



## Home- and Community Based Services (HCBS) 2014 Provider Quality Management Self-Assessment

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

- Health & Disability Waiver
- 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)

This form is setup as a Microsoft Word template and is to be completed and submitted as directed below. Each provider is required to submit one, six-section self-assessment by **December 1, 2014**. **Incomplete self-assessments will not be accepted.** For assistance working with this form, visit the [Provider Quality Management Self-Assessment webpage](#)<sup>1</sup> and access the link, "[Provider Quality Management Self-Assessment Slide Presentation](#)" or "[Provider Quality Management Self-Assessment Recorded Webinar](#)".

The completed *2014 Provider Quality Management Self-Assessment* should be returned to:

**Attention: Provider Quality Management Self-Assessment**  
**Iowa Medicaid Enterprise**  
**HCBS Quality Oversight**  
**P.O. Box 36330**  
**Des Moines, IA 50315**  
**Fax: 515-725-3536 (preferred)**

**Section A:** Identify the provider 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 at 800-338-7909 option 2 (515-256-4609 in Des Moines) or [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us).

**Section C-1:** Identify each location where this agency has offices. For agencies with only one office, the address in Section C-1 should identify that one location.

**Section C-2:** Identify each location where this agency provides HCBS services. For agencies with only one site where service is provided, the site address in Section C-2 should identify that one location.

**Section D:** Use the "select response" drop-down menu to indicate the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the provider and must be resubmitted.

**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 webpage [HCBS Waiver Provider Contacts](#)<sup>2</sup> and access the link, "[List of HCBS Specialists for each region](#)".

<sup>1</sup> <http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment>

<sup>2</sup> <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts>

## Section A – Provider Identification

Please identify your agency by providing the following information (please type using the text entry fields below).

Employer ID number (EIN) (9-digits):					
Provider name (as registered to EIN indicated above):					
Administrator/CEO:			Title:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Name of person responsible for agency quality improvement activities:				Phone number: Ext:	
Title of person responsible for agency quality improvement activities:				Fax number:	
Quality coordinator's email address:			Administrator's email address:		
Agency website address:					

## Section B – Service Enrollment

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 *2014 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.

<b>Program</b>	<input type="checkbox"/> <b>AIDS/HIV Waiver</b>	<input type="checkbox"/> <b>BI Waiver</b>	<input type="checkbox"/> <b>CMH Waiver</b>
<b>Services</b>	<input type="checkbox"/> Adult day services <input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC) <input type="checkbox"/> Counseling <input type="checkbox"/> Respite	<input type="checkbox"/> Adult day services <input type="checkbox"/> Behavior programming <input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC) <input type="checkbox"/> Family counseling and training <input type="checkbox"/> Interim Medical Monitoring and Treatment (IMMT) <input type="checkbox"/> Prevocational services <input type="checkbox"/> Respite <input type="checkbox"/> Supported Community Living (SCL) <input type="checkbox"/> Supported Employment (SE)	<input type="checkbox"/> Family and community support services <input type="checkbox"/> In-home family therapy <input type="checkbox"/> Respite

<b>Program</b>	<input type="checkbox"/> <b>Elderly Waiver</b>	<input type="checkbox"/> <b>Health &amp; Disability Waiver</b>	<input type="checkbox"/> <b>ID Waiver</b>
<b>Services</b>	<input type="checkbox"/> Adult day services <input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC) (includes assisted living providers) <input type="checkbox"/> Case management <input type="checkbox"/> Mental health outreach <input type="checkbox"/> Respite	<input type="checkbox"/> Adult day services <input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC) <input type="checkbox"/> Counseling <input type="checkbox"/> Interim Medical Monitoring and Treatment (IMMT) <input type="checkbox"/> Respite	<input type="checkbox"/> Adult day services <input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC) <input type="checkbox"/> Day habilitation <input type="checkbox"/> Interim Medical Monitoring and Treatment (IMMT) <input type="checkbox"/> Prevocational services <input type="checkbox"/> Residential-Based Supported Community Living (RBSCL) <input type="checkbox"/> Respite <input type="checkbox"/> Supported Community Living (SCL) <input type="checkbox"/> Supported Employment (SE)
<b>Program</b>	<input type="checkbox"/> <b>PD Waiver</b>	<input type="checkbox"/> <b>Habilitation Services</b>	
<b>Services</b>	<input type="checkbox"/> Agency Consumer-Directed Attendant Care (CDAC)	<input type="checkbox"/> Day habilitation <input type="checkbox"/> Home-based habilitation <input type="checkbox"/> Prevocational habilitation <input type="checkbox"/> Supported employment habilitation	

