviewed.
FY 10	182	21	3	3/3= 100%
FY 09	188	20	5	5/5=100%
FY08	216	25	6	6/6=100%

Action Plan/Remediation

No remediation necessary as over the past 3 fiscal years 100% of the deaths meeting criteria for mortality review were reviewed through the CT DDS mortality review system.

ASSURANCE IV: **Health and Welfare** - The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub-Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVav: Number and percent of staff who have received training in reporting and prevention of abuse, neglect and exploitation.

System Monitoring Processes

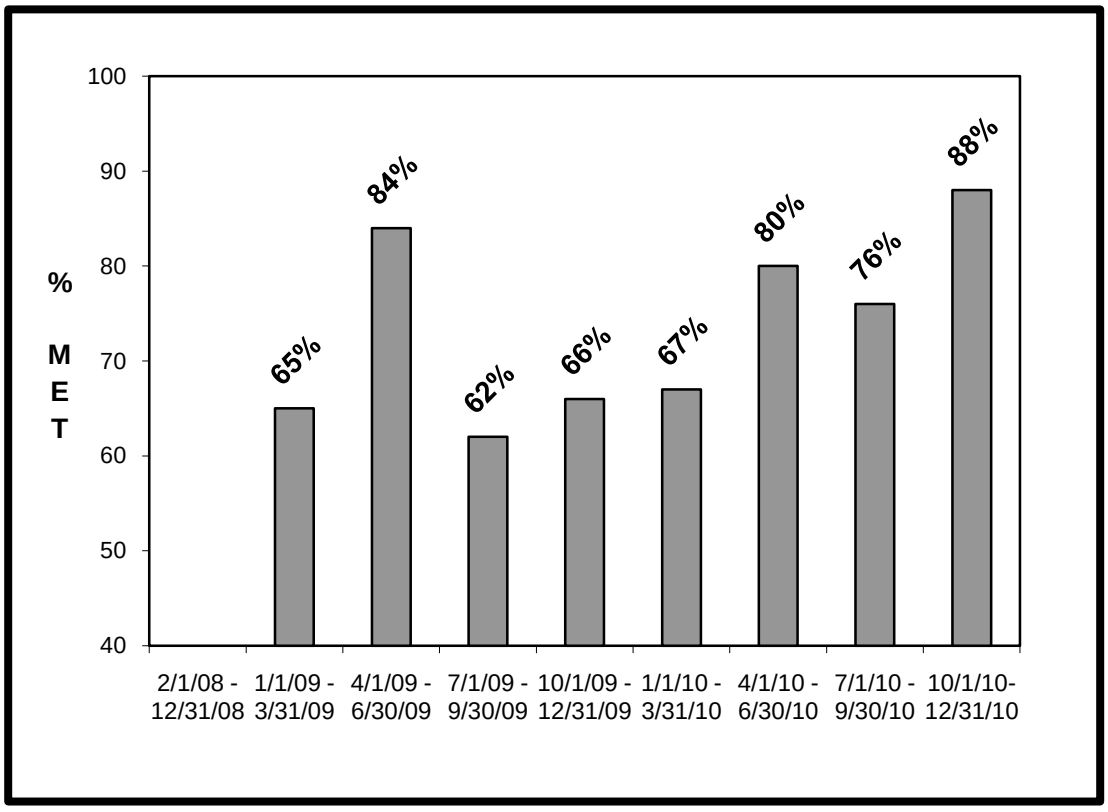
CT DDS policy requires Qualified Providers to provide annual training to all their staff (mandated reporters) in the recognition of, prevention of, and obligation to report abuse and neglect, as well as training in human rights.

The DDS Community Living Arrangement (CLA) regulations and Quality Service Review (QSR) Indicators require verification that direct support staff has documented training regarding abuse and neglect reporting and prevention, as well as training in individual rights. DDS quality reviewers conduct Quality Service Reviews across service settings to ensure that this indicator has been met.

The DDS Staff Development division maintains training records for all public sector program staff in a web-based learning management system (LMS). Training reports are made available via the LMS to public program supervisors, as well as CLA licensing and Quality Management reviewers. Private providers maintain their own training records, and make these available to CLA licensing inspectors and quality reviewers.

Evidence

Staff Who Have Received Training in Reporting/Prevention of Abuse, Neglect and Exploitation



*No QSR data available in 2008. Random sampling began on 7/1/10.

Action Plan/Remediation

In cases where CLA licensing inspectors determine that staff has not received training in the prevention and reporting of abuse/neglect, the provider is cited and must address the issue in a Plan of Correction. In cases where quality reviewers determine that the required training has not occurred this is indicated in the QSR report, that the providers receive real time and in aggregate form on an annual basis. Providers are expected to correct QSR "not met" findings and quality reviewers monitor the responses at a subsequent review. DDS Resource Managers address aggregate reports with providers during the annual review. If noncompliance with this requirement is identified for a provider on a repeated basis, the provider must include a remediation goal in their Continuous Quality Improvement Plan monitored by Resource Management.

ASSURANCE IV: **Health and Welfare** - The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub-Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVavi: Number and percent of critical incidents where there was follow up by the region per DDS policy.

System Monitoring Processes

The Department of Developmental Services (DDS) has established a system of reporting and monitoring critical and non-critical incidents that occur with individuals served by the department in order to manage and reduce overall risk. This procedure delineates a standardized process for reporting, documentation and follow-up of the following types of incidents involving individuals served by the department:
1. Injury
2. Restraint
3. Unusual Incidents
4. Medication errors

Critical incidents are reported to the region and DDS Central Office on the day they occur. Same day review and follow up is conducted in the region by the Regional Director, Assistant Regional Director for that division, Case Manager and Resource Manager (if appropriate).

Critical Incidents are reported on the Standard Incident Report Form, (DDS 255). The Incident is checked off as being "Critical".

