

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

This report summarizes the Alaska Department of Health and Social Services (DHSS) review of performance measures monitored to reflect the state's compliance with federal waiver assurances and sub-assurances for Alaska's Home and Community Based Services Waiver programs for November 2010.

- Adults with Physical Disabilities (APD) Waiver
- Older Alaskans (OA) Waiver
- Persons with Mental Retardation / Developmental Disabilities (MRDD) Waiver
- Children with Complex Medical Conditions (CCMC) Waiver

**Performance Measures:**

The **Aggregated Quality Report** includes the level of success for each performance measure for each waiver assurance and sub-assurance requiring monitoring, reported on a monthly basis. Alaska DHSS is responsible for all critical elements of waiver program management thus no Administrative Authority performance measures are monitored. Each of the four waiver programs are separately reflected within the reports. All data is unique to the individual program except for Qualified Providers as the providers cross waiver programs in their certification and service delivery.

The compliance standards for each performance measure are set at 100%. All performance measures that fall below 100% are addressed in remediation and/or system improvement at an individual level. Alaska strives to meet the 100% threshold and in any event, to correct non-compliance within 30 days of discovery.

On a statewide basis, across each of the four waiver programs, discovery occurs at least monthly, and in many cases daily, to identify occurrences of non-compliance. Identified occurrences of non-compliance and corrective actions are identified in the monthly report titled **Aggregated Quality Report**. As occurrences of non-compliance are identified, Alaska initiates a remediation action intended to resolve the non-compliance as swiftly as possible. For some performance measures, occurrences of non-compliance can be remediated quickly through the normal course of business, using existing processes. Other, more systemic issues causing non-compliance, are addressed through larger initiatives such as augmented training, technical assistance, policy development, and when needed, the development of new computer tools.

The goal is to remediate occurrences of non-compliance during the month that the instances are identified. When this type of rapid remediation is not possible, the specific instances are flagged, monitored, and resolved as quickly as possible through an extended review and remediation process.

**Adults with Physical Disabilities**

This waiver serves Alaskans between the ages of 21 and 64 who meet nursing facility level of care. This is a state-wide waiver program.

Through the data collection and discovery process for **Level of care**, one performance measures was assessed as below 100% compliant.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**LOC 2** – (number and percentage of participants who received an annual level of care determination within 12 months of initial determination or previous level of care determination) There were four of 83 individual findings in which level of care determination did not occur within 12 months of initial determination or previous level of care determination. All four of these findings were resolved within 3 weeks of their due dates.

Through the data collection and discovery process for **Service Plan**, five performance measures were assessed as at or below 100% compliant.

**SP 9** – (number and percentage of participants who have documented personal goals identified in the service plan). This measure reflects a need for service plans to include specific documentation that speaks to the individuals' personal goals as they relate to service provision. There were six of 27 findings for this measure during the reporting period. All six findings were remediated through the provision of technical assistance to care coordinators regarding personal goal development. The findings for this performance measure have been discussed with the Senior and Disabilities Services training unit and this area will be emphasized in trainings for both SDS staff and for providers, with webinar trainings currently scheduled for January through June of 2011.

**SP 11** – (number and percentage of completed service plans submitted to SDS within the required regulatory timeframes) Eighty of the 141 service plans reviewed did not comply with this performance measure. This is due primarily to a recent change in enforced policy by SDS. Prior to August, 2010, most care coordinators based their plan submission on a participant's "plan year" (the start and end dates for a service plan). However, this plan year may or may not be synchronized with a new level of care determination. In some situations a level of care is determined while a plan is still approved for several months. To impact this performance measure, SDS must enforce existing policies and communicate performance standards to care coordinators. These activities are occurring with training and through publication of draft policies for comments followed by publication of the final policies. These standards and policies are also being reviewed in teleconferences held with providers. Additionally, as SDS completed the "spike" of re-assessments due this Fall, care coordinators' workloads were heavy for completing the corresponding new service plan reviews. For November, of the 80 service plans that were overdue based on the requirement that care coordinator submit a new complete service plan within 30 days of the level of care determination, 58 had been received within four weeks of their due date with the remaining 22 having been requested from care coordinators. SDS has also recently implemented care coordinator notices alerting them ten days prior to a plan of care coming due