## Section C-1 – Office Locations

**INSTRUCTIONS** Identify each location from which your agency provides oversight of HCBS services. For agencies with only one office, details for “Location #1” (below) **MUST** be provided. Include additional copies of this page as needed.

■ **Location # 1**

NPI number(s) (10-digits):					
Provider/Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:		State:	Zip:	City:	
State:		Zip:	State:		Zip:
Office Hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:
	Saturday:	Sunday:			

■ **Location # \_\_\_\_**

NPI number(s) (10-digits):					
Provider/Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:		State:	Zip:	City:	
State:		Zip:	State:		Zip:
Office Hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:
	Saturday:	Sunday:			

## Section C-2 – Site Locations

**INSTRUCTIONS** Identify each location where your agency is providing HCBS services. For agencies with only one site, details for “Site #1” (below) **MUST** be provided. Provider owned, provider controlled, member owned, and member controlled categories are clarified in the link, “Iowa Exploratory Questions” found on the webpage [HCBS Settings Transition](#). Include additional copies of this page as needed.

■ **Site #** \_\_\_\_

NPI number (10-digits):			Site name:		
Provider/Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Site address:			<input type="checkbox"/> Provider owned/Provider controlled <input type="checkbox"/> Member owned/Member controlled		
City:	State:	Zip:	Type of residence (house, apartment, duplex, etc.):		
Total number of members living at this site:			For sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services: Select Response		

■ **Site #** \_\_\_\_

NPI number (10-digits):			Site name:		
Provider/Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Site address:			<input type="checkbox"/> Provider owned/Provider controlled <input type="checkbox"/> Member owned/Member controlled		
City:	State:	Zip:	Type of residence (house, apartment, duplex, etc.):		
Total number of members living at this site:			For sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services: Select Response		

## Section D – Iowa Administrative Code Standards

For each of the following standards, the provider must select a response from the drop-down menu beneath the heading “**Response Option**” (click on the “select response” text to activate the drop-down menu).

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

This *2014 Provider Quality Self-Assessment* will be returned to the provider if all sections are not completed, responses chosen are not compliant with Federal Regulations, Iowa Code, or IAC, or otherwise deemed unacceptable.

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

### I. Providers are required to establish and maintain fiscal accountability IAC Chapter 79

<b>At a minimum, there will be evidence of:</b>	<b>Response Options:</b>
1. The current rate setting system ( <i>for example</i> , D-4s, fee schedules, CRIS report)	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Documentation to support planning and tracking the use of member support dollars that are incorporated into the rate for SCL, RBSCCL, home-based habilitation, and family and community support services <b>BI and ID required IAC 78.43(2)“e” / 78.41(1)“f”</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3. The maintenance of fiscal and clinical records for a minimum of five years	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If indicating “No,”</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	

