PENNSYLVANIA OFFICE OF DEVELOPMENTAL PROGRAMS

Quality Assessment and Improvement
FY 21-22 Interim Year 2 Review Process

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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Pennsylvania Office of Developmental Programs Quality Assessment and Improvement FY 21-22 Interim Year 2 Review Process

As a result of the COVID-19 pandemic, the Office of Developmental Programs (ODP) received approval from the Centers for Medicare and Medicaid Services (CMS) to delay the Quality Assessment and Improvement (QA&I) activities associated to Cycle 2, Year 1 until July 1, 2022. For FY 21-22, ODP will be conducting a second interim review process with several temporarily modified QA&I activities of Administrative Entities (AE), Supports Coordination Organizations (SCO), Providers, including Agency with Choice (AWC) Financial Management Services (FMS) Providers, delivering services and supports to individuals with intellectual disabilities and autism spectrum disorders, as outlined below.

The QA&I Interim Year 2 review process (Interim Year 2) is used to demonstrate outcomes in the following areas: CMS Performance Measures, Information Sharing Advisory Committee (ISAC) recommendations, health and welfare, and ODP priorities. It also serves to validate an entity's adherence with federal and state requirements.

During Interim Year 2, AEs, SCOs and Providers that will receive an onsite review will not be required to complete a modified self-assessment. AEs, SCOs and Providers that will not receive an onsite review will complete and submit a modified self-assessment of their performance on the provision of services and supports to individuals based on key quality metrics and implementation of "*Everyday Lives: Values in Action*." Self-assessment, if used to accurately assess performance, can truly inform an entity's understanding of its progress towards achieving the goals of ODP and thus, the individuals and families that it serves. Information gained from completion of the self-assessment should inform quality improvement activities. The modified self-assessment for this year focuses on CMS Performance Measures where statewide performance is below the 86% threshold.

In addition, all QA&I activities must be conducted in accordance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Electronic distribution of materials is permitted, only if the parties involved have the means to distribute, receive and read information in electronic form, and the electronic distribution of the materials is completed in a secure and protected manner in compliance with HIPAA requirements.

All entities are required to have a QA&I contact(s) identified and will ensure that their contact information maintained with ODP is accurate and up to date. The contact information is posted on MyODP Training & Resource Center (MyODP) and includes separate tabs for each entity. For entities who are responsible for multiple functions within the QA&I Process, multiple contacts may need to be identified. For example, for AEs – there could be one contact for AE QA&I and additional contacts for ID/A Provider and AWC FMS QA&I reviews.

Please note, onsite reviews are subject to change to virtual reviews. ODP will make an informed decision on changing the method of onsite reviews to virtual reviews in alignment with applicable CDC COVID-19 guidance.

Interim Year 2: Sampling

For Interim Year 2, ODP will pull a core sample of individuals receiving services and supports using the proportionate random representative sampling methodology as described in the Intellectual Disability/Autism (ID/A) Waivers and Adult Autism Waiver (AAW). Entities included in the sample for Interim Year 2 will be notified by the QA&I team via email beginning in July 2021.

For the ID/A waivers, the AEs identified to be reviewed will be based on the individuals selected in the core sample. There will be a separate Level of Care (LOC) sample pulled of new ID/A waiver enrollees who have received an initial LOC assessment. This review of LOC determinations will focus on the timeliness and accuracy of initial LOC determinations performed by the AEs.

For the AAW and ID/A waivers, SCOs and Providers identified to be reviewed will be based on the individuals selected in the core sample. If an individual receives services and supports from multiple Providers, all Providers authorized in the individual's ISP will be reviewed. The number of individuals identified for the AE, SCO and Provider will vary with no minimum or maximum.

AEs will **not** select the individual records of the ID/A Providers to be reviewed. ODP will notify the AEs responsible for completing the Interim Year 2 review of Providers in July 2021 with the following information:

- List of ID/A Providers who will receive an Interim Year 2 review based on the QA&I FY 21-22 Interim Year 2 Review List.
    - In cases where an ID/A Provider is authorized for services with multiple AEs, the Provider will receive only one full interim review conducted by the Assigned AE. The Assigned AE completing the full interim review will go onsite and the other AEs associated with the ID/A Provider will complete the individual record reviews virtually.
    - In cases where an ID/A Provider is identified to receive a "Record Review Only" on the QA&I FY 21-22 Interim Year 2 Review List, the Assigned AE will complete the individual record reviews virtually.
    - **Note**: During Interim Year 2, the Assigned AE may be different than the AE identified in the Home and Community Services Information System (HCSIS) for Provider Qualifications.
- The individual records selected for review.
    - In cases where a Provider has individuals authorized for services with multiple AEs, each AE not identified as the Assigned AE will complete an individual record review for each individual authorized and will be responsible for all follow-up activities (remediation, PPR, etc.).