**SP 14** – (number and percentage of service plans reviewed and updated as needed prior to the annual redetermination date) One of the 18 service plans was not compliant with this measure. The finding is currently being remediated with the care coordinator through an insufficient documentation notice process that may ultimately lead to either a new care coordinator assignment or a closure process.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**SP16** – (number and percentage of participants who received services by type of service) Two of 27 service plans did not comply with this performance measure during the reporting period. For these two findings the issue involved a provider not billing for a specific type of service. These findings were based on historical billing records. The remediation for these findings was to review provider service provision records to identify if the service was rendered but not billed for.

**SP 17** – (number and percentage of participants who received services in the amount, duration and frequency described in the service plan) is problematic to assess because of the lags that occur between the time of service delivery and the time of billing. The findings show that 12 of the 27 reviews were deficient. The current method of data extraction and analysis involves looking at the prior 12 months of claims submitted by the provider during a chart review. Because providers have 12 months to bill, it is possible that the window of opportunity to bill has not closed by the time the analysis is performed therefore, services may have been delivered that have not yet been billed for. It is not possible, therefore, to determine if the gap between approved services and delivered services is a result of delayed billing for services or a failure to provide approved services. If the gap is the result of failure to provide services, that gap may be the result of a change in condition of the participant that is not captured in a requested amendment, particularly if there was an improvement in the participant's condition. These performance measures continue to be monitored and the criteria for findings are refined as needed to help pinpoint actual problems.

There were 42 individual findings total for the three performance measures within the **Qualified Provider** assurance. Alaska providers are certified by service type and may be certified to provide services to participate on all four waiver programs. The data presented below is reflective of Qualified Provider performance measure data across all waiver programs and will not be repeated in each waiver section.

**QP 23b** – (number and percentage of providers who continue to meet state certification requirements following initial certification.) One finding resulted in the initiation of a provider corrective action plan, which is currently on-going.

**QP 24b** – (number and percentage of providers who are in compliance with critical incident report training requirements.) Forty-one providers of 482 certified providers did not meet the critical incident report training requirement. Individual findings are currently in remediation with resolution pending. Certification is not renewed if this requirement is not met. Specific remediation action includes email notification and a warning letter to providers who are not currently compliant with a deadline of January 31, 2011. If these actions do not resolve the identified problems by the noted deadline, SDS sanction processes will be initiated within thirty days after the close of the deadline. Two additional critical incident reporting trainings are scheduled for January, 2011 to allow non-compliant providers to become compliant.

Through the findings and discovery process for **Health & Welfare**, three performance measures were found to be less than 100% compliant.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**HW 25** - (number and percentage of participants who received information on reporting abuse, neglect or exploitation) Two of 27 records reviewed did not include necessary signatures with appropriate dates. Validly-dated signatures were secured to remediate both of these findings.

**HW 26** – (number and percentage of critical incident reports that were reported by a provider within required timeframes). Twenty-one of 85 critical incidents were reported outside the established timeframe. The non-compliance for this performance measure is due to late submission of critical incident reports by provider agencies. This performance measure allows for 72 hours for the provider to report the critical incident from the time it was discovered. To resolve these individual findings, and to prevent future findings, technical assistance is provided by SDS to provider agencies at the time of late submission. When late submission of these reports becomes a recurring problem for a specific provider agency SDS will initiate a corrective action plan for the respective provider agency. **Of note:** Effective February 1, 2011, the time to report is 24 hours from the discovery of the critical incident and we anticipate compliance rates will drop, despite efforts to engage providers in the policy-drafting process and educating them via training, teleconferences and policy distribution online.

**HW 27a** – (number and percentage of critical incident reports (CIRs) reviewed by Adult Protective Service within one business day of receipt) Two of the 85 critical incident reports submitted in November were not reviewed in a timely manner due to staffing issues. The two reports were reviewed, and the involved staff was provided with technical assistance and was re-trained on the process and the staff coverage requirements for this activity.