**II. Providers are required to meet the following training requirements**

<p>Within 30 days of employment for full-time staff (unless otherwise indicated), the following training requirements must be met and documented for all staff providing services. Part-time staff must have these trainings documented and completed within 90 days of employment (unless otherwise indicated). 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.</p>	<p><b>Response Options:</b></p>
<p>1. The curriculum used by the provider is approved by the Iowa Department of Public Health, and includes the following: <b>IAC 641-93.1</b></p>	
<p>a. Child and/or Dependent Abuse training completed within six months of hire (or documentation of current status) <b>Iowa Code 235B.16 / 232.69</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p>b. Training every five years <b>Iowa Code 235B.16 / 232.69</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p>2. Member rights <b>IAC 77.37(1)“e” / 77.39(1)“e”</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>3. Rights restrictions and limitations <b>IAC for Hab, BI and ID 77.25(4) / 77.37(1)“e” / 77.39(1)“e”</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>4. Member confidentiality <b>Title 45 CFR 164</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p>5. Provision of member medication (must include policy training within 30 days of employment; according to provider policy thereafter) <b>IAC for BI and ID 77.37(1)“e” / 77.39(1)“e”</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>6. Individual member support needs <b>IAC for BI and ID waivers 77.37(1)“e” / 77.39(1)“e”</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>7. Training on behavior intervention plans (BIP) <b>IAC for Habilitation providers 77.25(4)</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>8. Incident reporting <b>IAC 441-Chapter 77</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p>9. Brain injury training - required prior to service provision to members <b>IAC for BI 77.39</b></p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>10. CMH Waiver: <b>IAC 441-77.46</b></p>	
<p>a. Staff must receive the following training within one month of employment and prior to providing direct service without the presence of experienced staff:</p>	
<p>1) Orientation on provider’s mission, policies and procedures</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>2) Orientation on HCBS philosophy and outcomes for rights and dignity</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> N/A</p>
<p>b. Staff must receive the following training within four months of employment and prior to providing direct service without the presence of experienced staff:</p>	

1) Training in serious emotional disturbance and provision of services to children with serious emotional disturbance	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2) Confidentiality	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3) Provision of medication according to agency policy and procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
4) Identification and reporting of child abuse	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
5) Incident reporting	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
6) Documentation of service provision	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
7) Appropriate behavioral interventions	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
8) Professional ethics training	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
c. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
d. Twelve hours of training every year thereafter in children's ID/DD/MH issues	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>11. RBSCCL IAC 441-77.37(23)</b>	
a. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. Twelve hours of training every year thereafter in children's ID/DD/MH issues	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	
<b>III. Providers are required to have policies and/or procedures for each of the following areas</b>	
<b>Requirement A: Intake/admissions IAC for BI 77.39(7), ID 77.37(9), and CMH 77.46(4) waivers</b> <b>At a minimum, there will be evidence of:</b>	<b>Response Options:</b>
1. Application process	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Referral process the provider must follow when the provider chooses not to admit the member	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3. Service coordination (activities designed to assist individuals and families locate, access and coordinate a network of supports and services within the community)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
4. Process members or other stakeholders may follow when in disagreement with the admission decision (e.g., applicant's recourse; the provider's appeals and grievance policy)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	

<b>If indicating “NA,” you must describe why the standard(s) are not applicable to your facility:</b>	
<b>Requirement B: Discharge IAC for BI 77.39(7), ID 77.37(9), and CMH 77.46(4) waivers</b> <b>At a minimum, there will be evidence of:</b>	<b>Response Options:</b>
1. Discharge procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Process members or other stakeholders may follow when in disagreement with the discharge decision (e.g., applicant’s recourse; the provider’s appeals and grievance policy)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating “No,” describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):</b>	
<b>If indicating “NA,” you must describe why the standard(s) are not applicable to your facility:</b>	
<b>Requirement C: Service plans required for all providers</b> <b>At a minimum, there will be evidence of:</b>	<b>Response Options:</b>
1. <b>All providers</b> at a minimum, the service plan will identify: <b>42 CFR 441.301(c)(4) and 42 CFR 441.710(a)</b>	
a. The setting is integrated in, and facilitates the individual’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 individuals without disabilities	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. The setting is selected by the individual among available alternatives and identified in the person-centered service plan	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. An individual’s essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Individual 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	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Individual choice regarding services and supports, and who provides them, is facilitated	<input type="checkbox"/> YES <input type="checkbox"/> NO
f. All rights restriction (for example to address the safety needs of an individual with dementia) must be time limited, contain member’s informed consent, supported by a specific assessed need and documented in the person-centered service plan	<input type="checkbox"/> YES <input type="checkbox"/> NO
g. In provider owned or provider controlled setting, each individual has privacy in their sleeping or living unit	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
h. In a provider owned or provider controlled setting, individuals sharing units have a choice of roommates in that setting	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
i. In a provider owned or provider controlled setting, individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

