



Division Directive Number

4.090

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Jeff Grosvenor

Jeff Grosvenor, Director

Title: Provider Relations Review Policy

Applies to: Regional Offices Provider Relations teams.

Purpose: Prescribes the functions of Provider Relations as relates to the review of contracted providers with the Division of Developmental Disabilities to ensure consistent application across the state and to develop partnerships that enhance the overall quality of services delivered.

Definitions:

Accreditation: A designation achieved by a provider participating in a review of practices and programs conducted by the accrediting body based on international standards. The accrediting bodies recognized by the Division are the Commission of Accreditation of Rehabilitation Facilities (CARF) and Council for Quality and Leadership (CQL).

Action Plan Tracking System (APTS): A database utilized by the Division designed to track issues requiring resolution as well as positive practices identified through Integrated Quality Functions. Issues tracked are identified through indicators categorized by health, safety, rights, services, and money, in addition to the Missouri Quality Outcomes.

Certification: A process used by the Division of Developmental Disabilities to review and approve specified providers for participation and funding through the Home and Community Based Medicaid Waiver program. Certification provides deemed status for licensure so both credentials are not required. Certification is granted for a 2-year period.

Individual and Family Supports: The Regional Office Unit responsible for development, implementation, and enhancement of the infrastructure of supports and services for individuals with developmental disabilities and their families. Individual and Family Supports will have staff comprised of support coordination, intake/eligibility, transition (school to post-secondary education life) and meaningful day/employment; transition (habilitation centers), family support coordinators, and in home support team.

Customer Information Management, Outcomes, and Reporting Event Management Tracking (CIMOR EMT) System: A Department database which contains information from event reports as required by 9 CSR 10-5.206. This database is also used to collect information on incidents meeting pre-specified severity criteria or investigations of abuse, neglect, and/or misuse of individual funds.

Issue: A point, matter, concern or question in regards to the health, safety and/or rights of an individual. A critical issue is when the health, safety and /or rights of an individual are in jeopardy.

Missouri Quality Outcomes: A collection of positive outcomes identified by people with disabilities, family members and friends outlined in the Missouri Quality Outcomes Discussion Guide <http://dmh.mo.gov/docs/dd/QualityoutMan.pdf>. The Discussion Guide document serves as a tool designed to assist the service delivery network to put these desired concepts into practice.

Outcome: The result of action to be taken as outlined in a plan that resolves issues, prevents reoccurrence, and increases opportunities for improvement in the TCM delivery system and implementation of the Missouri Quality Outcomes.

Primary Regional Office: The facility responsible to coordinate and facilitate the annual provider meeting when the provider, who serves multiple regions, serves the greatest number of people in that facility's region.

Provider Annual Plan: Annual plans are written by the provider. The plan describes outcome-based strategies and outlines actions formulated from information and issues discussed at the provider annual meeting. This information will be gathered from sources, including but not limited to the Action Plan Tracking System and the CIMOR Event Management Tracking System.

Provider Relations Contact Summary: Standardized form used to document periodic meetings with providers.

Provider File: A file maintained at the Regional Office specific to each contracted provider containing information including but not limited to: correspondence, contractual information, monitoring information, fiscal reviews, rate reviews, annual provider plans, critical status plans and improvement plans.

Provider Relations: The Regional Office unit responsible for provider development to enhance the capacity for the provision of supports and services. In addition, the staff will provide technical assistance and monitoring; allocate resources, and management of the contracts with providers of supports and services.

Provider Relations Outcome Based Review Tool: Standardized tool used to review various areas of provider service delivery.

Provider Technical Assistance: Provide information, training, and consultation to entities providing supports and services to persons with developmental disabilities and their families. It also includes contact with agencies regarding administrative and individual needs, such as administrative and staff changes.

Quality Enhancement Function: A process to monitor and affect services being provided, focusing upon health and welfare of individuals, meeting their needs and supporting them to achieve personal goals as outlined in Division Directive [4.080 - Integrating Quality Functions](#).