When an ID/A Provider is authorized for services with multiple AEs, the Provider will be contacted by the different AEs requesting information pertinent to individuals in the sample selected.

For Providers who are approved to render both AAW and ID/A services, the Assigned AE will complete the review and the individual sample record will include ID/A individual records only. ODP Bureau of Supports for Autism and Special Populations (BSASP) will complete the Interim Year 2 review for Providers who are only approved to render services in the AAW.

Interim Year 2: Modified Self-Assessment

Entities that will NOT complete a modified self-assessment:
AEs, SCOs and Providers that will receive an onsite review **will not** be required to complete and submit a modified self-assessment. In addition, Providers who are only approved to render services in the AAW **will not** be required to complete a modified self-assessment because training requirements are evaluated during the AAW Provider Qualifications process.

The requirement for all entities to complete an annual self-assessment will resume with the QA&I activities in Cycle 2, Year 1.

Entities that will complete a modified self-assessment:
During Interim Year 2, AEs, SCOs and Providers that **do not** receive an onsite review **will** be required to complete and submit a modified self-assessment of their performance on the provision of services and supports to individuals based on key quality metrics. A spreadsheet detailing the entities who will be required to complete a modified self-assessment will be posted on MyODP in July 2021. On September 1, 2021, each applicable entity's primary contact will receive an email with the QuestionPro link to the modified self-assessment for data entry.

Self-assessments are used to inform and build quality improvement activities for each entity. AEs, SCOs and Providers are required to review the results of their self-assessments to prioritize QI opportunities and if used to accurately assess performance, the self-assessment is intended to truly inform an entity's understanding of its progress towards achieving the goals of ODP and thus, the individuals and families that it serves.

The modified self-assessment for Interim Year 2 focuses on CMS Performance Measures where statewide performance fell below the 86% threshold in QA&I Cycle 1, Year 3 (FY19-20).

The bullets below provide a breakdown of the number of questions included in the modified self-assessment tool based on the CMS Performance Measures for each entity type:

- AE – Ten questions; four Administrative Authority and six Level of Care.
- ID/A SCOs – Nine questions; three Qualified Providers (training) and six Service Plan.
- AAW SCOs – Seven questions; six Service Plan and one Health and Welfare.
- ID/A Providers – One question; Qualified Providers (training).
- AWC FMS Provider – One question; Qualified Providers (training).

Modified Self-Assessment Sampling

As part of their self-evaluation of performance, AEs will pull their own sample of 10 individual records and 5 of the 10 individuals selected must be newly enrolled in an ID/A waiver in FY 20-21. These 10 individual records will be a cross-section of individuals served, waiver funding types, locations, and types of service.

SCOs will pull their own sample which will include 1% with a minimum of 5 and a maximum of 10 records as part of their self-evaluation of performance. If an SCO serves less than 5 individuals, 100% of the individual records must be a part of the review. These individuals will be a cross-section of the individuals served, waiver funding types, locations, and types of services. For the training questions included in the SCO modified self-assessment, SCOs in the ID/A waivers will review 25% of staff with no less than 5 staff and a maximum of 25 staff being reviewed.

Providers including AWC FMS Providers will review 25% of staff with no less than 5 staff and a maximum of 25 staff being reviewed for the training question(s). If a Provider organization has less than 5 staff, 100% of the staff records must be part of the review.

Organizations are expected to use their self-assessment results to engage in improvement activities and technical assistance provided by either ODP or AEs will focus on quality improvement. Organizations may request technical assistance at any time.

The modified self-assessment will be completed and submitted electronically to ODP via the designated web-based platform. Any area(s) identified as being out of compliance during the modified self-assessment should be remediated within 30 days. All modified self-assessments must be received electronically no later than October 31, 2021.

All documentation used to complete the modified self-assessment must be maintained and made available to ODP or the AE, as appropriate, upon request. The inability to produce such documentation will be viewed as non-compliance and will result in further actions by ODP, including sanctions.