j. In a provider owned or provider controlled setting, individuals are able to have visitors of their choosing at any time	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
k. In provider owned or provider controlled setting, the setting is physically accessible to the individual	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>2. All providers</b> at a minimum, the service plan will identify: <b>42 CFR 441.725</b>	
a. The service plan is based on the current assessment	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. The service plan identifies observable or measurable individual goals and action steps to meet the goals	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
c. The service plan includes interventions and supports needed to meet those goals with incremental action steps, as appropriate	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
d. The service plan includes staff, people, or organizations responsible for carrying out the interventions or supports	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
e. Services defined in the service plan are appropriate to the severity level of problems and specific needs or disabilities	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
f. The plan reflects desired individual outcomes	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
g. Activities identified in the service plan encourage the ability and right of the individual using the service to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
h. Staff monitors the service plan with review occurring regularly. At least annually, staff assess and revise the service plan to determine achievement, continued need, or change in goals or intervention methods. The review includes the individual using the service, with the involvement of significant others as appropriate.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
i. Staff develops a separate, individualized, anticipated discharge plan as part of the service plan that is specific to each service the individual receives.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>3. Habilitation providers:</b> <b>IAC 78.27(4)</b> The service plan shall set out service goals and activities:	
a. The goals are personal, as identified by the member and the consumer's interdisciplinary team	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. The goals and/or objectives are measurable and time limited	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
c. The goal action steps are specific, provide specific direction to staff implementing the goal, and identify the specific person(s) responsible for completing each step	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
d. The supports to be provided to the member	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	

<p><b>Requirement D:</b> Service documentation required for all providers  <b>IAC 79.3(2)</b>  <b>At a minimum, agency will provide evidence that all service documentation includes the following components:</b></p>	<p><b>Response Options:</b></p>
<p>1. Specific location, date, and times of service provision</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>2. Service(s) provided</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>3. Member's first and last name</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>4. Staff providing service(s), including first and last name, signature and professional credentials (if any)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>5. Specific interventions (staff supports related to service provision which shall also include name, dosage and route of medications administered)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>6. Any supplies dispensed as part of the service</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>7. Member's response to staff interventions</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>8. Identification of the timeframe for documentation completion, for example – "prior to billing"</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>9. Process to ensure units of service billed for payment are based on services provided with substantiating documentation</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p><b>If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):</b></p>	
<p><b>Requirement E:</b> Personnel records required for all providers  <b>Iowa Code 135C.33</b>  <b>At a minimum, there will be evidence of:</b></p>	<p><b>Response Options:</b></p>
<p>1. Completion of the following requirements is required prior to date of hire:</p>	<p><b>[REDACTED]</b></p>
<p>a. Dependent adult abuse check</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>b. Child abuse check</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>c. Criminal history background check</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>d. Department of Human Services (DHS) evaluation (if any record check is founded)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>e. Documentation of follow-through on any employment restrictions as stated in DHS evaluation</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>f. Verification of Office of Inspector General (OIG) excluded individual search</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p><b>Social Security Act, Sections 1128 and 1156</b>  <b>If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):</b></p>	

