Summary of Findings: DDD Quality Audit

June 28, 2018 – July 3, 2018

August 2018

AHCCCS Division of Health Care Management

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) Quality Management (QM) Unit within the Division of Health Care Management (DHCM) conducted an onsite audit of the Department of Economic Security/Division of Development Disabilities (DES/DDD), also referred to as the Division, QM department between June 28 and July 3, 2018. The audit was in response to identified patterns of non-compliance with QM requirements by DHCM through its routine monitoring activities as well as concerns raised by stakeholders. The audit included review of documentation provided by DES/DDD as well as interviews with DES/DDD staff and leadership.

The DES/DDD is in violation of its Contract YH06-0014, Section D, Paragraph 18 Quality Management and Performance Improvement and, as such, has failed to promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement processes and to execute processes to monitor, assess, plan, implement, evaluate and, report quality management and performance improvement activities, as specified in AHCCCS Medical Policy Manual (AMPM) Chapters 400 and 900, 42 CFR 438.330(a)(1) and (e), 42 CFR 438.330(a)(3), 42 CFR 438.330(e)(1), 42 CFR 438.330(e)(2).

The audit findings identify significant noncompliance with AHCCCS Contract and Policy requirements and immediate concerns regarding member health and safety as well as fundamental concerns about the Division's quality management structure and operations. The following provides a summary of the major audit findings.

1. *Ineffective Oversight of Member Health and Safety*
    - Insufficient clinical and quality expertise and knowledge to effectively ensure member health and safety
    - Medication errors not appropriately triaged as health and safety concerns; over 4500 errors were reported in the past year (June 1, 2017 to onset of audit) without any clinical review or corrective action intervention
    - Inappropriate triage of quality of care concerns with numerous incidents unreported and uninvestigated
    - Quality of care concerns (QOC) limited to incidents that directly involve a paid provider (e.g. a suicide attempt is viewed as a member's choice not a quality of care concern with no evidence of follow-up or support given to members in those instances)
    - Limited understanding of holistic member care and limited evidence of care coordination to obtain needed supports for members (e.g. behavioral health services for instances of suicide attempts)
    - Inconsistent reporting to appropriate authorities (e.g. law enforcement, Adult Protective Services, Department of Child Safety); there was at least one incident that documented member neglect, but staff stated they were not reporting it to authorities because they had already reports a similar event and did not see the necessity of reporting again
    - Lack of evidence of comprehensive quality monitoring of certain facilities/service sites (e.g. Adult and Child Developmental Homes, Group Homes)

- Investigations limited to a single main allegation without a comprehensive review of member care and services
- Providers asked to conduct investigations of themselves without independent onsite investigation by Division quality staff
- Lack of process/authority to hold vendors accountable for member care; evidence of numerous quality concerns without corrective actions or communication of findings to the vendors

2. *Lack of Quality Management Focus/Understanding*
    - Limited concept of quality management purpose and functions
    - Quality functions dispersed throughout the Division without a centralized accountable unit to triage, investigate, and implement corrective actions
    - Limited engagement of Clinical leadership (e.g. medical director); lack of effective oversight or leadership for the QM team
    - Limited focus on AHCCCS-reportable incidents; lack of comprehensive quality management program
    - Serious incidents (e.g. sexual assault; attempted suicides) documented as "member behavior" and not reported or assessed for appropriateness of placement/services
    - Limited knowledge of AHCCCS Contract and AMPM requirements

3. *Decentralized Organizational Structure; Lack of Clear Responsibility for Quality*
    - Lack of Division-level trending; fragmented/inconsistent approach to work between Districts with no comprehensive monitoring and oversight by Division from a quality management perspective
    - Ineffective organizational structure with numerous units responsible for aspects of quality management; incomplete records and lack of comprehensive investigations that include all aspects of a quality of care investigation
    - Limited clinical expertise and lack of general knowledge of clinical impacts to member care and well-being
    - General lack of quality management training for staff; limited introductory or ongoing QM-specific training for staff

4. *Ineffective Processes*
    - Critical incidents not consistently reported in a timely manner to AHCCCS
    - Case investigations only completed when a formal request for investigation is received from AHCCCS; other quality of care concerns not investigated
    - Formal feedback loops (unit to unit within the Division, Division to AHCCCS) nonexistent; numerous cases without complete investigations and/or findings/corrective action
    - Scale of leveling of cases in direct conflict with AHCCCS leveling (e.g. most severe for DDD = 1 on scale of 1-3; most severe for AHCCCS = 4, on scale of 0-4; all cases have to be converted to AHCCCS scale prior to submission to AHCCCS)
    - Lack of electronic infrastructure to support quality of care case documentation

- Lack of appropriate tracking and trending; no standardized process for Division-wide tracking and trending; interviews identified use of "feelings" and "memory" to substantiate trends;

During the course of the audit, QOCs were identified that were not managed as such by the Division and were subsequently opened for investigation by AHCCCS staff. AHCCCS identified several fail points in Division processes, limiting the potential of incidents appropriately being identified as QOCs as well as the scope of quality of care investigations. Additionally, numerous opportunities for improvement were documented.