**Financial Accountability** assurances were 100% compliant during the reporting period.

**Older Alaskans**

This waiver serves Alaskans 65 and over who meet nursing facility level of care. This is a state-wide waiver. For the Older Alaskans waiver, quality monitoring activities were conducted for all waiver assurances and sub-assurances for which performance measures have been developed.

Through the data collection and discovery process for **Level of Case**, one performance measures was found to be less than 100% compliant.

**LOC 2** – (number and percentage of participants who received an annual level of care determination within 12 months of initial determination or previous level of care determination) There were three individual findings for this measure that were not compliant. Each of these findings was remediated within 3, 4, and 6 weeks, respectively.

Through the data collection and discovery process for **Service Plan**, eight performance measures were found to be less than 100% compliant.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**SP 9** – (number and percentage of participants who have documented personal goals identified in the service plan) There were seven findings for this measure during the reporting period. Six of these findings were remediated through the provision of technical assistance to care coordinators regarding personal goal development. One finding is currently in the process of being remediated, again through the communication and provision of technical support to the respective care coordinator. The findings for this performance measure have been discussed with the Senior and Disabilities Services training unit and this area will be emphasized in trainings, with webinar trainings currently scheduled for January through June of 2011.

**SP 11** – (number and percentage of completed service plans submitted to SDS within the required regulatory timeframes) is due primarily to a recent change in enforced policy by SDS, as noted above in the Adults with Physical Disabilities’ findings. Of the 93 service plans overdue at the time of this report, 72 had been received complete within 4 weeks of the due date, and the remaining 21 had been requested from the respective care coordinators.

**SP14** – (number and percentage of service plans reviewed and updated as needed prior to the annual redetermination date) Three of the 23 service plans due to be reviewed during the reporting period were not reviewed timely. All of the findings were remediated within four weeks, with the service plans having been reviewed and approved.

**SP15** – (number and percentage of participants whose change in needs required a change in their service plan, and whose service plan was appropriately revised to address those changing needs) There was one finding for this measure which was remediated by receipt of a service plan amendment.

**SP 16** - (number and percentage of participants who received services by type of service) is problematic to assess because of the lags that occur between the time of service delivery and the time of billing, and also because it is difficult to determine whether or not a participant chose not to use a specific type of service. The compliance percentage for this measure was 78.6% for the reporting period. For this measure the primary problem is that it is difficult to tell from a billing utilization report whether or not a participant chose not to utilize a particular type of service. Of the 28 records reviewed during the reporting period, 6 participant service plans contained services where the provider had not billed for a specific service on the service plan. The remediation for these findings was to review provider service provision records to identify if the service was rendered but not billed for.

**SP 17** - (number and percentage of participants who received services in the amount, duration and frequency described in the service plan), the primary issue was that the 12-month window of opportunity for billing was not closed. Because this report is based on claims data, if the billing for the service has not been submitted, service delivery may be under-represented. The compliance percentage for this measure was 64.3% for the reporting period. These performance measures continue to be monitored and the criteria for findings are refined as needed to help pinpoint actual problems.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**SP 18** - (number and percentage of participant records with an appropriately completed freedom of choice form that specified choice was offered among waiver services) There was one finding for this performance measure which was remediated by receipt of a signed and updated freedom of choice form.

**SP 19** – (number and percentage of participant records with documentation that the participant received a list of qualified providers and was provided a choice of providers) As with the previous measure, there was one finding for this measure that was remediated by receipt of a signed and updated freedom of choice form.

**SP 20** – (number and percentage of participant records with an appropriately completed and signed freedom of choice form that specified that choice was offered between institutional care and home and community-based waiver services) This measure had one finding which was remediated through the receipt of a signed and updated freedom of choice form.

Through the findings and discovery process for **Health & Welfare**, one performance measures was found to be less than 100% compliant.

**HW 25** – (number and percentage of participants who received information on reporting abuse, neglect or exploitation) There were two findings for this measure that were due to a clerical error contained on a submitted form. These findings were remediated by the receipt of the appropriate signed and updated forms.