<p><b>Requirement F: Abuse reporting required for all providers Iowa Code Chapter 232.69 and 235B.3</b></p> <p><b>At a minimum, there will be evidence of:</b></p>	<p><b>Response Options:</b></p>
<p>1. Reporting incidents in accordance with the IAC definition</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>2. Compliance with Iowa Code 232.75</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>3. Process staff must follow to report allegations immediately (oral report within 24 hours; written report within 48 hours) to Department of Human Services (DHS) or Department of Inspections and Appeals (DIA) when the environment is certified or licensed by this entity</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>4. Process staff must follow to ensure the member's safety upon learning of an allegation</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>5. Process the provider will follow when the alleged perpetrator is an employee</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>6. Process the provider will follow to ensure any provider investigation does not impede the DHS/DIA investigation</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>7. Process for ensuring staff receive a statement of the abuse reporting requirements within one month of employment</p> <p><b>Iowa Code 235B.16 / 232.69</b></p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p><b>If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):</b></p>	
<p><b>Requirement G: Incident reporting required for all providers IAC Chapter 77</b></p> <p><b>At a minimum, there will be evidence of:</b></p>	<p><b>Response Options:</b></p>
<p>1. What constitutes an incident in accordance with the IAC definition</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>2. The mechanism for ensuring the routing of incidents to the:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>
<p>a. Supervisor by the end of the next calendar day after the incident (major); within 72 hours (minor)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>b. Case manager/service worker by the end of the next calendar day after the incident (major)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>c. Legal guardian by the end of the next calendar day after the incident (major)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>d. Member by the end of the next calendar day after the incident if the incident took place outside service provision (major)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>e. Bureau of Long-Term Care by the end of the next calendar day after the incident via direct data entry (major)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>3. The centralized location for the filing of incident reports</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>4. The process for noting the completion of an incident report form in the member record, including using the notation that reports are kept in a separate location</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>5. The submission of follow-up reports as requested by case manager/service (major)</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>
<p>6. Tracking and trending of all incident reports</p>	<p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p>

7. Evidence the provider is currently enrolled in IMPA for incident reporting and to receive informational letters	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>Requirement H:</b> Safeguarding consumer information required for all providers <b>45 Code of Federal Regulations, section 164.508 (HIPAA)</b> <b>At a minimum, there will be evidence of:</b>	<b>Response Options:</b>
1. Process for the utilization of the <i>Release of Information</i> form	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Process the provider must follow for obtaining emergency consent for release of information (verbal before written)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Process for verifying the existence of an authorization prior to releasing information	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Guidelines for ensuring member confidentiality, including the:	
a. Training requirements for staff on proper completion of the <i>Release of Information</i> form	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Timelines for expiration of the <i>Releases of Information</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Process for maintaining confidential records and safeguarding personal member information	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>Requirement I:</b> Contracts with members <b>IAC 77.37(3), 45 CFR 441.301(c)(4) and 42 CFR 441.710(a)</b> <b>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:</b>	<b>Response Options:</b>
1. 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 individual receiving services, and the individual 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	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Provider owned or provider controlled home has entrance doors lockable by the individual, with only appropriate staff having keys to doors	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3. In a provider owned or provider controlled home individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
4. 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 (IAC 77.37(3))	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

5. Contracts shall be reviewed at least annually (IAC 77.37(3))	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	
<b>IV. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance IAC 77.37(1)“f”(1-7) / 77.39(1)“f”(1-7)</b>	
<b>Requirement A: Quality Improvement (QI) policy</b> <b>At a minimum, there will be evidence the organization:</b>	<b>Response Options:</b>
1. Ongoing schedule or timeline for quality improvement activities, to include the:	
a. Specific timeframes for data collection	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. Specific timeframes for data analysis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
c. Entities with whom results will be shared	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Discovery (methods to be used to identify specific issues to be monitored for quality improvement), included identification of the:	
a. Outcomes and outcome indicators	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. How information will be collected	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3. Remediation (specific action steps taken to address issues revealed during discovery) will include:	
a. Plans that identify:	
1) Specific timelines for development and completion of action steps	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
4. Improvement (steps taken to monitor the impact of remediation plans), including:	
a. Identifying that action steps are completed	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	