Quality Enhancement Plans:

- **Provider Improvement Plan:** Written outcome-based strategies outlining actions formulated from the integration or synthesis of information and issues gathered utilizing the Action Plan Tracking System (APTS), Customer Information Management, Outcomes, and Reporting system (CIMOR) as well as other available monitoring. Improvement Plans are written for the purpose of increasing performance above current levels, overall system improvement or to put processes into place to prevent an issue from developing into a more serious situation. These plans are only required under the criteria in the Provider Improvement Plan section of this directive.
- **Provider Critical Status Plan:** Written outcome-based strategies outlining actions formulated from the integration or synthesis of information and issues gathered utilizing the Action Plan Tracking System (APTS), Customer Information Management, Outcomes, and Reporting system (CIMOR) as well as other available monitoring data. A Critical Status Plan is considered a serious situation that must be mitigated and/or corrected. A Critical Status Plan may result from a provider not resolving issues as specified in the Improvement plan and could result in adverse action including termination of contract.
- **Regional Office Quality Enhancement Plan:** Written outcome-based strategies for the identified region, outlining actions formulated from the integration or synthesis of information and issues gathered utilizing APTS and CIMOR-EMT, as well as other available monitoring data. Quality Enhancement Plans are written for the Regional Office for the purpose of increasing performance above current levels and overall system improvement.
- **Division Quality Enhancement Plan:** Statewide plan based on the trend data from all quality enhancement processes to affect overall system improvement.

Regional Quality Enhancement Team: Staff designated at each Regional Office to review, track, trend and report data from the quality enhancement functions as well as respond to special requests for data based upon current standards, outcomes and promising practices.

Secondary Provider Relations: One Regional Office/Provider Relations is assigned as the primary or responsible facility for each provider contract. Any additional Regional Offices/Provider Relations who access the contract for services are secondary.

Senate Bill 40 Board (SB 40): Statutorily authorized county board that funds and/or provides services for people with developmental disabilities. As referred to in this directive, those specific SB 40 boards that fund or provide case management for the specified service in partnership with the Division of DD. <http://www.moga.mo.gov/statutes/c205.htm>

Significant Issue: Multiple systems issues of concern and/or patterns of concern that repeatedly occur or that are pervasive throughout the provider’s systems or issues where the health, safety and/or rights of an individual are in jeopardy.

Site: Location where provider documentation is maintained. The site could be in the individual’s residence, site of delivered service, or the provider’s administrative office.

OVERVIEW

Provider Relations is responsible to review and provide guidance on all provider systems, as well as assist the provider in developing their own internal quality assurance systems.

Provider Relations role is to partner with providers in order to enhance service development, self-assessment and best practice by offering technical assistance and reviewing provider information systems such as employee

files, policies and procedures, facility systems and safety, staffing patterns, contract language and modifications. Provider Relations staff will work with contractors to ensure service delivery is consistent with best practices, State Rules, Medicaid waiver guidelines and DMH contract and policy.

Provider Relations staff will conduct a review of all Division of DD contracted providers with authorization to provide services utilizing a standardized tool and sample size. An annual meeting will be held for performance review and goal development for the upcoming year. The amount and frequency of the review is a minimum and the sample size can be expanded if significant system wide issues are identified.

Provider Relations staff will also meet with contracted providers as needed and/or at the request of the provider utilizing the Provider Contact form to document and communicate the purpose and resolution of the meeting.

PROCESS

Provider Relations staff will conduct reviews with each contracted provider of residential, day habilitation, personal assistant, supported employment, respite, and other identified services when appropriate such as transportation, counseling, behavioral analysis, etc. Review of contracted providers is intended to be completed electronically however may occur at the site of service and/or at the provider's primary business location at the providers request or if the provider is on a critical status plan, improvement plan or plan of correction from Accreditation or Certification. During the years that either accreditation or certification does an onsite survey, the report generated by the accrediting body or the certification team is reviewed and any systems concerns identified in those reports are evaluated for needed documentation and follow up. Systems not monitored by certification/accreditation will be reviewed by Provider Relations staff.

Non Certified/Non Accredited Providers: will be reviewed every two years through on-site reviews by the provider relations team member using the statewide outcomes based review tool and data-sources already collected by the provider and regional office tracking and trending reports.

Certified Providers: will be reviewed every three years by the provider relations team member using the statewide outcomes based review tool and data-sources already collected by the provider and regional office tracking and trending reports. In the year of a Certification Survey, the Survey Report, in addition to Regional Office data tracking and trending reports, will satisfy review requirements. In the event that reports do not contain sufficient information to satisfy Provider Relations reviewing requirements, Provider Relations will request and review needed documentation.

Accredited Providers: will be reviewed every three years by the provider relations team member using the statewide outcomes based review tool and performance reports that document results and/or corrective measures to address any deficiencies in addition to the Accreditation Survey, the Survey Report, and Regional Office data tracking and trending reports. This information will satisfy review requirements. In the event that reports do not contain sufficient information to satisfy Provider Relations review requirements, Provider Relations will request and review needed documentation.