**HW 26** – (number and percentage of critical incident reports that were reported by a provider within required timeframes). Forty of 221 critical incident reports were submitted by provider agencies outside of the 72 hours allowed from identification of the critical incident. To resolve these individual findings, and to prevent future findings, technical assistance is provided by SDS to provider agencies at the time of late submission. The compliance percentage for this measure was 81.9% for the reporting period. When late submission of these reports becomes a recurring problem for a specific provider agency SDS will initiate a corrective action plan for the respective provider agency.

**HW 27a** – (number and percentage of critical incident reports (CIRs) reviewed by Adult Protective Service within one business day of receipt) Two of the 221 critical incident reports submitted in November were not reviewed in a timely manner due to staffing issues. The two reports were reviewed, and the involved staff was provided with technical assistance and was re-trained on the process and the staff coverage requirements for this activity.

The Older Alaskans waiver shares the same **Qualified Provider** performance measure findings as the Adults with Physical Disabilities waiver. The findings and action outcomes for the Older Alaskans waiver are identical to that of the Adults with Physical Disabilities waiver. Please refer to page 3 of this document to review **Qualified Provider** performance measures.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

There were no **Financial Accountability** findings within the reporting period. Compliance for Financial Accountability was 100% during November 2010.

**Mental Retardation / Developmental Disabilities**

This waiver serves Alaskans who meet an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care. This is a state-wide waiver program.

Through the data collection and discovery process for **Level of Care**, one performance measure was found to be less than 100% compliant.

**LOC 2** – (number and percentage of participants who received an annual level of care determination within 12 months of initial determination or previous level of care determination) There were sixteen individual findings for the Level of Care in which level of care determination had not occurred within the required time frames. Each of these sixteen findings was resolved by the time this report had been developed; level of care for each participant had been determined. The time to determine level of care after the due date ranged from 1 week to 7 weeks.

Through the data collection and discovery process for **Service Plan**, six performance measures were assessed at below 100% compliant. As with the other waiver programs the Mental Retardation / Developmental Disabilities waiver also has significantly low compliance percentages related to timely submission of service plans.

**SP 8** – (number and percentage of waiver participants who have service plans that were adequate and appropriate based on the needs identified in the assessment) had a compliance percentage of 32.1%. These findings appear to be systemic and are currently being addressed through the provision of individual technical assistance when needed and by incorporating this issue into our standard care coordination trainings. Case record review criterion continues to be evaluated for appropriateness, and refined as needed.

**SP 11**- (number and percentage of completed service plans submitted to SDS within required regulatory timeframes). Seventy-seven of 85 service plans were not submitted within the regulatory timeframe (30 days after the determination of level of care). All of these 77 were submitted within 4 weeks of being due. The remaining 43 individual plans that were still due at the time of reporting have been requested from the respective care coordinators. Again, as with the other waivers, timely submission of service plans is an issue that SDS will continue to work with providers on improving. For performance measure SP 11 the compliance percentage was 9.4% during the reporting period.

**SP 14** – (number and percentage of service plans reviewed and updated as needed prior to the annual redetermination date) is similar in nature to SP 11 in that timeliness of submission by the care coordinator is a factor, and in most cases the primary factor. Eleven of the 15 services

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

plans that were non compliant were received within 4 weeks of the due date. An additional four findings resulted in a request for a new service plan from the care coordinator. To address these findings SDS has implemented a standardized insufficient documentation notice process that alerts care coordinators when necessary documentation is required.

**SP 15** – (number and percentage of participants whose change in needs required a change in their service plan, and whose service plan was appropriately revised to address those changing needs) There were two findings for this measure that were both remediated through a revision and update to the service plan.

**SP 16** - (number and percentage of participants who received services by type of service). Six of 28 participants did not receive services by type of service. The types of services not provided for these participants were Adult Day, Chore, and Lifeline. As with the other waiver programs, the primary problem is that it is difficult to tell from a billing utilization report whether or not a participant chose not to utilize a particular type of service. Providers are able to bill for services up to a year after rendering the service(s) to the participant. This performance measure had a compliance percentage of 78.6% during the reporting period. The remediation for these findings was to review provider service provision records to identify if the service was rendered but not billed for.