Critical Incident: An incident as defined below which is considered critical in that it requires immediate reporting to the DDS Regional Director, Assistant Regional Director (public or private as appropriate) or designee.
1. Deaths (Document a death that resulted from an injury using *DDS form 255*, and also report the death following DDS procedure I.D.PR.001, Mortality Reporting, Reporting Deaths of Individuals)
2. Severe injury
3. Vehicle accident involving moderate or severe injury
4. Missing person
5. Fire caused by the individual that required emergency response and/or involved a severe injury (Fires caused by staff, others, or cause unknown would be reported but not using the 255 process)
6. Police arrest
7. Victim of Aggravated Assault or Forcible Rape

After the Interdisciplinary Team (IDT) has met and reviewed the incident, a "Critical Incident Follow up" form should be received by the appropriate DDS Region. This form indicates the cause of the Critical incident and the course of action taken by the

Interdisciplinary Team. The "Critical Incident Follow up" form is routed to the respective Assistant Regional Director to determine if further follow up with the agency is required. The respective Resource Manager receives a copy of the" Follow Up" report and follows up with the agency (1) regarding the actions they are taking to ensure that they are in compliance with the requirements, and (2) following up with the agency to ensure that the actions indicated are completed. The Resource Manager may review the agency's policy and procedures with the provider and provide technical assistance and/or training if deemed necessary. The Resource Manager maintains this information in the agency records and if a trend is indicated, there is a discussion at the annual quality review, where the agency would need to add the issue to their Quality Improvement Plan.

Critical incidents that occur within the family home where there is in-home supports, the assigned Case Manager conducts the follow up and maintains the documentation of the follow up in the individual's master file. The notification of the follow up is made to their Case Management Supervisor and Assistant Regional Director

Evidence

DDS Critical Incidents

Quarter	# of Critical	Follow Up	No fw/up	Action Taken*
02/01/08 - 06/30/08	7	6	1	
07/01/08 - 09/30/08	2	1	1	
10/01/08 - 12/31/08	3	2	1	
2008 Totals	**12**	**9**	**3**	
01/01/09 - 03/31/09	10	10		
04/01/09 - 06/30/09	6	6		
07/01/09 - 09/30/09	5	5		
10/01/09 - 12/31/09	8	4	4	
2009 Totals	**29**	**25**	**4**	
01/01/10 - 03/31/10	8	5	3	
04/01/10 - 06/30/10	9	4	5	
07/01/10 - 09/30/10	8	8		
10/01/10 - 12/31/10	4	4		
2010 Totals	**29**	**21**	**8**	
Grand Total	**70 (100%)**	**55(79%)**	**15(21%)**	

***no data available**

Action Plan/Remediation

Each region will maintain a "Critical Incident" database. This database will include information on follow up received by the Case Manager or Interdisciplinary Team and actions taken by DDS when the follow up did not occur or was inadequate.

The Department will be looking to review and revise (as necessary):

- Incident reporting procedure
- DDS 255, Incident Reporting Form
- DDS 255 Follow-up Form
- Critical Incident Database
- Regional on-call procedure as related to critical incidents

ASSURANCE IV: Health and Welfare - The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub- Assurance IVa: The state on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure IVavii: Number and percent of substantiations of abuse or neglect.

System Monitoring Processes

All completed investigation reports result in the substantiation or the non-substantiation of the allegation (s) by those agencies (DCF, OPA, DDS, DSS) authorized by CT General Statutes to substantiate abuse or neglect. The DDS process for investigation review incorporates methods to address disagreements by the applicable state agency in the review of the investigatory process outcome, i.e. substantiation of abuse or neglect.

The results (substantiated or not substantiated) of all completed investigations are tracked by the three DDS regional Abuse and Neglect Liaisons. If an allegation is substantiated and recommendations are generated as a result of the substantiation, or if the allegation is not substantiated but recommendations are generated, the three DDS regional Abuse and Neglect Liaisons track recommendation responses and receive verification of timely implementation. The implementation of recommendations contained in an investigation report is also monitored by the state Quality Service Review system.

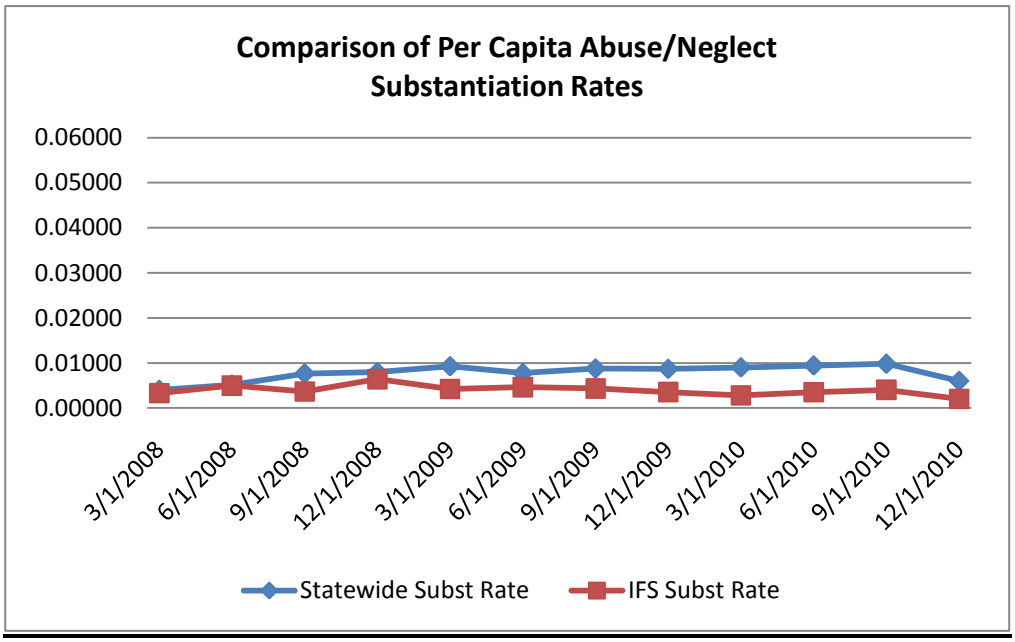
As mandated by CT General Statutes related to the DDS Abuse and Neglect Registry, if an employee is terminated for substantiated abuse or neglect by an authorized state agency, the employer must notify the DDS of the termination. After verification of necessary information contained in the investigation report, the DDS will notify the terminated employee of the DDS Registry Notification and the right to an administrative hearing, the outcome of which will determine if the individual's name should be placed on the DDS Abuse and Neglect Registry.

Prior to the employment of any applicant by a DDS service provider, the employer must inquire to the DDS if the potential employee's name is on the DDS Abuse and Neglect Registry. If on the Registry, the employer shall not hire said applicant.