<p><b>Requirement B: Discovery</b>  Collecting and reviewing data in order to assess the ongoing implementation of the program, identifying strengths as well as opportunities for improvement. MUST include methods used to identify specific issues to be monitored for quality improvement, including identification of outcomes and outcome indicators, acceptable thresholds, specific methodology for collecting data, and sample size.</p> <p><b>The review shall include the implementation of the QI activities and find evidence to support the following:</b></p>	<p><b>Response Options:</b></p>
<p>1. Ongoing review of member records (including service documentation)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>2. Ongoing review of personal records to ensure evidence of:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>
<p>a. Background checks</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>b. Required trainings</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>c. Completion of job performance evaluations (at least annually)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>3. Ongoing review of responses to all member/stakeholder appeals and grievances:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>
<p>a. To ensure compliance with provider policy</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>b. To determine the need for systemic changes</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>c. Distribution of appeals and grievance procedure according to agency policy</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>4. Ongoing review of outcomes for rights and dignity to ensure the:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>
<p>a. Member's achievement of the outcomes</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>b. Provider's support of members in achieving the outcomes</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>5. Ongoing review of stakeholder input from:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>
<p>a. Members</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>b. Provider staff</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p>c. Other stakeholders (i.e., case managers/service workers, family members, central points of coordination (CPCs), other providers, etc.)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>
<p><b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):</p>	
<p><b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:</p>	
<p><b>Requirement C: Remediation</b>  Involves taking action to remedy specific problems or concerns that arise. Required for any of the items discovered not to meet the provider's identified thresholds.</p> <p><b>The review shall find implementation and evidence to support:</b></p>	<p><b>Response Options:</b></p>
<p>1. The development of a plan to address areas for improvement:</p>	<p style="background-color: black; color: black;">[REDACTED]</p>

a. Timeframes for completion of specific action steps	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
b. Expected outcomes of action steps	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	
<p><b>Requirement D: Improvement</b>  Evaluation of the remediation plan. Shall include steps taken to monitor the impact of remediation plans, including identification of completed action steps, identification of the staff title(s) responsible for monitoring the progress of action steps, documentation that identifies whether or not action steps taken were effective (including completion date).</p> <p><b>The review shall find implementation and evidence to support:</b></p>	<b>Response Options:</b>
1. The implementation of the plan	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. The collection of data measuring the results of current QI plan implementation	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
3. A summary of QI plan outcomes	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
4. Evidence of distribution of QI plan outcome(s) according to provider policy	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>If indicating "No,"</b> describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
<b>If indicating "NA,"</b> you must describe why the standard(s) are not applicable to your facility:	

Iowa Department of Human Services  
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**Section E – Guarantee of Accuracy**

In submitting this Self-Assessment or signing this Guarantee of Accuracy, the provider and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Further, the provider 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.**

Is this organization in good standing with the Iowa Secretary of State's Office? Select Response

In order to qualify as an HCBS provider for the services your agency is enrolled to provide, indicate which accreditation, licensure or certification qualifies your agency to provide HCBS waiver services.

- |                                                                      |                                                                |
|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Council on Accreditation                    | <input type="checkbox"/> Department of Inspections and Appeals |
| <input type="checkbox"/> The Council on Quality and Leadership (CQL) | <input type="checkbox"/> The Joint Commission (TJC)            |
| <input type="checkbox"/> Iowa Department of Public Health            | <input type="checkbox"/> Other:                                |
| <input type="checkbox"/> HCBS Certification                          |                                                                |

Dates of accreditation/licensure/certification:

Is your organization in good standing with the accreditation/licensing/certifying organization? Select Response

**If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed 2014 HCBS Provider Quality Management Self-Assessment.**

Does your organization attest to being compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a), or have a plan to come into compliance with this rule prior to March 17, 2019? Select Response

**If your organization is not currently fully in compliance with CMS requirements for provider owned and provider controlled settings, your organization must submit your plan to become compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a).**

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PRINT NAME of *Provider*

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PRINT NAME of *Executive Director*

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SIGNATURE of *Executive Director*

*Date*

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PRINT NAME of *Chairperson, Board of Directors*

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SIGNATURE of *Chairperson, Board of Directors*

*Date*

Iowa Department of Human Services  
**2014 Provider Quality Management Self-Assessment**

**Section F – Direct Support Professional Workforce Data Collection**

**Direct Support Professional Workforce Data Collection**

**Provider Name** \_\_\_\_\_

**NPI Provider Number(s)** \_\_\_\_\_

(Complete only one form and list all NPI Numbers)

**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 Services
- 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 individuals eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording individuals' physical, mental, and emotional conditions.

\_\_\_\_\_ Number of Nursing Aides (including contract employees)