**SP 17** – (number and percentage of participants who received services in the amount, duration and frequency described in the service plan). Twenty-two of 28 participants did not receive services in the amount, duration and frequency described in the service plan. The issue of receipt of services will require a closer analysis to determine if there are certain types of services that experience utilization abnormalities regarding amount, duration and frequency. The compliance percentage for SP 17 was 21.4% during the reporting period.

Through the findings and discovery process for **Health & Welfare**, four performance measures were found to be less than 100% compliant.

**HW 25** – (number and percentage of participants who received information on reporting abuse, neglect or exploitation) There was one finding for this measure which was remediated by the receipt of a signed and updated form.

**HW 26** – (number and percentage of critical incident reports that were reported by a provider within required timeframes) Eight of 61 critical incident reports were submitted by provider agencies outside of the 72 hours allowed from identification of the critical incident. To resolve these individual findings, and to prevent future findings, technical assistance is provided by SDS to provider agencies at the time of late submission. The compliance percentage for this measure was 86.9% for the reporting period. When late submission of these reports becomes a recurring problem for a specific provider agency SDS will initiate a corrective action plan for the respective provider agency.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**HW 27a** – (number and percentage of critical incident reports (CIRs) reviewed by Adult Protective Service within one business day of receipt) Three of the 57 critical incident reports submitted in November were not reviewed in a timely manner due to staffing issues. The three reports were reviewed, and the involved staff was provided with technical assistance and was re-trained on the process and the staff coverage requirements for this activity.

**HW 27b** – (number and percentage of critical incident reports (CIRs) involving children reviewed by SDS within one business day of receipt). SDS is responsible for reviewing critical incident reports involving children within one business day of receipt. In addition, the critical incident report is provided to the Office of Children's Services for review. The compliance percentage for this performance measure was 50% for the reporting period. The non-compliance for this performance measure was due to SDS monitoring processes that kept two individual cases from being reviewed in a timely manner. These two instances were reviewed with the appropriate SDS staff, and this performance measure will be monitored to determine if the problem has been resolved.

As with the Older Alaskans waiver, the Mental Retardation / Developmental Disabilities waiver shares the same **Qualified Provider** performance measure findings as the Adults with Physical Disabilities waiver. The findings and action outcomes for the Mental Retardation / Developmental Disabilities waiver are identical to that of the Adults with Physical Disabilities waiver. Please refer to page 3 of this document to review **Qualified Provider** performance measures.

There were no **Financial Accountability** findings within the reporting period. Compliance for Financial Accountability was 100% during November 2010.

**Children with Complex Medical Conditions**

This waiver serves Alaskans between the ages of 3 and 21 who meet nursing facility level of care. This is a state-wide waiver program.

Through the data collection and discovery process for **Level of Care**, two performance measures were found to be less than 100% compliant.

**LOC 2** – (number and percentage of participants who received an annual level of care determination within 12 months of initial determination or previous level of care determination) There was one individual finding for this measure that was not compliant. This individual finding was remediated within one week.

**LOC 6** – (number and percentage of initial and annual level of care determination criteria applied correctly) There was one finding for this measure which was remediated through the receipt of a required signed document.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

Through the data collection and discovery process for **Service Plan**, three performance measures were found to be less than 100% compliant.

**SP 11-** (number and percentage of completed service plans submitted to SDS within required regulatory timeframes). Again, as with the other waivers, timely submission of service plans is an issue that SDS will continue to work with providers on improving. For performance measure SP 11 the compliance percentage was 5.6% during the reporting period. Ten of the 17 non-compliant service plans were submitted after their respective due dates, but prior to the writing of this report. The time to receipt of these plans after the due date ranged from 1 to 4 weeks. At the time of reporting seven plans are still due; the respective care coordinators have been noticed and these plans have been requested.

**SP 14 –** (number and percentage of plans reviewed and updated as needed prior to the annual redetermination date) There were two findings for this performance measure. Both findings were remediated within 2 and 3 weeks, respectively, by the receipt of service plans that were reviewed and approved.