Entities required to complete the modified self-assessment and **do not,** will automatically be issued a Directed Corrective Action Plan (DCAP) regarding non-compliance. Any time a self-assessment is not completed by an entity, ODP and/or AEs may elect to conduct an unscheduled onsite review.

Interim Year 2: Desk Review

ODP and/or AEs will conduct a desk review for each individual selected to identify evidence of compliance with key performance metrics and quality outcomes including, but not limited to, CMS Performance Measures, ISAC recommendations, health and welfare, and ODP priorities. The questions being used for the desk review have been aligned between the ID/A and AAW waivers so there will continue to be one tool for SCOs and one tool for Providers. For the ID/A waivers, there will be a separate tool for AEs. For each question, the timeframe under review is 12 months from the date of the review unless otherwise specified by the questions in the applicable Interim Year 2 Review Tool. The same review period must be used when completing the desk review and onsite review. The desk review will use all available data sources, which may include but are not limited to:

- HCSIS – service notes, monitoring tools, Individual Support Plans (ISPs) Prioritization of Urgency of Need of Services (PUNS), Supports Intensity Scale (SIS), Scales of Independent Behavior Revised (SIB-R), Periodic Risk Assessment (PRE), Quality of Life assessment, Independent Monitoring for Quality (IM4Q) considerations, Health Risk Screening Tool (HRST)
- Enterprise Incident Management (EIM) – incident reports
- Documentation – progress notes, policies and procedures, and training records

In July 2021, the QA&I team will begin notifying entities being reviewed during Interim Year 2. This notification will include details about the individuals included in the sample and a list of documents that must be organized and submitted to the QA&I team. Any documentation submitted should include the entity's name on it.

Findings from the desk review may identify areas that will require additional follow-up. If this is discovered during a review, the QA&I team will notify the entity as soon as possible.

Interim Year 2: Onsite Review

Onsite reviews for AEs, SCOs and AAW-Only Providers will be conducted by a small team of staff from ODP. For efficiency's sake, these reviews may occur on the same day, however the Interim Year 2 process for AEs and SCOs is separate and distinct. The ODP QA&I team will consist of the QA&I Lead, the staff person who conducted the desk review and supplemental regional staff, as needed. This team will be responsible for all aspects of the onsite review. The onsite QA&I team may be joined at any time by staff from ODP central office to provide support to the QA&I team and to conduct observation to inform the overall QA&I process. At least one member of the onsite QA&I team will possess ODP Quality Management Certification.

The Assigned AE will conduct onsite reviews for ID/A and AWC FMS Providers, as well as Providers who are approved to render both AAW and ID/A services. BSASP will complete the Interim Year 2 review for Providers who are only approved to render services in the AAW. The AE QA&I team may be joined at any time by staff from ODP regional or central office to conduct observation that will inform Interim Year 2.

At least one member of the AE QA&I team will possess and maintain ODP Quality Management Certification.

Onsite reviews will begin with an entrance conference. The entrance conference time and location will be established with the entity's leadership at the time the onsite review is scheduled. Each entity will receive a confirmation letter of the onsite review two weeks prior to the visit. The letter will include details about the individuals included in the sample, the timing of the onsite review and instructions about documentation that must be organized and made available to the QA&I team upon arrival for the onsite review. In addition, the confirmation letter will request support from at least one entity staff while the QA&I team is onsite.

The entrance conference will be facilitated by the QA&I Team Lead. This meeting with the entity's organizational leadership is intended to offer introductions of all QA&I team members and entity staff participating in the review process, provide an overview of the onsite review purpose and outline expectations of the QA&I team while onsite. This will also be an opportunity for the entity to share the agency's mission, vision and quality improvement priorities.

While onsite, the QA&I team will focus on gathering quality improvement and compliance evidence related to the sample of individuals and other organizational responsibilities. The entity will be expected to provide the official record of the individuals included in the sample, organized in accordance with guidance provided prior to the onsite review. Entities can expect the QA&I team to be onsite no more than two full business days, unless mitigating circumstances dictate that additional time onsite is needed; which will be communicated with the entity.

At the conclusion of the onsite review, the QA&I team will facilitate an exit conference with entity leadership and staff. ODP encourages entities to invite their leadership to join the exit conference, which will be a verbal, preliminary summary of findings and discussion of how the overall onsite review 'experience' can be improved in the future. Where possible, any opportunities for quality improvement and recognition of promising practices will be shared. In addition, instances of non-compliance discovered in the review will be noted during the exit conference so that the entity may immediately address these items. The QA&I team may elect during the exit conference to share high level trends from QA&I visits as well as state and regional data from the previous QA&I cycle.

