Home- and Community-Based Services (HCBS)
2018 Provider Quality Management Self-Assessment

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health and Disability Waiver (HD)
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

Each provider is required to submit one, six-section self-assessment by **December 1, 2018**. This form is to be completed and submitted via fillable PDF as directed on the Provider Quality Management Self-Assessment[1] webpage. A password-protected electronic signature is required in Section E. in order for this document to be accepted. **Incomplete self-assessments will not be accepted.**

Section A. Identify the agency submitting this form.

Section B. Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services via email imeproviderservices@dhs.state.ia.us or phone at 800-338-7909, option 2.

Section C. Select the response option from the "Response Option" column that indicates the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the agency and must be resubmitted.

- Response options Include:
  - Yes or No response are available if required for the service
  - Yes, No, and N/A responses are available when the standard is not required for all service providers

    *Note: All standards are considered best practices

Section D. Please fill out the information as requested

Section E. Please complete and sign as directed

Section F. Please fill out the information as requested.

Questions should be directed to the HCBS Specialist assigned to the county where the parent agency is located. For a complete list of HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please go to the DHS webpage HCBS Waiver Provider Contacts[2]

[1] https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts

Section A. Agency Identification

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Please identify your parent agency by providing the following information using the text entry fields below.

Employer ID Number (EIN) (9 digits):					
Associated NPI:					
Agency Name (as registered to EIN):					
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Executive Director/Administrator:			Title:		
Email:			Telephone:		
Self-Assessment Contact Person:			Title:		
Email:			Telephone:		
Agency Website Address:					

Identify below any affiliated agencies covered under this self-assessment.

Agency Name	City	County	Associated NPI (10 digits)

Section B. Service Enrollment

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Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the annual Provider Quality Management Self-Assessment. If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

Program	AIDS/HIV Waiver	BI Waiver
Services	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Counseling ☐ Respite	☐ Adult Day Care ☐ Behavior Programming ☐ Agency Consumer-Directed Attendant Care ☐ Family Counseling and Training ☐ Interim Medical Monitoring and Treatment ☐ Prevocational Services ☐ Respite ☐ Supported Community Living ☐ Supported Employment
Program	**CMH Waiver**	**Elderly Waiver**
Service	☐ Family and Community Support Services ☐ In-home Family Therapy ☐ Respite	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Assisted Living Service ☐ Case Management ☐ Mental Health Outreach ☐ Respite

Program	HD Waiver	ID Waiver
Services	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Counseling ☐ Interim Medical Monitoring and Treatment ☐ Respite	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Day Habilitation ☐ Interim Medical Monitoring and Treatment ☐ Prevocational Services ☐ Residential-Based Supported Community Living ☐ Respite ☐ Supported Community Living ☐ Supported Employment
Program	**PD Waiver**	**Habilitation Services**
Services	☐ Agency Consumer Directed Attendant Care	☐ Day Habilitation ☐ Home-based habilitation ☐ Prevocational Habilitation ☐ Supported Employment Habilitation

Section C. State and Federal Standards

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For each of the following standards, the agency must select a response from each dropdown menu.

- Indicating "**Yes**" means the agency currently has in place policies and/or practices meeting the proposed standards and can provide documented evidence verifying such.
- Indicating "**No**" means the agency does not currently have policies, practices, and documented evidence in place. When a "**No**" is indicated, the agency must document in the space provided at the end of each area or requirement plans to meet the standards. The plan must identify the agency's timeline for meeting the standards. **Implementation of corrective action to address current Code of Federal Regulations (CFR), Iowa Code, or Iowa Administrative Code (IAC) standards must be completed within 30 days of the date in Section F of this form.**
- The selection of **"NA"** indicates the item is not applicable to the programs and services your agency is enrolled for, and is not applicable in accordance to Centers for Medicare and Medicaid, Code of Federal Regulations, Iowa Code, or IAC.

This annual Provider Quality Management Self-Assessment will be returned to the agency if all sections are not completed, responses chosen are not compliant with CFR, Iowa Code, or IAC, or otherwise deemed unacceptable.