**SP 16 -** (number and percentage of participants who received services by type of service), as with the other waiver programs, the primary problem is that it is difficult to tell from a billing utilization report whether or not a participant chose not to utilize a particular type of service. This performance measure had a compliance percentage of 57.1% during the reporting period. The remediation for these findings was to review provider service provision records to identify if the service was rendered but not billed for.

**SP 17 –** (number and percentage of participants who received services in the amount, duration and frequency described in the service plan). The issue of receipt of services will require a closer analysis to determine if there are certain types of services that experience utilization abnormalities regarding amount, duration and frequency. The compliance percentage for SP 17 was 7.1% during the reporting period.

Through the findings and discovery process for **Health & Welfare**, two performance measures were found to be less than 100% compliant.

**HW 25 –** (number and percentage of participants who received information on reporting abuse, neglect or exploitation) There were two findings for this measure that were due to a clerical error contained on a submitted form. These findings were remediated by the receipt of the appropriate signed and updated forms.

**HW 26 –** (number and percentage of critical incident reports that were reported by a provider within required timeframes). One of two critical incidents submitted was not submitted within the required timeframe. The non-compliance for this performance measure is due to late submission of critical incident reports by provider agencies. To resolve these individual findings, and to prevent future findings, technical assistance is provided by SDS to provider agencies at the time of late submission. When late submission of these reports becomes a recurring

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

problem for a specific provider agency SDS will initiate a corrective action plan for the respective provider agency.

As with the both the Older Alaskans waiver and the Mental Retardation / Developmental Disabilities waiver, the Children with Complex Medical Conditions waiver shares the same **Qualified Provider** performance measure findings as the Adults with Physical Disabilities waiver. The findings and action outcomes for the Children with Complex Medical Conditions waiver are identical to that of the Adults with Physical Disabilities waiver. Please refer to page 3 of this document to review **Qualified Provider** performance measures.

There were no **Financial Accountability** findings within the reporting period. Compliance for Financial Accountability was 100% during November 2010.

**Data Source(s):**

Alaska has standardized its data sources in an effort to introduce consistency in the collection methods. Additionally, Alaska is working to automate many of the processes to avoid data errors and ensure the reliability of the data. The ***Aggregated Quality Report*** lists the data source next to the respective performance measure.

**Who collects/generates reports?**

The DHSS is responsible for collecting and reporting all data. Within DHSS, Senior and Disabilities Services is responsible for collecting most of the compliance data and generating the ***Aggregated Quality Report***, and this ***Quality Monitoring Report***. Additionally, the Division of Health Care Services is responsible for collecting all data pertaining to Fiscal Accountability. Senior and Disabilities Services Quality Assurance staff and leadership analyze the data and draft reports.

**Sampling Approach?**

There are currently two methods used for collecting and analyzing performance measure data. The first approach involves collecting 100% of the participant records for a particular performance measure.

The second approach involves randomly sampling waiver participants. A random sampling approach with a  $\pm 5\%$  confidence interval is used.

**How often?**

Data is collected continuously and is currently presented in monthly reports to performance measure task committees. As the continuous quality improvement practices mature, the report data will be rolled up into quarterly and annual reports and presented to the oversight committee, the Quality Improvement Steering Committee.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

**Who is responsible to address individual issues identified?**

Individual issues are generally remediated by Senior and Disabilities Service staff, often with the assistance of community care coordinators. Senior and Disabilities Services make every effort to remediate identified problems within 30 days.

**Who aggregates/analyzes?**

**How often?**

Data that is collected is aggregated by the Quality Assurance unit within Senior and Disabilities Services in an ongoing fashion. This aggregated data is then presented to the respective performance measure task committees where issues and trends are analyzed and reviewed on a monthly basis.

**How are systemic issues addressed?**

Performance measures are assigned to content-specific task committees that meet monthly to analyze the data and findings. The task committees submit their findings and analysis, with recommendations, to the Quality Improvement Workgroup monthly. Collectively, these committees evaluate systemic causes for non-compliance and identify corrective actions. Corrective actions may include policy development, training, regulatory changes, technical assistance, and best practice research. Issues that rise to a level of concern as determined by the Division Director (chair, Quality Improvement Workgroup), will be communicated to the Quality Improvement Steering Committee and/or the DHSS Commissioner.