Interim Year 2: Individual Interviews

In order to fully evaluate the individual's experience with services and supports, individual interviews are considered a critical component of the QA&I process. Interviews for each individual in the core sample and Base and SC Services Only sample will be conducted by Independent Monitoring for Quality (IM4Q) local programs on behalf of ODP. AEs and ODP staff will not conduct any individual interviews during Interim Year 2. The individual interviews will begin September 1, 2021 and must be completed by December 31, 2021.

All individuals in the samples will be offered an interview. In keeping with person-centered practices, the individual is encouraged to participate in the interview but may also choose to decline. If an individual refuses or declines to participate, the refusal is required to be entered electronically in ODP's designated web-based platform. Where appropriate, a person familiar with the individual will be asked to assist in the interview. The individual may choose who is present during the interview.

Individuals to be interviewed will receive the standard introduction letter prior to scheduling of interviews. Local IM4Q Programs will use the QA&I Interim Year 2 Interview Questions Tool and record all individual interview responses in ODP's designated web-based platform by January 31, 2022.

If during an individual interview any issue related to health and safety is discovered, the interviewer must ensure follow-up and reporting to ODP's Customer Service Line or Adult Protective Services (APS) as appropriate. If any issue related to service quality is identified, ODP regional staff in both the ID/A and AAW waivers will be responsible for any follow-up required from the interview and will collaborate with the SCOs and AEs as appropriate.

Interim Year 2: Remediation, Plan to Prevent Recurrence (PPR), Validation, Directed Corrective Action Plan (DCAP) and QM Plans

A key to the QA&I process is the identification of and action regarding opportunities for improving the overall services and supports for individuals with intellectual disabilities and autism. All entities, including ODP, will engage in quality improvement activities throughout Interim Year 2.

Remediation

When there are instances of entities not meeting the standard of a question or series of questions, the QA&I spreadsheet will indicate the review findings, including areas where remediation is required, i.e., a question will be marked "No" and highlighted in red. ODP expects that remediation will occur within 30 days of receipt of the QA&I spreadsheet unless there are concerns for health and safety where remediation must occur immediately.

The remediation actions by the entity must be captured on the QA&I spreadsheet and include proof of remediation already completed, including the time frame of completion in its response. The QA&I Lead will review and determine approval of all remediation. Once approved and validated, a copy of the completed QA&I spreadsheet along with the CAP/DCAP (if applicable) will be sent electronically to the entity reviewed. Receipt of this information indicates that the Interim Year 2 review for the entity is complete.

Plan to Prevent Recurrence (PPR)

A Plan to Prevent Recurrence (PPR) is required when the compliance score for the requirement on the QA&I spreadsheet is less than 86% or when nine (9) or fewer records were reviewed and there are two (2) or more instances of non-compliance. The QA&I Team will use the ODP-approved Corrective Action Plan (CAP) template to catalog any areas that require a PPR including identification of instances where a QM Plan will be developed when appropriate. Once the CAP is received, the entity will review the results and use the CAP template to outline PPR actions that will be taken to ensure instances of noncompliance do not occur in the future. Proof of remediation and a PPR must be submitted to the QA&I Lead within 30 calendar days of receipt of the CAP. Entities are responsible for submitting evidence of PPR implementation at the completion of all associated PPR actions. If there are no areas where a PPR is required, a CAP will not be issued.

Within 20 calendar days of receipt of the entity's CAP response, including proof of remediation and PPR, the QA&I Lead will either approve the CAP or request further clarification and/or corrections. If further clarification/corrections are required, the QA&I Lead will send the entity's remediation and improvement documentation, along with a detailed email providing specific concerns and information. The entity must then submit revised materials within 15 calendar days of receipt.

If the entity does not submit the CAP response, including required remediation and improvement documentation within 30 calendar days of receipt, ODP will determine further action and/or sanctions that will occur.

All PPRs and QM Plans, when appropriate, shall be submitted and remediation activities completed by April each year, unless the entity has an agreement with ODP or the AE that an extended period for improvement is permitted. For any PPR activity requiring longer than 3 months to implement, the entity is responsible to identify and describe the plan in place that includes an update on the progress of such activity(s) to the QA&I Lead. The QA&I Lead will provide informal feedback within 30 days of the entity's update.