If the agency requires technical assistance, contact the regional HCBS Specialist assigned to the agency (see page one).

I. Fiscal Accountability

IAC Chapters 78 and 79

At a Minimum, all providers will maintain evidence of:	
1. A system for setting rates based on reasonable and proper costs of service provision (for example: D-4s, fee schedules, County Rate Information System CRIS Report, Documentation to support assigned tier rate)	Choose One
2. The maintenance of fiscal and clinical records for a minimum of five years	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

II. Training Requirements

IC 235B.16, 232.69 and IAC Chapter 77

Trainings are required for certain habilitation and waiver programs as listed below. It is recommended as a best practice that each waiver program provide all the trainings listed below.

1. The curriculum used by the provider is approved by the Iowa Department of Public Health, and includes the following:	
a. Child and/or dependent abuse training completed within six months of hire (or documentation of current status)	Choose One
b. Training every five years	Choose One
2. Member rights	Choose One
3. Rights restrictions and limitations	Choose One
4. Member confidentiality	Choose One
5. Provision of member medication	Choose One
6. Individual member support needs, including Behavior Intervention Plans (BIP) when applicable	Choose One
7. Incident reporting	Choose One
8. Brain injury training completed within 60 days of beginning service provision	Choose One
9. CMH Waiver:	
a. Staff must receive the following training within one month of employment and prior to providing direct service without the presence of experienced staff:	
1. Orientation on provider's mission, policies, and procedures	Choose One
2. Orientation on HCBS philosophy and outcomes for rights and dignity	Choose One
b. Staff must receive the following training within four months of employment and prior to providing direct service without the presence of experienced staff:	
1. Training in serious emotional disturbance and provision of services to children with serious emotional disturbance	Choose One
2. Confidentiality	Choose One
3. Provision of medication according to agency policy and procedure	Choose One
4. Identification and reporting of child abuse	Choose One
5. Incident reporting	Choose One
6. Documentation of service provision	Choose One
7. Appropriate behavioral interventions	Choose One
8. Professional ethics training	Choose One
c. Twenty-four hours of training during first year of employment in children's mental health issues	Choose One
d. Twelve hours of training every year thereafter in children's mental health issues	Choose One
10. RBSCL (Residential-Based Supported Community Living)	
a. Orientation on agency's purpose, policies, and procedures within one month of hire	Choose One
b. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues	Choose One

c. Twelve hours of training every year thereafter in children's ID/DD/MH issues	Choose One
11. Prevocational Services	
a. A person providing direct support shall, within six months of hire complete at least 9.5 hours of employment service training as offered through Direct Course or through the Association of Community Rehabilitation Educators (ACRE) certified training program	Choose One
b. Prevocational direct support staff shall complete four hours of continuing education in employment services annually	Choose One
12. Supported Employment	
a. Supported employment direct support staff shall complete four hours of continuing education in employment services annually	Choose One
1. Long-term job coaching	
a. A person providing direct support must hold an associate degree or high school diploma or equivalent and 6 months relevant experience	Choose One
b. A person providing direct support shall, within six months of hire or within six months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program	Choose One
c. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching	Choose One
2. Small-group supported employment	
a. A person providing direct support shall, within six months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program	Choose One
b. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching	Choose One
3. Individual supported employment	
a. A person providing direct support must hold a bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business	Choose One
b. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

III. Policies and Procedures

42 CFR 441-310 (c)(4), 42 CFR 441-710, 45 CFR 164.508, Iowa Code 135C.33, 232.69 and 236B.3, IAC Chapters 77 and 79

Requirement A. Intake, Admission, Service Coordination, Discharge and Referral ***At a minimum, there will be evidence of:***	
1. An intake/admission process	Choose One
2. A referral process	Choose One
3. Service coordination (defined as activities designed to assist members and families locate, access and coordinate a network of supports and services within the community)	Choose One
4. A discharge process	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement B. HCBS settings required for all providers ***At a minimum, there will be evidence of:***	
1. The setting is integrated in, and facilitates the member's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community like members without disabilities	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