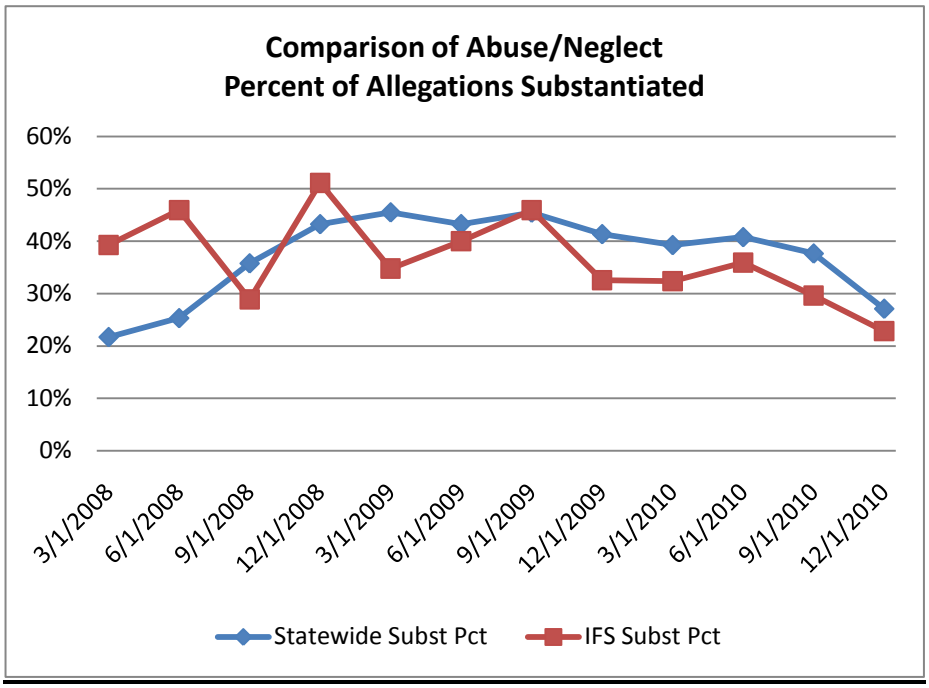
Evidence

The regional abuse and Neglect Liaisons track allegations, investigations, substantiations including any recommendations generated from the findings of the investigation, as applicable and enter related data into the DDS eCAMRIS. The following tables represent a compilation of eCAMRIS abuse and neglect data related to IFS Waiver participants. Also, please see PM IVaii for more data related to abuse and neglect.

Per Capita Substantiation Rates		
Qtr End Date*	Statewide Subst Rate	IFS Subst Rate
3/31/2008	0.00402	0.00331
6/30/2008	0.00517	0.00496
9/30/2008	0.00764	0.00366
12/31/2008	0.00794	0.00639
3/31/2009	0.00924	0.00420
6/30/2009	0.00773	0.00462
9/30/2009	0.00874	0.00432
12/31/2009	0.00866	0.00354
3/31/2010	0.00899	0.00277
6/30/2010	0.00942	0.00350
9/30/2010	0.00979	0.00404
12/31/2010	0.00600	0.00201



Qtr End Date*	Statewide Subst Pct	IFS Subst Pct
3/31/2008	22%	39%
6/30/2008	25%	46%
9/30/2008	36%	29%
12/31/2008	43%	51%
3/31/2009	46%	35%
6/30/2009	43%	40%
9/30/2009	45%	46%
12/31/2009	41%	33%
3/31/2010	39%	32%
6/30/2010	41%	36%
9/30/2010	38%	30%
12/31/2010	27%	23%



Action Plan/Remediation

Deviations from any of the above listed processes would include, but not be limited to, investigation training, training in the DDS abuse and neglect policy and procedures, enhanced monitoring, training in the DDS Quality Service Review system, training in the DDS Abuse and Neglect Registry, or any other areas deemed necessary by the DDS or the agency having statutory jurisdiction over the reporting, investigation, and investigation outcome processes.

State of Connecticut

Department of Developmental Services

Individual and Family Support

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance V: Administrative Authority – The State Demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.

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

Performance Measure Vai: DSS meets with DDS to evaluate DDS summary reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity, and to monitor compliance with the interagency agreement.

Performance Measure Vaii: DSS conducts the Fair Hearing process and provides instruction to DDS on the implementation of waiver policies.

Performance Measure Vaiii: Number and percent of records reviewed by DSS that met the LOC and POC requirements.

ASSURANCE V: **Administrative Authority** - The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for facets of the program.

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

Performance Measure Vai: DSS meets with DDS to evaluate DDS summary reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity, and to monitor compliance with the interagency agreement.

System Monitoring Processes

DSS management staff meets with DDS management staff to review DDS' performance of delegated waiver functions. Topics of review include quality and timeliness of LOC determinations, quality and timeliness of Individual Plans, review of new policies and procedures that relate to aspects of the waiver including provider qualifications, review and approval of service rates, review and approval of waiver amendments, comparison of waiver enrollment against authorized slots, comparison of approved expenditures to actual expenditures. If either agency identifies an area that needs correction or improvement a plan or strategy is developed and progress is reviewed at future meetings.

Evidence

FY 08—As a result of several untimely deaths due to choking incidents between 2005 and 2008 DSS and DDS reviewed records of individuals who had dysphagia or other choking risks. Inconsistencies between assessments and Individual Plans were found in some of the records.

FY 09—The need for DDS waiver regulations was identified.

Review of approved waiver slots and enrollment showed that the number of approved slots needed to be reduced.

FY10—DSS and DDS reviewed waiver rates and utilization.

Medicaid Operations reports downloaded from DSS data were added to the DDS eCAMRIS system so that Case Managers could easily track Medicaid information including redetermination dates for individuals on their caseload. DDS and DSS Central Office staff conducted trainings for DDS Case Managers in all regions.

FY11—Record reviews showed that some information was not being completed on the IP forms.

Action Plan/Remediation

FY08-- DDS identified a list of items for Planning and Support Teams to review and address when developing an IP for an individual with choking risks. Case Managers were trained by their supervisors on how to ensure that IPs address risk areas identified in assessments and that physician orders and other documents in the file do not have conflicting information that could confuse staff working with the individual (eg. One document stated that food should be cut in ¼ inch pieces and another document said quarter size pieces).