The Provider Relations staff will contact each provider to facilitate a system so that provider reviews are distributed across a three year period so that no one year contains more than 35% of the provider population.

The Provider Relations staff will utilize a statewide outcome based tool and all review activities will be summarized utilizing Provider Relations Contact Summary. The provider will receive a copy of the tool and summary documentation and a copy will be placed in the Regional Office provider file.

The Provider Relations Contact Summary shall be completed and processed as follows:

A summary will be completed containing positive information gathered regarding provider achievements, systems and overall best practices.

Provider Relations staff will forward the contact summary to the Regional Office Director, Agency Director, responsible Professional Manager, the Regional Quality Enhancement, Individual and Family Support Unit any TCM entities working with the provider, and any secondary Provider Relations leads within 10 working days of the review.

Provider Relations staff will continue to review system issues until resolved and forward individual issues to Individual and Family Support Unit for resolution.

All achievement, best practices, issues and the results of the resolution will be recorded in the APTS database for trending of information.

APTS and EMT data may lead to further planning as described in Division Directive 4.080 Integrating Quality Enhancement Functions. Throughout the year, it may be necessary for additional reviews to occur due to information gathered from other monitoring activities.

MINIMUM REVIEW FREQUENCY OVERVIEW

2 Year Cycle Review	3 Year Cycle Review	Review/Meeting as Identified
Non Certified/ Non Accredited Providers	Accredited and Certified providers	Transportation Counseling Interpreter Person Centered Strategies Consultation Behavioral Services Behavior Intervention Specialist Senior Behavior Consultant Functional Behavioral Assessment Medical Consultations Occupational Therapy Physical Therapy Speech Therapy Community Specialist Professional Assessment and Monitoring Other miscellaneous services as identified.

Review Parameters:

Provider Relations staff will randomly sample service sites. The record reviews will emphasize new staff or individuals receiving services. If at any time during the process significant issues are identified, the Provider Relations Team Member will work with the provider to expand the service sample size and offer technical assistance if necessary in looking for the best practice for correction or enhancement of the system.

The services identified in the third column as “Review/Meeting as Identified” indicates that these services are temporary, intermittent or indirect services such as home modifications, dental, etc. Provider Relations will have no routine contact with these service providers after the implementation of their contract unless a specific referral is made to Provider Relations by Fiscal Review or Support Coordination due to a system issue that requires technical assistance.

MINIMUM PROVIDER RELATIONS SAMPLE SIZE PER CONTRACTED PROVIDER

Service Description	Service Location	Individual Records	Personnel Records
RCF	20% no less than 5	3 records	3 per location
Group Homes 4+ individuals	20% no less than 5 Maximum of 10	3 records across all group home sites selected	3 per location
Group Homes 1-3 individuals	20% no less than 5 Maximum of 10		2 per location
ISL/Shared Living	20% no less than 5 Maximum of 10	3 records across all ISL/Shared Living sites selected	2 per location
FLA	100%	100%	2 per location
Day Services	100% On Site Programs	3 records	3 records
Personal Care Assistant	n/a	3 records	3 records
Home Health Care/Quality Nursing Care I & II	n/a	3 records	3 records
Employment Services	n/a	3 records	3 records
Respite	n/a	3 records	3 records

In the event a provider of residential services provides multiple types of residential services the service location sample size of 20% no less than 5 with a maximum of 10 will be distributed amongst all residential services. If a provider of residential services also provides non-residential services, those non-residential services will each be sampled separately according to the sample size above.

Example: Provider A has 2 group homes, 10 ISL locations and an On-site Day Service Program; the review will pull information from 5 service sites (which includes at least one group home), and a review of the on-site day service. The review of personnel records applies as indicated above for each service.

Technical Assistance:

Provider Relations staff will meet with contracted providers throughout the year at the provider’s request or as needed to facilitate enhancement and identification of best practices. Examples of technical assistance may include but are not limited to, requests for resource information regarding training sources, policy, and systems development. Technical assistance may be offered due to updates of provider system requirements, ongoing consultation for resolution of issues identified through the APTS, EMT and other data gathering activities, or due to issues identified through routine monitoring. Provider Relations staff will document the purpose and outcome of the meeting on the Provider Relations Contact Summary. Documentation will be maintained in the Regional Office provider file and may be used as an information source during the Annual Provider Meeting.