2. The setting is selected by the member among available alternatives and identified in the person-centered service plan	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation	NA
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
3. Members’ essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA

Prevocational Habilitation	NA
Supported Employment Habilitation	NA
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
4. Members’ initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation	NA
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
5. Members’ choice regarding services and supports, and who provides them, is facilitated	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA

Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation (SE)	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
6. All rights restrictions are time limited, contain the member's informed consent, are supported by a specific assessed need and documented in the person-centered service plan	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation (SE)	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

Requirement B. 7 through 14 applies to services in provider-owned or controlled settings. As indicated in the approved Statewide Transition Plan (STP), services are provider-owned or provider-controlled if the following conditions are present:

If the HCBS provider leases from a third party or owns the property, this would be considered provider-owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, it would be presumed that the setting was provider-controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants. If the member leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled.

7. In provider-owned or provider-controlled setting, each member has privacy in their sleeping or living unit	
Agency Consumer-Directed Attendant Care (CDAC)	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Habilitation Services	
Home-based Habilitation	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
8. In a provider owned or provider controlled setting, members sharing units have a choice of roommates in that setting	
Agency Consumer-Directed Attendant Care (CDAC)	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Habilitation Services	
Home-based Habilitation	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
9. In a provider owned or provider controlled setting, members have the freedom and support to control their own schedules and activities, and have access to food at any time	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA

Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation (SE)	NA
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
10. In a provider owned or provider controlled setting, members are able to have visitors of their choosing at any time	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA
Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation (SE)	NA
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
11. In a provider owned or provider controlled setting, the setting is physically accessible to the member	
Adult Day Care	NA
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Behavior Programming	NA

Counseling	NA
Day Habilitation	NA
Family Counseling and Training	NA
Family and Community Support Services	NA
In-home Family Therapy	NA
Interim Medical Monitoring and Treatment (IMMT)	NA
Mental Health Outreach	NA
Prevocational Services	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Supported Employment (SE)	NA
Habilitation Services	
Day Habilitation	NA
Home-based Habilitation	NA
Prevocational Habilitation	NA
Supported Employment Habilitation (SE)	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
12. Provider owned or provider controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity	
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Habilitation Services	
Home-based Habilitation	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
13. Provider owned or provider controlled home has entrance doors to the member's living and sleeping unit which can be locked by the individual with only appropriate staff having keys	
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Habilitation Services	
Home-based Habilitation	NA

If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
14. In a provider owned or provider controlled home members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	
Agency Consumer-Directed Attendant Care (CDAC)	NA
Assisted Living Service	NA
Residential-Based Supported Community Living (RB-SCL)	NA
Supported Community Living (SCL)	NA
Habilitation Services	
Home-based Habilitation	NA
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement C. Person Centered Planning *At a minimum, there will be evidence of:*	
1. Provider participation in interdisciplinary team meetings	Choose One
2. The member's file contains a copy of the written person centered plan	Choose One
3. The provider's plan is consistent with the case manager's person centered plan	Choose One
4. The provider's service plan includes interventions and supports needed to meet member goals with incremental action steps, as appropriate	Choose One
5. The provider's plan reflects desired member outcomes	Choose One
6. The provider's service plan includes documentation of all rights restrictions, the need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement D. Service Documentation *At a minimum, service documentation shall include:*	
1. Specific location, date, and times of service provision	Choose One
2. Service(s) provided	Choose One
3. Member's first and last name	Choose One
4. Staff providing service(s), including first and last name, signature and professional credentials (if any)	Choose One
5. Specific interventions, including name, dosage, and route of medications administered	Choose One
6. Any supplies dispensed as part of the service	Choose One
7. Member's response to staff interventions	Choose One
8. Process to ensure units of service billed for payment are based on services provided with substantiating documentation	Choose One