Validation

Entities are responsible for submitting evidence of remediation and PPR to the QA&I Lead. Documents submitted should support the remediation option chosen on the QA&I spreadsheet and the PPR described in the CAP. This may include documents such as staff training records, updated policies, etc.

If necessary, follow-up meetings or site visits may also be conducted to adequately assure that all remediation and PPR actions have been completed and for ODP or the AE, as appropriate, to provide technical assistance.

Directed Corrective Action Plan (DCAP)

A Directed Corrective Action Plan (DCAP) will be issued when an entity fails to respond to the CAP from ODP or the AE, as appropriate. In addition, a DCAP will be issued if the revisions to the CAP are not approved. The QA&I Lead will require a DCAP to be developed, under mandatory technical assistance, within 45 calendar days from the date the initial response to the CAP was submitted by the entity. The AE must collaborate with the ODP QA&I Lead when issuance of a DCAP is required for a Provider.

QM Plans

When performance is at or below the threshold of 86% or performance is consistently low over time, the entity should evaluate whether the cause for poor performance represents a systemic problem in need of a quality improvement project, supported by a QM Plan and its Action Plan. ODP or the AE, as appropriate, will offer input and feedback to the entity in identifying any systemic opportunities for improvement. The QM Plan, updated as a result of the QA&I review, must be submitted within 30 days of the CAP closure.

The entity should regularly evaluate and internally report on their progress implementing the QM Plan, via its Action Plan and determine the effectiveness and impact of the interventions taken to improve performance during the self-assessment. ODP or AEs, as appropriate, will also follow up with the entity on their progress in implementing QM Plans and provide technical assistance as needed during the course of the QA&I Cycle. Entities should be prepared to share their data and progress reports as evidence of their use of data to not only inform development of their QM Plan but also to assess their progress.

Interim Year 2: Comprehensive Report

For Interim Year 2, reviewed entities will **not** receive a Comprehensive Report; however, a copy of the completed QA&I spreadsheet, along with the CAP/DCAP (if applicable) will be sent electronically. The summary of results from the Interim Year 2 review will be included in the Statewide QA&I Report. The development and distribution of the Comprehensive Report will resume with the QA&I activities in Cycle 2, Year 1.

As a reminder, a copy of the approved and validated QA&I spreadsheet along with the CAP/DCAP (if applicable) will be sent electronically to the entity reviewed. Receipt of this information indicates that the Interim Year 2 review for the entity is complete.

Interim Year 2: Statewide QA&I Report

ODP will compile all data collected from Interim Year 2 into a report that represents statewide performance of reviewed AEs, SCOs and Providers and the overall system as it relates to quality of services and supports and promising person-centered practices.

Interim Year 2: Terms & Definitions

The following terms and definitions apply to the ODP QA&I Process:

Adult Autism Waiver (AAW): The Adult Autism Waiver (AAW) is a 1915(c) Home and Community-Based Services (HCBS) Medicaid waiver designed to provide long-term services and supports for community living, tailored to the specific needs of adults age 21 or older with Autism Spectrum Disorder.

Assigned AE: The AE assigned to monitor a Provider of ID/A services by ODP. The AE with the most individuals authorized with the Provider is designated as the Assigned AE for Interim Year 2. This assignment will be identified on the QA&I FY 21-22 Interim Year 2 Review List.

Core Sample: A random sample of records generated by ODP of individuals receiving Home and Community Based Waiver Services in the ID/A and Adult Autism Waivers. This is the sample that is used to measure statewide performance and report on Waiver performance to the Centers for Medicare & Medicaid Services.

Corrective Action Plan (CAP): An ODP-approved template to catalog any areas that require a PPR including identification of instances where a QM Plan will be developed when appropriate.

Desk Review: A review of the required documentation used to demonstrate outcomes which answer questions included in the Interim Year 2 tools.

Directed Corrective Action Plan (DCAP): A plan developed by the entity under mandatory technical assistance by ODP or the AE, as appropriate, when the entity has demonstrated, including but not limited to, failure to respond to imminent risk or chronic non-compliance within the QA&I process.

Entrance Conference: A meeting of the QA&I team and entity leadership at the beginning of the onsite review to discuss the scope and schedule for the visit, including objectives and approximate timeline and the entity's quality improvement priorities, successes and challenges.