The **Quality Improvement Steering Committee (QISC)** provides oversight to SDS's continuous quality improvement activities. This is a multi-divisional group within DHSS that includes, at a minimum:

- a. Deputy Commissioner for Medicaid and Health Care Policy;
- b. Deputy Commissioner for Family, Community and Integrated Services, Committee Chair;
- c. Director, SDS;
- d. Deputy Director, SDS;
- e. Chief of Programs, SDS;
- f. State Medicaid Director;
- g. Program Integrity Manager, Finance and Management Services;
- h. Medicaid Special Project Administrator; and
- i. Additional Division or Department staff at the invitation of the committee.

***As the Committee Chair, the Deputy Commissioner for Family, Community and Integrated Services has the authority to make administrative/programmatic decisions in response to information received by the QISC and to report any findings, outcomes and/or corrective***

**Quality Monitoring Report**  
**January 7, 2011 (for November 2010)**

***actions taken to the DHSS Commissioner. The QISC provides monitoring to the Quality Improvement Workgroup.***

The Steering Committee may invite additional DHSS staff representatives as necessary to accomplish the work of the committee. This committee meets quarterly and more often if necessary to address concerns of SDS. They review the Quarterly Quality Improvement Steering Committee Report submitted by the Quality Improvement Workgroup (QIW). This report provides the status of performance measures, remediation efforts, system improvement efforts and action plans. The QISC reviews the reports, evaluates the results, approves the actions of the QIW and/or makes recommendations for augmenting remediation or system improvement efforts that were initiated at the program level by Unit Managers and monitors system improvement efforts.

The QISC is responsible for approving, implementing and monitoring the Quality Improvement Strategies. The QISC assumes responsibility for the proper implementation of SDS policies and procedures affecting the health, safety and welfare of waiver recipients and the provision of quality services to these recipients. The QISC monitors, recommends, and implements changes in the Quality Improvement Strategy to assure the health, safety and welfare of waiver recipients and improve the quality of services provided to recipients. The QISC reviews and approves the development of Performance Measures and reviews data collection processes to ensure that useful information is gathered to improve quality of service delivery and to assure the health, safety and welfare of waiver recipients. The QISC identifies training, technical assistance or other activities based upon analysis of Quality Improvement Workgroup data or other available information sources. The QISC ensures that information obtained from analysis of Performance Measures data is disseminated, as appropriate, to stakeholders and staff. The QISC interfaces with the DHSS Audit Committee to participate in implementation of financial accountability monitoring.

The monitoring committee of SDS's daily processes and activities is SDS's ***Quality Improvement Workgroup (QIW)***. During this monthly meeting, Unit Managers, who also serve as Task Committee Chairs, present data on performance measures and remediation activities initiated by individual Unit Managers. QIW reviews the data collected through quality assurance task committees and programs to discover what system changes may be necessary to meet performance measures and what remediation efforts have been undertaken. The QIW applies the continuous quality improvement strategy through discovery by analyzing and trending data, identifying problems, recommending and requiring system changes and ensuring that the individual problem was remediated by the Unit Manager. They monitor remediation and system improvement activities to determine the effectiveness of changes made.

**Gaps/Issues/Strategic Plans**

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

Conducting systematic data collection, review and analysis is instrumental in identifying gaps and issues. This process, while still new to Alaska's operations, is already informative regarding emerging gaps and issues.

Having discussed the various compliance gaps across all four of the waiver programs, two specific assurances have been identified as requiring immediate systemic change to improve specific performance measure compliance. The following compliance plans have been developed to help address some of the systemic issues identified in the previous discussion:

**Service Plan:**

**SP 9 - Number and Percentage of participants who have documented personal goals identified in the service plan.**

1) Incorporate person centered planning and goal development into all service plans:

a) Implement person centered planning and goal training for both SDS staff and providers. The SDS trainer will provide multiple training dates to afford better participation.

Target Date: January-June, 2011

Responsible Persons: Operations Integrity Unit Manager

b) Develop and distribute a plan of care standards document that clearly defines the work product that is expected to be submitted by all care coordinators.