If indicating "No," describe plan to meet the standard(s):	
Requirement E. Personnel records required for all providers *At a minimum, there will be evidence of:*	
1. Completion of the following requirements is required prior to date of hire	Choose One
a. Dependent adult and child abuse checks	Choose One
b. Criminal history background and Department of Human Services (DHS) evaluation where applicable	Choose One
c. Evaluation of hits by the Department of Human Services when applicable	Choose One
d. Documentation of follow-through on any employment restrictions as stated in DHS evaluation	Choose One
e. Verification of Office of Inspector General (OIG) excluded individual search Social Security Act, Sections 1128 and 1156	Choose One
2. Job performance evaluations	Choose One
If indicating "No," describe plan to meet the standard(s):	
Requirement F. Abuse Reporting *At a minimum, there will be evidence of:*	
1. A process staff must follow the agency's procedure to report allegations immediately (oral report within 24 hours; written report within 48 hours) to the Department of Human Services (DHS) or Department of Inspections and Appeals (DIA) when the environment is certified or licensed by this entity	Choose One
2. A process staff must follow the agency's procedure to ensure the member's safety upon learning of an allegation	Choose One
3. A process the provider will follow when the alleged perpetrator is an employee	Choose One
4. A process for ensuring staff receive a statement of the abuse reporting requirements within one month of employment	Choose One
If indicating "No," describe plan to meet the standard(s):	
Requirement G. Incident Reporting *At a minimum, there will be evidence of:*	
1. What constitutes an incident in accordance with the IAC definition	Choose One
2. The mechanism for ensuring the routing of incidents to the:	
a. Supervisor by the end of the next calendar day after the incident (major); within 72 hours (minor)	Choose One
b. Case manager/service worker by the end of the next calendar day after the incident (major)	Choose One
c. Legal guardian by the end of the next calendar day after the incident (major)	Choose One
d. Member by the end of the next calendar day after the incident if the incident took place outside service provision (major)	Choose One
e. Bureau of Long-Term Care or appropriate entity by the end of the next calendar day after the incident via direct data entry into Iowa Medicaid Portal Access (IMPA) or as determined by the department	Choose One
3. A centralized location for the filing of incident reports	Choose One
4. A process for noting the completion of an incident report form in the member record	Choose One
5. The submission of follow-up reports as requested by case manager/service/integrated health home care coordinator (major)	Choose One

If indicating "No," describe plan to meet the standard(s):	
Requirement H. Safeguarding Consumer Information *At a minimum, there will be evidence that:*	
1. The provider has a process for maintaining confidential records and safeguarding personal member information	Choose One
2. An expiration date or event is identified if a release of information form is utilized	Choose One
If indicating "No," describe plan to meet the standard(s):	
Requirement I. Contracts with members *At a minimum, the agency shall have written procedures which provide for the establishment of an agreement between the member and the provider and evidence will be supplied that:*	
1. The agreement shall define the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, all room and board and co-pay fees to be charged to the member and the sources of payment	Choose One
2. Contracts shall be reviewed at least annually	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

IV. Quality Improvement

IAC Chapter 77

Requirement A. Quality Improvement (QI) *At a minimum, the plan will identify the:*	
1. Ongoing schedule or timeline for quality improvement activities, to include the specific timeframes for data collection, data analysis, and to identify entities with whom results will be shared	Choose One
2. Discovery	
a. Collecting and reviewing data to identify issues to be monitored for quality improvement to include sample size and acceptable thresholds	Choose One
b. Ongoing review of responses to all member/stakeholder input to determine the need for systemic changes	Choose One
c. Ongoing review of member records to include medication management, health and safety, incident reporting, and documentation	Choose One
d. Tracking and trending of incidents	Choose One
3. Remediation. The development of a plan to address areas of improvement identified during discovery to include specific timelines for development and completion of action steps	Choose One
4. Improvement. Summary of QI activities to include monitoring the impact of remediation plan	Choose One
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

Section D. CMS Final Setting Rule

During any HCBS Quality Oversight review process has your agency been required to submit a corrective action plan related to the requirements identified **in Section II. Requirement B. HCBS Settings Rule** or **Section II. Requirement C. Person-Centered Planning**? 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)	Choose One

If "Yes," your agency must submit a status update to your corrective action plan to provide evidence that your agency is on track to meet compliance in this area. Include update below.