FY09-- DSS reviewed waiver regulations drafted by DDS and gave feedback on those draft regulations.

DDS prepared an amendment to reduce the number of waiver slots. DSS reviewed the amendment and submitted it to CMS for approval.

FY10-- Medicaid Operations reports downloaded from DSS data were added to the DDS eCAMRIS system so that Case Managers could easily track Medicaid information including redetermination dates for individuals on their caseload. DDS and DSS Central Office staff conducted trainings for DDS Case Managers in all regions.

FY11-- An IP Training Tool was developed and DDS Case Managers were trained.

ASSURANCE V: **Administrative Authority** - The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.

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

Performance Measure Vaii: DSS conducts the Fair Hearing process and provides instruction to DDS on the implementation of waiver policies.

System Monitoring Processes

When DDS denies a new service or additional services to a waiver participant the participant is notified of the decision in writing by the CO Waiver Policy and Enrollment Unit. The decision is sent to the participant or the legal representative by Certified Mail with a return receipt. Instructions and a form for requesting a Fair Hearing with the Department of Social Services are included with the written service denial. If the participant or the legal representative requests a Fair Hearing it is scheduled by DSS and conducted by a DSS Hearing Officer.

Evidence

Timeframe	# of Service Denials	# of Hearings Requested	Number of Hearings Held
2/1/08-1/31/09	4	0	0
2/1/09-1/31/10	3	1	1
2/1/10-1/31/11	1	0	0

Action Plan/Remediation

Only one out of eight service denials resulted in a Fair Hearing. The DSS Hearing Officer disagreed with the DDS decision to deny the request for 1:1 staff support at the participant's day program. DDS provided the 1:1 staff support while waiting for the Hearing Officer's decision and then continued the funding for the support once the decision was rendered.

ASSURANCE V: **Administrative Authority** - The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.

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

Performance Measure Vaiii: Number and percent of records reviewed by DSS that met the Level of Care and Plan of Care requirements.

System Monitoring Processes

DSS reviews 10-15 randomly selected records each quarter to ensure that the individuals meet the LOC required for the IFS waiver, that the LOC redetermination was done within 365 days and that the Individual Plans address identified personal goals and risk areas.

Evidence

FY 08—Inconsistencies between information found in assessments and the Individual Plans were found in some of the records. All individuals reviewed met the LOC requirement and redetermination timeframes.

FY 09— Inconsistencies between information found in assessments and the Individual Plans were found in some of the records. All individuals reviewed met the LOC requirement. In some cases the redeterminations were not completed within 365 days.

FY10—No records were sent to or reviewed by DSS due to loss of staff at both agencies as a result of the Retirement Incentive Program and the inability to refill positions.

FY11—Record reviews showed that some information was not being completed on the IP forms.

Action Plan/Remediation

FY08--DDS identified a list of items for Planning and Support Teams to review and address when developing an IP. Case Managers were trained by their supervisors on how to ensure that IPs address risk areas identified in assessments and that physician's orders and other documents in the file do not have conflicting information that could confuse staff working with the individual.

FY09—Case Managers were trained on waiver requirements including the need for LOC redeterminations to be completed within 365 days.

FY10—No records were reviewed by DSS, however, Medicaid Operations reports downloaded from DSS data were added to the DDS eCAMRIS system so that Case Managers could easily track Medicaid information including redetermination dates for individuals on their caseload. DDS and DSS Central Office staff conducted trainings for DDS Case Managers in all regions.

FY11-- An "IP Training Tool" was developed and DDS Case Managers were trained.

State of Connecticut

Department of Developmental Services

Individual and Family

Independence Plus Home and Community-Based

Services Waiver:

February 1, 2008 – January 1, 2011

Assurance VI: Financial Accountability – The State demonstrates that it has designed and implemented an adequate system of assuring financial accountability of the waiver program.

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

Performance Measure VIai: Number and percent of attendance and billing records reviewed and found to be accurate.

Performance Measure VIaii: Number and percent of audits conducted on reported allegations of potential irregularities.

Performance Measure VIaiii: Number and percent of submitted billing records found by the Department of Administrative Services to be lacking requisite participant eligibility and authorization.

ASSURANCE VI: Financial Accountability - The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Sub- Assurance VIa: State Financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measure VIai: Number and percent of attendance and billing records reviewed and found to be accurate.

System Monitoring Processes

Each quarter the Department's Internal Auditors conduct a Waiver Spectrum Audit in each region of DDS. The Waiver Spectrum Audits review a sample of case management records in each DDS Region. The records are tested to ensure compliance with DDS policies and procedures with enrollment verification, form completion, Plans of Care completion, etc. As part of this review, if it is determined that forms are not present to support services being rendered and billed, a recoupment is done for the services that were not properly supported by case records. The results of the audits are shared with DDS Regional Directors and the PRAT/Waiver Managers and they are given a 30-day period to present absent or inadequate documentation before a recoupment is finalized. The specific citations are reviewed for the individual corrective action and the Regions are instructed to review all case records to ensure that on a system-wide basis the same citations are not occurring with other consumers not audited. On at least a semi-annual basis, a list of recoupments is submitted to the Department of Administrative Services (our DDS billing agent) to process the recoupments. This audit has been in place since May 2007 and reviews consumers on both the IFS and the Comp Waivers.

As part of the Waiver Spectrum Audits, beginning in April 2010, the Audit Unit implemented a review of all Waiver Spectrum Audit Sampled Participants billing for a sampled period in comparison to attendance reports as recorded in the DDS Web Res Day attendance system for any consumers using a contracted vendor (i.e. no direct hires are tested). The attendance of the participants in contracted programs is tested to ensure that the Waiver billing matched the reported attendance data. When billing irregularities are determined in the auditing process, the reason for exception is identified. If the service was rendered but not billed, and the service is a waivered service, we coordinate with the Central Office Web Res Day supervisor to ensure that the attendance is submitted and billed. However, if we billed for a service that was not documented in the attendance system, we would process a correction in the billing process to reverse the inappropriate billing service.

The reporting of billing reviews is done with the Waiver Spectrum Audit Reports if the testing is completed at the same time, or it is issued once the billing testing is completed.