Technical assistance is intended to support the providers’ development and enhancement of internal systems which should include self-assessment as relates to service delivery and individual and stakeholder satisfaction.

Annual Meeting:

The purpose of this meeting is to review the service delivery system to assist in developing enhancement goals the provider has identified.

Provider Relations staff will coordinate and facilitate an annual meeting when the following criterion exists:

Provider is on an improvement plan, critical status plan, no growth and/or no referral status.

An annual meeting as facilitated by the Regional Office Provider Relations staff is optional for providers who are not captured in the above criterion.

Providers may choose to invite their respective Regional Office Provider Relations and Quality Enhancement representatives to attend their agency facilitated meeting. The provider will notify their Provider Relations staff at least two months prior to the meeting to obtain information from the Regional Office data sources.

Annual Provider Plan:

Every provider as defined in the definitions shall receive annual data in order to evaluate their practices and progress towards outcomes. Provider Relations staff will forward information from various data sources including, APTS data and trending reports and EMT data. The provider shall already have copies of Licensure/Certification/Accreditation reports, contractual and fiscal reviews, and Improvement or Critical Status Plans from which can be utilized to develop a plan. Providers may develop outcome-based goals designed to promote quality improvement. Provider Relations staff will assist providers as necessary to develop their goals.

The provider's goals may incorporate Missouri Quality Outcomes which focus on individual services such as:
#17 Action at all levels of the organization is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported

#18 The agency initiates and maintains positive working relationships with other organization within and outside the service delivery

#19 The agency empowers staff to meet people's needs

#20 The agency regularly evaluates its success in meeting people's needs

Providers shall develop an annual plan for submission to Provider Relations when the following criteria exist:

Provider has a current improvement plan, critical status plan, no growth and/or no referral status.

Provider has a plan of correction resulting from a Certification or Accreditation survey.

Provider has been on an improvement or critical status plan and/or no growth no referral status in the previous 12 months.

Providers current Certification status is conditional.

Providers current Accreditation was granted for less than 3 years.

All plans will be forwarded to the Provider Relations team member within 30 days of the meeting. This will ensure that the Provider Relations team member is informed of and prepared to research needed information and assist the provider in achieving their goals throughout the year. A copy of the plan will be kept in the Regional Office provider file for referencing, updating and submission to certification/accreditation upon request.

Provider Relations staff will forward the Provider's Annual Plan to the Regional Director, Agency Director, responsible Professional Manager, the Regional Quality Enhancement, Individual and Family Support Unit, any TCM entities working with the provider, and any secondary Provider Relations leads within 10 working days of receipt.

When a provider delivers services in more than one region, the primary Regional Office Provider Relations team member will be responsible to collect the annual data from each Regional Office and forward the information to the provider. The primary team member will also be responsible to coordinate and facilitate the annual meeting if required or requested to include provider relations and quality enhancement staff participation from other Regional Offices accessing the provider's contract. In the event that an annual plan is required due to a region specific issue, the plan shall be facilitated by the region who has placed the provider on an improvement plan, critical status plan, no growth and/or no referral status. Information from all Regional Offices will be shared to assist in the provider's goal development.

Authority:

HCB Medicaid Waiver: <http://manuals.momed.com/manuals/hyperlinkPage.render?idLinkParmName=dmh>

9 CSR 10-1.010, 9 CSR 45-5.010 and 9 CSR 45-5.060: <http://www.sos.mo.gov/adrules/csr/current/9csr/9csr.asp#9-45>

DMH/ Division of DD Contract <http://www.dmh.mo.gov/docs/dd/POSContract.pdf>

Division of DD Non-Waiver Services Definitions <http://www.dmh.mo.gov/docs/dd/ServiceDefinitions.pdf>

Missouri Department of Mental Health
 Division of Developmental Disabilities
 Provider Relations Review

Outcome 1: A system is in place to ensure that staff are qualified and trained to meet people’s needs.