Responsible Persons: Service Plan Task Committee Chairs

Target Date: June, 2011

2) Continue to refine case record review criteria and provide written clarification to case record review staff to ensure accurate inter-reviewer reliability and consistent findings.

Responsible Persons: QA Service Unit Manager

Target Date: Current and ongoing.

**SP 11 - Number and percentage of completed service plans submitted to SDS within required regulatory timeframes (7AAC 130.230 (h)).**

1. Develop and Implement an automated service plan system for all four waivers to:

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

- a) Continue to issue notices alerting care coordinators that service plans are coming due, 10 days prior to the previous expiration date. (current and ongoing)
- b) Generate a level of care approval notice that includes a due date for plan of care based on regulatory timeframes.
- c) Allow Participants and Care Coordinators access to an automated system to enter service plans with business rules imbedded in the plan to ensure a “complete” plan is received.

Responsible Persons: Service Plan Task Committee Chairs, Information Technology (IT)

Target Date: October 1, 2011

**SP 16 - Number and percentage of participants who received services as documented in the Service Plan by type of service.**

1. Develop and Implement an automated service plan system for all four waivers to:
  - a) Allow Participants and Care Coordinators access to an automated system which allows them to see their approved services and utilization.
  - b) Allow Care Coordinators access to update plans in timely.
  - c) Allow Quality Assurance and program staff access to review utilization in a more current timeframe.

Responsible Persons: Service Plan Task Committee Chairs, Information Technology (IT)

Target Date: October 1, 2011

2. Conduct further discovery on findings to review provider records for “real time” utilization. (providers currently have up to 12 months to bill for rendered services).

Responsible Persons: Service Plan Task Committee Chair

Target Date: March 1, 2011

**SP 17 - Number and percentage of participants who received services as documented in the Service Plan in the amount, duration and frequency.**

1. Develop and Implement an automated service plan system for all four waivers to:
  - a) Allow Participants and Care Coordinators access to an automated system which allows them to see their approved services and utilization.
  - b) Allow Care Coordinators access to update plans in timely.

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

- c) Allow Quality Assurance and program staff access to review utilization in a more current timeframe.
2. Findings from the Older Alaskans waiver will be targeted, and provider billing records will be gathered directly from providers to analyze possible reasons for underutilization.

Responsible Persons: Service Plan Task Committee Chairs, Information Technology (IT)

Target Date: October 1, 2011

**Health and Welfare:**

**HW 26 - Number and percentage of critical incident reports that were reported by a provider within required timeframes.**

1. Implement new incident report form once public comment period closes on January 21, 2011 to
  - a) Collect additional information on date "incident known" by provider
  - b) Identify service(s) being provided at time of incident

Responsible Persons: Health and Welfare Task Committee Co -Chairs

Target date February 1, 2011

2. Update Division's critical incident reporting policy once public comment period closes on January 21<sup>st</sup>, 2011. to
  - a) Reduce reporting period to 24 hours and one business day
  - b) Describe Adult Protective Service (APS) role in screening all critical incidents involving vulnerable adults within one business day
  - c) Define use or unauthorized use of restrictive interventions that require reporting

Responsible Persons: Health and Welfare Task Committee Co -Chairs

Target date February 1, 2011

3. Monitor and address all instances of provider not reporting within required timeframe
  - a) Provide and record technical assistance
  - b) Make referral to certification (or other agencies as applicable) for repeated non-compliance or indicators of ongoing risk to participants
  - c) Require critical incident improvement plan be implemented and completed as applicable
  - d) Implement provider remediation as described in regulation and policy

Responsible Persons: Health and Welfare Task Committee Co –Chairs

**Quality Monitoring Report  
January 7, 2011 (for November 2010)**

Target date: Current and ongoing

4. Refine electronic tracking system in DS3 to
  - a) Connect multiple reporters to one event
  - b) Identify more quickly mandated reporters that failed to report
  - c) Indentify more quickly repeated non compliance by providers or patterns of risk to participants

Responsible Persons: Health and Welfare Task Committee Co-chairs and Information Technology (IT)

Target date May, 2011

**Evidence**

Evidence is provided via Aggregated Quality Reports for each waiver.