Evidence

As documented on the attached chart, the Waiver Billing Audits have been done (as of December 31, 2010) on a total of 107 participants in the IFS Waiver with contracted services and determined that of the 107 sampled consumers, 66 had contracted services and of those, and 63 (95.5%) had properly billed services. The fourth quarter of SFY 2010 noted two exceptions in the billed services, due to providers not having a Medicaid Performing Provider number during the period of the services being rendered (without a Performing Provider number, the Waiver billing cannot be processed); therefore we were unable to bill the services. The second quarter of SFY 2011 noted one exception for a service that was rendered, but unable to be billed as it is not a waivered service and was therefore unable to be billed.

As we have seen thus far, the exceptions are for incidents where a service was provided but was not able to be billed for various reasons (not a waivered service, lacking Medicaid Performing Provider number for the service period, etc.) please see below.

Action Plan/Remediation

The Action Plan is to continue to conduct the quarterly billing audits and address each noted inconsistency that is identified in the audits.

Pender, Krista M

From: Pender, Krista M
Sent: Wednesday, January 20, 2010 12:45 PM
To: O'Connell, Vincent
Cc: Bremmer, Rosa J
Subject: Waiver Audit Expansion

Vince,

We've been requested to expand our Waiver Audits to test the use of the new self-hire timesheets by the ISA consumers who hire their own staff. This is as a result of the PERM audit bringing to our attention that the self-hire staff were not documenting the IP goals and objectives that were being worked on in their supports they provided to our consumers, which is stated in our Waiver and in the Waiver manual that will be done. The new timesheets were implemented Dec 1, 2009. I have committed to testing timesheets during our Waiver Audits, as I do believe this should be a somewhat easy test step. However, it will be the case manager/PRAT Liaison's responsibility to obtain all self-hire timesheets from the FI's and have them onsite at our audits for the testing.

The second addition to the Waiver Audit is a request from Deb to supplement the Waiver Quality Improvement Assurances that we need to show that we are reviewing certain aspects of our Waiver compliance. This step would test services being billed and verifying that they match the documented services that we are to be providing to our consumers. I believe this can be done with documents already pulled and reviewed in the Waiver Audits, namely the ECamris placement screens, IP6 budget data, and the actual IP's on file. However, this particular test step will NOT be conducted by audit staff, but will be undertaken by either Marie or myself. The billing procedure codes are complicated as is the Medicaid system, which the audit staff do not (and will not) have access to; additionally determining if the correct procedure code is used would be better suited to our review on the Revenue Enhancement side.

I am planning to implement the timesheet testing in the February audit in North Region and perhaps starting the billing at that same time (this particular aspect is still in the development phase). I wanted to run this by you so that you were aware that there are changes to the scope of the Waiver Audits, but I believe these are positive changes and should be implemented. However, these additional steps will be reported on separately (as I am currently planning at this point in time). I believe a report to the Self Determination Directors would be the best method to report on self-hire timesheet compliance. I am developing the billing test steps and reporting at this point in time.

Thanks very much,

Krista

Krista Pender, Director, Audit, Billing, and Rate Setting
DDS State of Connecticut
Fiscal Division
Voice (860) 418-6109 Fax (860) 418-6001 RightFax (860) 622-2641
Send to: Krista.Pender@ct.gov
<http://www.ct.gov/dds>

ASSURANCE VI: Financial Accountability - The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Sub- Assurance VIa: State Financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measure VIaii: Number and percent of audits conducted on reported allegations of potential irregularities.

System Monitoring Processes

The Department's Audit Unit conducts numerous audits on agencies who contract with the Department and of the Department's operations to ensure compliance with policies and procedures. Allegations of potential irregularities are reviewed upon notice to determine the proper actions to be taken, either audit or investigations. Allegations are typically submitted based on specific provider concerns or individual concerns and are not specified by the Waiver that the provider provides services under or that the participants are enrolled in. Therefore, while the Audit Unit conducts many audits, the Waiver is secondary to the audit. All audits are reviewed to determine proper staff assignment and scheduling. Audits are reported to the entity or department requesting the audit, and draft audit reports are required to be responded to formally by the auditee. These responses are incorporated into the final audit report.

Evidence

Audit reports that do pertain to IFS individuals are included for examples (reports on the ------ ISA and the ------- ISA) please see following pages. Both of these audits were referred to the Department of Social Services as the State's Medicaid Agency with the request for a fraud review and for their determination of further action if appropriate. The ------- ISA was referred by DSS to the Chief State's Attorney Office, Medicaid Fraud Unit and was prosecuted. The ------- ISA is currently March 11, 2011) under review at DSS for potential referral to the Chief State's Attorney's Office, Medicaid Unit.

Action Plan/Remediation

The ------ ISA was referred by DSS to the Chief State's attorney Office, Medicaid Fraud Unit and was prosecuted. The ------ ISA is currently (March, 2011) under review at DSS for a potential referral to the Chief State's attorney Office, Medicaid Fraud Unit. The action plan is to continue to conduct the audits as they are received and continue to issue timely reports. DDS will begin to note what waiver the allegations are affecting on a go forward basis.

[Samples of actual audits were attached here.]

State of Connecticut

Department of Developmental Services

DDS 4-33a Report Form

Reporting of Allegations of Unauthorized, Irregular or Unsafe Handling of State Funds in Accordance of DDS False Claims Policy Act

Use this form to report allegations of unauthorized, irregular, or unsafe handling of state funds, as noted in Connecticut General Statutes (CGS) 4-33a. Please note the this form is used to report issues under CGS 4-33a and that this Statute also applies to client personal funds of individuals living in DDS operated residential settings.

Please answer the topic areas as accurately and completely as possible. All details will remain confidential and only be shared with the appropriate parties in the disposition of the allegations as the DDS deems appropriate to be shared.

Additional questions may arise in the course of reviewing the allegations supplied. However, your contact information will also be protected and only be shared as deemed necessary by management of DDS.