Personnel File Review	If provider contracts for multiple services/sites, each employee file review counts towards 1 service or site, regardless if they work across services/sites.
Staff Education	Direct staff: Verification of high school diploma/GED or written exception from RO. Professional Manager: Verification of degree and/or experience. RN: Verification of current RN license.
Background Checks	Documentation available; initiated prior to the employee having contact with people supported; staff not listed on the DMH, DHSS, or DSS disqualification
CPR/First Aid	Documentation available & current [Red Cross or American Heart Association-every 2 years].
Abuse and Neglect Training	Documentation available and current (prior to contact with individuals and every 2 yrs)
Medication Aid training	Documentation available & current (initial and update every 2 yrs)
Individual Support plan training	Documentation available & current within one month of employment and ongoing.
Missouri Quality Outcomes training	Documentation available for staff with less than 1-year experience
Positive Behavior Support training	Training occurred within 90 days of employment
Confidentiality	Review of the agency policy or training occurred upon hire and annually.
MANDT, CPI or other approved curriculum	Documentation exists if required.
Driver’s license	For staff transporting individuals, a current driver’s license is on file.
Vehicle Insurance	For staff transporting individual in their personal vehicle, evidence of insurance is on file.
Employment Eligibility	Completed I-9 form, Employment Eligibility Verification form, documentation available.
Shared Living Only	Host Home Study or Companion Evaluation is on file Annual Contract between host/companion and administering agency is on file Background screenings exist for anyone residing in the home age 18 or older

Outcome 2: A system exists to ensure individual’s documentation is in place at the service site.

<p>Individual Information Review</p>	<p>If the individual receives multiple services from the provider, each individual’s record review counts towards 1 service.</p> <p>The following documentation exists in a consumer file at the site of service. Applicable documentation should be contained and available in the entirety of the individual's record.</p>
<p>Individualized Support Plan</p>	<p>Provider has a current signed plan on file.</p>
<p>Monthly Reports</p> <ul style="list-style-type: none"> • Review to look for last 3 consecutive months. 	<p>Provider has monthly reports on file.</p> <p>Monthly Report Contains:</p> <ul style="list-style-type: none"> • First name, last name, and either middle initial or date of birth of the individual • Month and year of service covered by report • Monthly summaries describe progress on the ISP's goals & objectives and the overall status of the individual-all necessary signatures should be on the documents (Support Coordinator, provider, Professional Manager, etc.) • Author has signed, printed (or typed) name, title and date of report completion • If author is other than the Professional Manager, the Professional Manager shall also sign, print name, title and date of review

<p>Daily Progress Notes</p> <ul style="list-style-type: none"> Review to look at 3 progress notes per individual 	<p>Provider has daily progress notes on file.</p> <p>Progress Notes Contain:</p> <ul style="list-style-type: none"> First name, last name, and either middle initial or date of birth of the individual Accurate, complete, legible description of each service provided Name, title, & signature of the person delivering the service Date of service (mm/dd/yy). All documentation that is date specific REQUIRES the date of service. Month, day, and year. This is specified in the manual for each service For services reimbursed according to the amount of time spent in delivering or rendering a service, the actual begin and end time taken to deliver the services (i.e. 4:00 pm -4:30 pm/ clock time) must be documented. Documenting start and stop 'clock' time for all services provided in a measured unit, 15 or 30 minutes, 1 hour, etc. Excludes services such as home modification, equipment & supplies, transportation, etc. Individual's progress toward the goals stated in the treatment plan or ISP Setting in which the service was rendered
<p>Attendance or census records</p>	<p>Documenting days of service, signed by the provider or designated staff; records of which staff provided each unit of service.</p> <ul style="list-style-type: none"> Census record should contain First name, last name, and either middle initial or date of birth of the individual

Professional Manager Logs <ul style="list-style-type: none"> Review to look at 3 months 	Provider has Professional Manager Logs on file for ISL and Group Home Services Professional Manager Logs equal hours allocated for each individual/month reviewed. <ul style="list-style-type: none"> First name, last name, and either middle initial or date of birth of the individual Accurate, complete and legible summary of activities performed for each date of service Name, title, & signature of the person delivering the service Date of service (mm/dd/yy). All documentation that is date specific REQUIRES the date of service. Month, day, and year. This is specified in the manual for each service Time spent per each date
Community RN Logs <ul style="list-style-type: none"> Review to look at 3 months 	Provider has RN Logs on file for ISL and Group Home Services Community RN Logs equal hours allocated for each individual/month reviewed. Same content as first 5 bullets in Daily Progress Notes Above
Mileage Ledgers <ul style="list-style-type: none"> Review to look at 3 months 	Provider has mileage logs on file for ISL mileage and include <ul style="list-style-type: none"> First name, last name, and either middle initial or date of birth of the individual Accurate, complete, and legible Name, title, & signature of the person delivering the service Date of service From and to location Mileage per trip

Outcome 3: A system exists to maintain, update and implement required policy and procedure.