2018 Provider Quality Management Self-Assessment

Section E. Guarantee of Accuracy

Click for help

In submitting this Self-Assessment or signing this Guarantee of Accuracy, the agency and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Further, the agency and all signatories each acknowledge (1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate regional HCBS Specialist (see contact instructions on page one) in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint. **NOTICE: Any person that submits a false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.**

Indicate which accreditation, licensure or certification held, including those which qualify your agency to provide HCBS. Include dates of accreditation/licensure/certification for each selection chosen (MM/YY begin – MM/YY end):

Check Box	Accreditation, Licensure or Certification	Start Date	End Date
☐	Council on Accreditation		
☐	CARF International		
☐	Iowa Department of Public Health		
☐	The Council on Quality and Leadership (CQL)		
☐	Department of Inspections and Appeals		
☐	The Joint Commission (TJC)		
☐	Chapter 24		
☐	Other:		

Question	Response
Is your organization in good standing with the accreditation/licensing/certifying organization? *If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed 2018 HCBS Provider Quality Management Self-Assessment.	Choose One
Is this organization in good standing with the Iowa Secretary of State's Office?	Choose One

PRINT NAME of ***Agency***

PRINT NAME of ***Executive Director***

SIGNATURE of ***Executive Director*** ***Date***

PRINT NAME of ***Chairperson, Board of Directors***

SIGNATURE of ***Chairperson, Board of Directors*** ***Date***

Section F. Direct Support Professional Workforce Data Collection

Instructions

For the purposes of these questions, a direct support professional is an individual who provides supportive services and care to people who are elderly, experiencing illnesses, or disabilities. This definition *excludes* individuals working as nurses, social workers, counselors, and case managers.

Individuals providing the following waiver services should be considered direct support professional workers:

- Adult Day Care
- Behavioral Programming
- CCO
- CDAC
- Family and Community Support Services
- Home Health
- Homemaker
- Interim Medical Monitoring and Treatment
- Prevocational Services
- Respite
- Residential SCL
- SCL
- Supported Employment

1. Please list your organization's total number of full-time and part-time employees (including contract employees).

   Total number of full-time and part-time employees

   Of this total, please list the number of full-time and part-time employees providing direct support services according to the definition provided above. Please include supervisors and coordinators who provide direct support services.

   Number of full-time direct care workers (including contract employees)

   Number of part-time direct care workers (including contract employees)

2. The U.S. Department of Labor utilizes the following three titles and definitions to gather information on the direct support professional workforce.

   Please list the number of individuals you employ in the following three categories. Choose the category that best reflects services provided. Individuals do not need to be certified as a home health aide or nurse aide to be included in those categories. An individual cannot be counted in more than one category.

   Personal and Home Care Aides

   Often called direct support professionals, these workers provide support services such as implementing a behavior plan, teaching self-care skills, and providing employment support, as well as providing a range of other personal assistance services. They provide support to people in their homes, residential facilities, or in day programs, and are supervised by a nurse, social worker, or other non-medical manager.

   Number of personal and home care aides (including contract employees)

   Home Health Aides

   Home health aides typically work for home health or hospice agencies and work under the direct supervision of a medical professional. These aides provide support to people in their homes, residential facilities, or in day programs. They help with light housekeeping, shopping, cooking, bathing, dressing, and grooming, and may provide some basic health-related services such as checking pulse rate, temperature, and respiration rate.

   Number of home health aides (including contract employees)

   Nursing Aides

   Most nursing aides have received specific training for the job and some have received their certification as a Certified Nursing Assistant (CNA) in Iowa. According to the Department of Labor, nursing aides provide hands-on care under the supervision of nursing and medical staff in hospitals and nursing care facilities, although they do work in home- and community-based settings as well. Nursing aides often help members eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording members' physical, mental, and emotional conditions.

   Number of nursing aides (including contract employees)