Allegations of Inappropriate Use of State Funds	
Please answer the following questions to the best of your knowledge of the allegations	
Activities performed by (Company Name, Individual Hire Employee Name, other):	
Organization Structure (Qualified Provider, Direct Hire, State Employee, Family Member, etc.)	
Fiscal Intermediary	☐ *Yes* *If yes, note which FI* ☐ *No*

Allegations of Inappropriate Use of State Funds	
Funds involved (check one)	☐ *State Funds* ☐ *Client Personal Funds*
If client funds, please note client name and DDS number	
Other parties notified (i.e. case manager, broker, family member, Fiscal Intermediary, Regional Director, etc)	
Details of allegations	
Time period involved	
Contact person, name and number/email (information to be kept confidential by DDS)	
Any other supporting documentation pertaining to allegations:	
Documentation of allegations submitted with complaint (list data supplied, if any)	

_____ _____ _____

Signature of Complaintant Printed Name of Complaintant Date Completed

December 6, 2005

ASSURANCE VI: Financial Accountability - The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Sub- Assurance VIa: State Financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measure VIaiii: Number and percent of submitted billing records found by the Department of administrative Services to be lacking requisite participant eligibility and authorization.

System Monitoring Processes

DDS funds all providers of services and supports from State General Funds directly appropriated to the DDS. For HCBS waiver services DDS serves as the Medicaid Billing Provider and holds Performing Provider Agreements with private providers of service through delegation by the Medicaid Agency (DSS).

DDS sends waiver billing to the Department of Administrative Services (DAS) for processing through the Medicaid Management Information System (MMIS). When the requirements for Federal Financial Participation are not met for the billing for a specific individual, service, or provider that billing is rejected by the system and no FFP is claimed. The most common reasons for billing to be rejected by the system are: the individual has not met the eligibility requirements; the provider was not certified/eligible to be paid for the service on the date of the service; the claim was denied as the services are included in the MCO coverage; and the procedure billed is not a covered service under the individual's benefit plan. DAS sends quarterly reports of rejected billing to DDS for correction. If the error is corrected within 12 months the bill can be reprocessed for payment. If a bill cannot be corrected or is not corrected within the required timeframe no FFP is claimed.

Evidence

Fiscal Year	Total Billing	Federal Revenue	Rejected Billing	% of billing lacking eligibility and authorization
FY 08	$61,627,052	$61,400,662	$226,390	**0.37%**
FY09	$74,140,908	$73,614,486	$526,422	**0.71%**
FY10	$112,470,305	$112,995,638	$1,170,742	**1.00%**
FY11	$54,918,432	$54,530,785	$387,647	**0.71%**

The FY 08 data represent only five months of billing, February through June and the FY 11 data represent only 6 months of billing, July through December. We believe that the slight increase in rejected billing in FY 10 was the result of a decrease in staff due to retirement and the inability to refill the position. As a result not as many corrections were able to be done prior to billing as were done in previous years. In FY 11 a temporary staff person was hired and thus far the percentage of rejected billings is equal to FY09.

Action Plan/Remediation

The percentage of rejected billing is generally less that 1% of all IFS waiver billing. Rejected billing shows that the billing system is catching errors prior to them being submitted for federal reimbursement. The state is losing on federal reimbursement when the rejected billing isn't corrected and resubmitted within the required timeframe. DDS has submitted a request for permanent replacement staff but no one has been hired yet.

Connecticut Department of Developmental Services
IFS Evidence Report – List of Reference Materials

I. Level of Care

A. Performance measure Iai: Number and percent of new enrollees who had a LOC indicating a need for ICF/MR prior to receipt of services.

1. DDS Policy, Waiver Management, No. I.B. PO. 2
2. DDS Procedure, Application for New or Additional Services/Supports and Enrollment Procedures for the MR HCBS Waiver – Working Draft No. I.B.2 PR. 001.
3. DDS Procedure, Coordination of Waiver Enrollment Activities for Individuals Receiving State Funded Services.
4. DMR Directive, Maximizing Enrollment in DMR HCBS Waivers for Individuals Receiving or Seeking DMR Services and Supports No. I.B.DIR. 001.
5. Medicaid Operations Trainings 2009-2011, Information Packets and Sign-in Sheets.
6. DDS 219e, Waiver Enrollment Referral Form
7. eCAMRIS Medicaid Operations Reports.

B. Performance Measure Ibi: Number and percent of LOC determinations that are reevaluated at least annually

1. DDS Procedure, Application for New or Additional Services/Supports and Enrollment Procedures for the MR HCBS Waiver, No.I.B.2. PR. 001.
2. DDS Procedure, Enrollment and Eligibility Maintenance for the DMR Comprehensive HCBS Waiver, No.I.B.2.PR. 003.
3. DDS Procedure, Components of Individual Plan, No. I.C.1.PR. 002.a.

C. Performance Measure Ici: Number and percent of initial LOC determinations verified by a QMRP qualified staff.

1. DDS Policy, Waiver Management, No. I.B. PO. 2

2. DDS Procedure, Application for New or Additional Services/Supports and Enrollment Procedures for the MR HCBS Waiver – Working Draft No. I.B.2 PR. 001.
3. DDS Procedure, Coordination of Waiver Enrollment Activities for Individuals Receiving State Funded Services.
4. DMR Directive, Maximizing Enrollment in DMR HCBS Waivers for Individuals Receiving or Seeking DMR Services and Supports No. I.B.DIR. 001.
5. Medicaid Operations Trainings 2009-2011, Information Packets and Sign-in Sheets.
6. DDS 219e, Waiver Enrollment Referral Form.
7. eCAMRIS Medicaid Operations Reports.
8. DDS Waiver Policy and Enrollment QMRP List.

II. Service Plan

A. Performance Measure IIai: Number and percent of quality indicators scored "met" on indicators related to assessments, identified needs and personal goals that were incorporated into the IP.

1. DDS Procedure, Components of Individual Plan, No. I.C.1.PR.002a
2. DDS, Individual Plan Guide
3. DDS QSR Workflow Diagrams, 2009 - Present
4. DDS QSR Rating Criteria, March 6, 2009
5. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

B. **Performance Measure IIbi: Number and percent of waiver participants who had an IP developed within one year of the previous IP.**

1. DDS Procedure, Components of Individual Plan, No. I.C.1.PR. 002.a.
2. DDS, Individual Plan Guide

C. **Performance Measure IIbii: Number and percent of "met "quality indicators related to giving individuals information on and assistance with selecting qualified providers.**

1. DDS Procedure, Components of Individual Plan, No. I.C.1.PR.002a.
2. DDS, Individual Plan Guide

3. "Making Good Choices about Your DMR Supports and Services, A Handbook
4. DDS QSR Workflow Diagrams, 2009
5. DDS QSR Rating Criteria, March 6, 2009
6. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

D. Performance Measure IIci: Number and percent of "met" quality indicators that IPs are updated/revised annually or when warranted by changes in the waiver participant's needs.