Exit Conference: A meeting of the QA&I team and entity leadership at the conclusion of the onsite review to discuss preliminary observations and recommendations from the onsite review.

Full Interim Review: A review completed by ODP and/or the AEs where the data and policy and record review questions of an entity are answered based on the desk review.

Individual Interview: The process by which individual experience is gauged as part of the QA&I process. Each person in the Core, Base and SC Services Only Samples will be offered an individual interview affiliated with Interim Year 2. IM4Q local programs will conduct the individual interviews.

Intellectual Disability/Autism (ID/A) Waivers: The current approved Consolidated, Community Living, and Person/Family Directed Support (P/FDS) Waivers.

Level of Care (LOC) Sample: A representative sample of records generated by ODP of the initial LOC assessments completed by AEs for new enrollees in ID/A Waiver services.

Onsite Review: The component of the QA&I process where staff from ODP and/or the AE conduct an in-person visit of the AE, SCO or Provider, as appropriate, to assess the entity's performance in all areas associated with the QA&I process.

Plan to Prevent Recurrence (PPR): Actions that will be taken to ensure instances of non-compliance do not occur in the future.

QA&I Lead: The person designated as the lead for the QA&I Team.

QA&I Team: The ODP and/or AE staff, as appropriate, assigned to conduct desk reviews and necessary follow-up associated with the entity's QA&I process.

QA&I Tool: The document containing the QA&I review and interview questions. The QA&I tool includes guidance for each question as well as references to source documentation for each question.

Quality Management (QM) Plan: The entity's written plan to address systemic opportunities for quality improvement.

Record Review: A review of the individual selected in the sample where all record review questions are answered.

Remediation: Corrective action for specific instances of non-compliance.

Review Period: The time frame for which the QA&I team will look back over documentation and records to determine compliance with QA&I questions or series of questions.

Statewide QA&I Report: The annual report compiled by ODP to provide a review and analysis of statewide data on system performance in all areas associated with the QA&I process.

Validation: The QA&I Lead activity completed to verify and accept the evidence of remediation and PPR completion submitted by the entity.

Virtual Conference: A remote meeting of the QA&I team and entity leadership that would occur if an onsite review is not conducted. The purpose is to discuss findings and recommendations from the Interim Year 2 review as well as the entity's quality improvement priorities, successes, challenges and any

instances of non-compliance discovered during the desk review. The virtual conference would replace the entrance and exit conferences, if needed.

Virtual Review: The component of Interim Year 2 where staff from ODP and/or the AE conduct a desk review and virtual conference of the AE, SCO and Provider, as appropriate, to assess the entity's performance in all areas associated with Interim Year 2.

Interim Year 2: Timeline

Year-round as needed	• All entities should review the QA&I contact list on MyODP and ensure it is up to date
July 2021	• ODP provides a listing of all entities selected for the Interim Year 2 review • ODP notifies AEs of the Providers and individual sample records • ODP notifies IM4Q of Interim Year 2 individual interview sample • ODP and AEs begin contacting entities included in the Interim Year 2 review to request required documents • ODP and AEs begin desk reviews
9/1/21	• Modified self-assessments begin for all entities who are not a part of Interim Year 2 review • Each applicable entity's primary contact will receive an email with the QuestionPro link to the modified self-assessment for data entry • ODP staff and AEs will receive an email with the QuestionPro link for Interim Year 2 data entry • QA&I individual interviews and onsite reviews begin
10/31/21	• Deadline for completed self-assessment responses to be submitted electronically into QuestionPro by applicable entities
12/31/21	• Deadline for IM4Q local programs to complete all Interim Year 2 individual interviews • Deadline for ODP and AEs to complete all desk reviews and onsite reviews
1/31/22	• Deadline for IM4Q local programs to enter all Interim Year 2 individual interview data into QuestionPro • Deadline for ODP and AEs reviewers to issue remediation and PPR activities for review and completion
2/28/22	• Deadline for all entities to complete remediation and respond to CAP detailing remediation actions taken and PPR activities
3/31/22	• Deadline for ODP and AEs to enter all Interim Year 2 data into QuestionPro
4/15/22	• ODP begins development of Statewide QA&I report

As previously mentioned, onsite reviews are subject to change to virtual reviews. ODP will make an informed decision on changing the method of onsite reviews to virtual reviews in alignment with applicable CDC COVID-19 guidance.