Policy & Procedures	Current policies & procedures available for review; Review policies for revisions requested by the Division since last PR review was performed.
Existence of 24-hour agency & administrative contact system	Verify by policy or verbal discussion with owner/administrator that agency has a system in place to be contacted 24 hrs a day and that the agency administration can be contacted 24 hrs a day if necessary.

Outcome 4: A system is in place to ensure staff support is provided at appropriate level to meet individual needs.

Group Home and ISL and Shared Living System Review	
If the site is a group home: The group home meets the necessary level of staff supervision.	Verify direct care staff are scheduled in accordance with the necessary level of staff supervision for each group home site chosen as part of the review.
Professional Manager coverage meets the needed level of supervision.	Verify enough Professional Manager FTE(s) is present for total hours/month contracted.
Community RN coverage meets the required level of supervision.	Verify enough Community RN FTE(s) is present for total hours/month contracted.
Individualized Supported Living System Review	
Staffing Pattern	Staffing pattern exists and matches ISL budget for each ISL site chosen as part of the review. For ISLs that are full time supports the <u>combined ISL budgets should total at least 730 Direct Staff hrs</u> unless live in staff; if more than 730 hrs then documented on staffing pattern and there is documented need in annual plan[s] for extra hours needed. Verify direct care staff is scheduled in accordance with staffing pattern.
Professional Manager coverage meets the needed level of supervision. (1 month)	Verify enough Professional Manager FTE(s) is present for total hours of CS/CIST contracted.
Community RN coverage meets the required level of supervision.	Verify enough Community RN FTE(s) is present for total hours/month contracted.
Shared Living System Review	
Relief Staff Hours (3 months)	Verify that relief staff hours are provided as allocated by the shared living budget per each site chosen as part of the review.

Outcome 5: A system is in place to meet contract specific requirements.

Contractual Requirements	
Missouri taxes paid annually	Documentation available to prove agency has paid taxes.
Insurance	Documentation is available for agency insurance for general liability, professional liability, workman's compensation, etc. If the agency is contracted for host homes, the host home is responsible to maintain homeowners or renters insurance. In companion models the administrative agency is responsible for this.
Uniform Cost Report	Agency submitted their UCR within 180 days of the end of their fiscal year on a three year rotation.
Office of Inspector General	Verify through the online database to ensure the provider has not been added to the exclusion list. http://oig.hhs.gov/
Secretary of State	Verify through online search to ensure the provider remains registered with SOS, if required, https://www.sos.mo.gov/BusinessEntity/soskb/csearch.asp
Annual Plan	The provider has submitted their annual plan(s) since last PR Review.

Any agency system may be reviewed by PR if warranted through APTS data review, EMT data review, or other Integrated Function sources.

NOTES:

Outcome 1: only review staff education; MANDT, CPI or other training approved by the Division; vehicle insurance; employment eligibility and additional Shared Living documentation during the calendar year of Accreditation/Certification.

Outcomes 2-5 will be reviewed during years of Accreditation/Certification.

Missouri Department of Mental Health
 Division of Developmental Disabilities
 Provider Relations Contact Summary

Provider:	Date:
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Location(s) of Meeting:

Type of Contact

<input type="checkbox"/> Routine Provider Review	<input type="checkbox"/> Follow up CATS, EMT, Inquiries, Investigation
<input type="checkbox"/> Monitoring Improvement Plan	<input type="checkbox"/> Follow up on referral from TCM or QA
<input type="checkbox"/> Monitoring Critical Status Plans	<input type="checkbox"/> Review of Data Summary from QA
<input type="checkbox"/> Technical Assistance	<input type="checkbox"/> Review of PM, or RN provision
<input type="checkbox"/> Follow up on issues from prior review	<input type="checkbox"/> Annual Meeting
<input type="checkbox"/> Follow up on MMAC issues	<input type="checkbox"/> Other

Overview

Type of location: ISL, group home, day program, office; agenda if appropriate; type of files reviewed if any; type of systems reviewed; policy and procedure
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Findings

Summary of findings – best practices, achievements, # of files reviewed with no issues/issues, etc.

Recommendations

Summary of recommendations for enhancement and growth.
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Nothing to report that requires follow up action.

Need for Specific Identified

Individual Name:	
Description of Issue:	
Action Taken:	
Person Responsible:	Timeline:

Next Meeting Date:

Provider Relations Representative:	Agency Representative:
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The fields of this document will expand as information is needed and additional space is required.

Cc:
Missouri Department of Mental Health
Division of Developmental Disabilities