1. DDS Procedure, Components of Individual Plan, No. I.C.1.PR.002a
3. DDS, Individual Plan Guide
4. DDS QSR Workflow Diagrams, 2009
5. DDS QSR Rating Criteria, March 6, 2009
6. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

E. Performance Measure IIdi: Number and percent of FI service billings that match the service authorizations.

F. Performance Measure IIdii: Number and percent of "met" quality indicators related to delivery of services in accordance with the service plan including type, scope, amount and frequency.

1. DDS Procedure, Components of Individual Plan, No. I.C.1.PR. 002a
2. DDS, Individual Plan Guide
3. DDS Procedure, Planning and Support Team, No.1.C.1.PR.002
4. DDS QSR Workflow Diagrams, 2009
5. DDS QSR Rating Criteria, March 6, 2009
6. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

G. Performance Measure IIei: Number and percent of new applications showing that each new enrollee makes a choice between waiver services and institutional care.

1. DDS Policy, Waiver Management, No. I.B. PO. 2
2. DDS Procedure, Application for New or Additional Services/Supports and Enrollment Procedures for the MR HCBS Waiver – Working Draft No. I.B.2 PR. 001.

3. DDS Procedure, Coordination of Waiver Enrollment Activities for Individuals Receiving State Funded Services.
4. DMR Directive, Maximizing Enrollment in DMR HCBS Waivers for Individuals Receiving or Seeking DMR Services and Supports No. I.B.DIR. 001.
5. Medicaid Operations Trainings 2009-2011, Information Packets and Sign-in Sheets.
6. DDS 219e, Waiver Enrollment Referral Form.
7. eCAMRIS Medicaid Operations Reports.
8. DDS 222, HCBS Service Selection Form.

H. Performance Measure IIeii: Number and percent of "met' quality indicators showing that individuals are given a choice between/among waiver services and providers.

1. DDS Procedure, Components of an Individual Plan, No.I.C.1.PR>002.a.
2. DDS Individual Plan Guide
3. "Making good Choices about Your DDS Supports and Services", a Handbook
4. DDS QSR Workflow Diagrams, 2009
5. DDS, QSR Rating Criteria, March 6, 2009
6. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

III. Qualified Providers

A. Performance Measure IIIai: Number and percent of new provider applicants qualified per DDS procedure.

1. DDS Procedure: Enhanced Monitoring; II.C.PR.003

2.DDS Application Requirements:
http://www.ct.gov/lib/dds/operations_center/application_for_qualified_providers.pdf

3.DDS Assurance Agreement:
http://www.ct.gov/dds/lib/dds/operations_center/agency_assurance_agreement.pdf

4.DDS Provider Agreement:
http://www.ct.gov/dds/lib/dds/operations_center/providers/provider_agreement.pdf

B. Performance Measure IIIaii: Number and percent of professionals who submit licensure or certification documentation annually.

1. DDS Procedure: Enhanced Monitoring; II.C.PR.003
2. DDS Application Requirements: http://www.ct.gov/lib/dds/operations_center/application_for_qualified_providers.pdf
3. DDS Assurance Agreement: http://www.ct.gov/dds/lib/dds/operations_center/agency_assurance_agreement.pdf
4. DDS Provider Agreement: http://www.ct.gov/dds/lib/dds/operations_center/providers/provider_agreement.pdf

C. Performance Measure IIIaiii: Number and percent of providers certified per DDS certification process.

D. Performance Measure IIIbi: Number and percent of staff newly hired by participants who are qualified to provide services.

E. Performance Measure IIIci: Number and percent of "met" quality indicators that relate to support person training.

F. Performance Measure IIIcii: Number and percent of direct hire staff who have received required training.

IV. Health and Welfare

A. Performance Measure IVai: Number and percent of new staff hired by participants who self-direct that received training on identifying abuse and neglect and all statutory reporting.

1. DDS Policy: Staff Training; II.D.PO.005
2. DDS Policy: Abuse and Neglect; I.F.PO.001 (http://www.ct.gov/dds/lib/dds/dds_manual/if/abuse_neglect/ifpo001_abuse_neglect_policy_web_rev_8-09.pdf)
3. DDS Procedure: Investigation: Recommendations and Prevention Activities: I.F.PR.004 (http://www.ct.gov/dds/lib/dds/dds_manual/if/abuse_neglect/ifpr004_abuse_neglect_inv_re_prev_rev_8-09.pdf)

4. DDS Community Living arrangement Licensing Regulation 17a-227-14: Staff Development (http://www.ct.gov/dds/cwp/view.asp?a=2839&q=331684)
5. DDS Quality Service Review Interpretive Guidelines – Documentation (D), pp.33-5 (http://www.ct.gov/dds/lib/dds/qualitymgmt/qsrig/documentation.pdf)
6. DDS Training Requirements for Direct Hire Employees, 2009 (http://www.ct.gov/dds/lib/dds/self_determination/direct_hire_training_requirements_5_2009.pdf)
7. DDS HCBS Consolidated Waivers Operations Manual, Sec. 7 (http://www.ct.gov/dds/lib/dds/waiver/hcbs_consolidated_waiver_operations_manual.pdf)
8. DDS Tainting Material for Direct Hire Employees (http://www.ct.gov/dds/lib/dds/self_determination/abusesheet.pdf)
9. The College of Direct Support (http://info.collegeofdirectsupport.com/go/curriculum/courses)

B. Performance Measure IVaii: Number and percent of reported instances of abuse or neglect allegations that are investigated.

1. DDS Policy: Abuse and Neglect; I.F.PO.001
2. DDS Procedure: Allegations: Reporting and Intake Processes; I.F.PR. 001
3. DDS Procedure: Notification: Allegations and Completed Investigations to Appropriate Parties; I.F.PR.002
4. DDS Procedure: Investigation: Assignment, Tracking, Review, Completion; I.F.PR.003
5. DDS Procedure: Investigation: Recommendations and Prevention Activities: I.F.PR.004
6. DDS and Office of Protection and Advocacy for Persons with Disabilities Interagency Agreement; June, 2008

C. Performance Measure IVaiii: Number and percent of "met" quality indicators related to the implementation of recommendations resulting from abuse/neglect investigations.

1. DDS procedure: Investigations: Recommendations and Prevention activities: I.F.PR.004
2. DDS QSR Workflow Diagrams, 2009
3. DDS QSR Rating Criteria, March 6, 2009

4. DDS Procedure: Case Management Quality Services Review Procedure; I.C.PR.001g

D. Performance Measure IVaiv: Number and percent of mortality reviews conducted annually on deaths that meet the DDS policy on mortality reviews.

1. DDS Policy: Mortality Reporting Review; I.D.PO.001
2. DDS Procedure: Mortality Review; I.D.PR.005
3. DDS Mortality Annual Report, SFY 2010
4. DDS Mortality Annual Report, SFY 2009
5. DDS Mortality Annual Report, SFY 2008
6. DDS, Confidential Minutes of IMRB Meetings.

E. Performance Measure IVav: Number and percent of staff who have received training in reporting and prevention of abuse and neglect individual rights.

1. DDS Policy: Staff Training; II.D.PO.005
2. DDS Policy: Abuse and Neglect; I.F.PO.001 (http://www.ct.gov/dds/lib/dds/dds_manual/if/abuse_neglect/ifpo001_abuse_neglect_policy_web_rev_8-09.pdf)
3. DDS Procedure: Investigation: Recommendations and Prevention Activities: I.F.PR.004 (http://www.ct.gov/dds/lib/dds/dds_manual/if/abuse_neglect/ifpr004_abuse_neglect_inv_re_prev_rev_8-09.pdf)
4. DDS Community Living arrangement Licensing Regulation 17a-227-14: Staff Development (http://www.ct.gov/dds/cwp/view.asp?a=2839&q=331684)
5. DDS Quality Service Review Interpretive Guidelines – Documentation (D), pp.33-5 (http://www.ct.gov/dds/lib/dds/qualitymgmt/qsrig/documentation.pdf)
6. DDS Training Requirements for Direct Hire Employees, 2009 (http://www.ct.gov/dds/lib/dds/self_determination/direct_hire_training_requirements_5_2009.pdf)
7. DDS HCBS Consolidated Waivers Operations Manual, Sec. 7 (http://www.ct.gov/dds/lib/dds/waiver/hcbs_consolidated_waiver_operations_manual.pdf)
8. DDS Tainting Material for Direct Hire Employees (http://www.ct.gov/dds/lib/dds/self_determination/abusesheet.pdf)

9. The College of Direct Support (http://info.collegeofdirectsupport.com/go/curriculum/courses)

F. Performance Measure IVavi: Number and percent of Critical Incidents where there was follow-up by the region per DDS policy.

1. DDS Procedure: Incident Reporting; I.D.PR.009
2. DDS procedure Incident Reporting for Individuals Who Live in Their Own/Family Home & Receive DDS Funded Services; I.D.PR.009a

G. Performance Measure IVavii: Number and percent of substantiations of abuse or neglect.

1. DDS Policy: Abuse and Neglect; I.F.PO.001
2. DDS Procedure: Allegations: Reporting and Intake Processes; I.F.PR.001
3. DDS Procedure: Notification: allegations and Completed Investigations to Appropriate Parties; I.F.PR.002
4. DDS Procedure: Investigation: Assignment, Tracking, Review, Completion; I.F.PR.003
5. DDS Procedure: Investigation: Recommendations and Prevention Activities: I.F.PR.004
6. DDS Abuse and Neglect Registry; I.F.PR.005
7. DDS and Office of Protection and Advocacy for Persons with Disabilities Interagency Agreement; June, 2008
8. DDS and Department of Public Safety Memorandum of Understanding; March 2011
9. E-CAMRIS Data

V. Administrative Authority

A. Performance measure Vai: DSS meets with DDS to evaluate DDS summary reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity, and to monitor compliance with the interagency agreement.

1. Memorandum of Understanding Department of Social Services and the Department of Developmental Services Regarding Home and Community Based Waivers: The Comprehensive Supports Waiver effective 10/1/2008

through 9/30/2013 and the Individual and Family Support Waiver effective 2/1/2008 through 1/31/2013

2. IP Improvement Committee Review Checklist-developed Spring 2008 and revised June 2010

3. Food Consistency Guidelines
http://www.ct.gov/dds/lib/dds/health/attachf_guidelines_consistency_mod_foodsliquids.pdf

4. Swallowing Risks
http://www.ct.gov/dds/lib/dds/health/attacha_med_dsyphagia_swallowing_risks.pdf

5. Dysphagia Train the Trainer
http://www.ct.gov/dds/lib/dds/edsupp/cal2010/dysphagia_registration_06_07_2010.pdf

6. Dysphagia Fact Sheet
http://www.ct.gov/dds/lib/dds/factsheets/fs_dysphagia.pdf

7. FORM-State of Connecticut Department of Social Services Request for Administrative Hearing *Home and Community Based Services (HCBS) Waiver for Persons with Mental Retardation*

8. http://www.ct.gov/dds/lib/dds/waiver/medicaid_fair_hearing_rights_faqs.pdf

9. QSR Interpretive Guidelines
http://www.ct.gov/dds/cwp/view.asp?a=2839&q=464614

10. DDS, QSR Handbook for Case Management Issued 12-17-2010

11. DDS,FORM-IP Revised Training Document, 2010

B. Performance Measure Vaii: DSS conducts the Fair Hearing process and provides instruction to DDS on the implementation of waiver policies.

1. See VA above

C. Performance Measure Vaiii: Number and percent of records reviewed by DSS that met the LOC and Plan of Care requirements.

1. See VA above

VI. Financial Accountability

A. Performance Measure VIai: Number and percent of attendance and billing records reviewed and found to be accurate.

1. Request from the DDS system design Committee to conduct a waiver bulling review during the quarterly waiver compliance audits. Email to Chief Financial Officer of 1/20/10.

B. Performance Measure VIaii: Number and percent of audits conducted on reported allegations of potential irregularities.

1. DDS Procedure: False Claims Act Dissemination Procedure; II.A.PR.002

C. Performance Measure VIaiii: Number and percent of submitted billing records found by the Department of Administrative Services to be lacking requisite participant eligibility and authorization.