Based on the findings summarized above, AHCCCS has implemented immediate corrective actions including but not limited to the special assignment of AHCCCS staff to the Division to manage all aspects of quality management and to build an effective quality management unit. Additionally, AHCCCS has required the Division to procure quality management consultant services to support efforts to achieve quality management contract compliance within the Division. Additionally, the Division is onboarding temporary clinicians (e.g. Registered Nurses) to address backlog of potential quality of care concerns as well as active quality of care investigations while the overall quality management structure and processes are under comprehensive review and development.

PROCESS OVERVIEW

The AHCCCS Quality Management (QM) Unit within DHCM conducted an onsite investigation of the DDD QM department between June 28 and July 3, 2018. As per standard DHCM audit practice, a notification was sent to the Division approximately two weeks ahead of the onsite audit. The notification included a set of twelve (12) standards for evaluation during the audit process and outlined documentation requirements. The Quality Management team utilized a set of standard metrics as well as internal (confidential) evaluation tools to determine compliance.

Areas of concerns identified by AHCCCS that underscored the need for a comprehensive focused audit included but were not limited to the lack of comprehensive investigation of QOCs, inconsistent findings for QOCs, alleged limitations of reviews including direction to not investigate internal issues, alleged releveling of cases to lessen the severity of findings, and alleged lack of and/or insufficient monitoring of certain placement settings (e.g. group homes, adult and children developmental homes).

The audit took place at the Division office that houses its Quality Management Unit. AHCCCS staff that participated in the audit included the DHCM Operations and Clinical Assistant Director, Clinical Administrator, Operations Administrator, Quality Management Manager, Lead Quality Management Coordinator, five Quality Management Coordinators, and the Division assigned Operations Compliance Officer. A majority of the staff were onsite throughout the four-day investigation. The onsite review included an in-depth evaluation of supplied documentation, system/process demonstrations, question and answer sessions with Division-identified subject

matter experts, and staff/leadership interviews. Specific findings from evaluated standards are documented below.

QUALITY STANDARDS - SPECIFIC FINDINGS

STANDARD 1: The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution.

This standard included a review of medication error reports, mortality cases, AHCCCS-reported quality of care investigations, and non-AHCCCS reported incident investigations.

Finding: Non-Compliant

Rationale:

Medication Errors:

A sample size of 32 medication errors, representing eight (8) unique members was selected for review. Per Division staff, medication errors are not considered to be quality of care concerns unless there is a significant adverse outcome. The evaluation focus for this standard was for cases that could potentially indicate a trend at either the member or provider level. Findings highlight member and provider trends that have not been addressed as well as significant incidents and adverse outcomes that were not investigated as a quality of care concern.

Reported QOCs to AHCCCS:

A sample of 30 QOCs that had previously been submitted to AHCCCS were selected for review during the audit. Noted concerns included incomplete records on the part of DES/DDD. The initial file that was provided to AHCCCS for sample selection indicated that there were 380 reported cases during the evaluation period; however, AHCCCS records indicated over 1,000 reported cases. Of additional concern was that for the 380 cases submitted to AHCCCS, only 10 (2.6 percent) indicated that corrective actions were implemented by DES/DDD post review of the case. It was noted that the records were incomplete and that numerous cases indicated referrals to other Division units for follow-up; however, there was no closure or feedback documented once the cases were referred by the QM Unit. Additionally, AHCCCS has significant concern about the confidentiality of quality of care cases and the Division's understanding of the additional level of security/privacy for QOCs under federal regulation and state policy requirements.

Significant concerns were also identified regarding case work based on description and processes shared during the audit. For example, under current DES/DDD protocol, if a referral is made to AHCCCS, the case is not proactively assigned or investigated until an acknowledgment is received from AHCCCS. If there is no acknowledgement from AHCCCS, then no action is taken by the Division and no outreach is conducted to confirm receipt by AHCCCS. The Division could not provide a monitoring or oversight process for case assignments and indicated that there are no checks and balances to ensure that case assignments are made or investigated. The Administrative Support staff person for the Unit maintains a spreadsheet; however, updates are only made upon receipt of information; there is no follow-up or process if information is not supplied. There are no automated supports or a comprehensive system to ensure consistent and complete QOC reviews.

Additionally, DES/DDD does not maintain a mechanism to the support tracking and trending of cases; it was indicated that tracking and trending is limited to a "feeling" or "memory" of past occurrences.

Non-Reportable Cases/Incidents:
Just under 5000 "non-AHCCCS reportable" incidents were submitted to AHCCCS for sample selection. Upon query of the data, immediate concerns were identified, as over 1500 incidents (25 percent) were categorized as death, abuse, neglect, other abuse, or suicide attempt – all of which are required reportable incidents to AHCCCS. As a result, AHCCCS selected a sample of 94 cases (representative of 30 unique members) for evaluation. Upon review of those cases, numerous instances of required reportable QOCs to AHCCCS were identified but the cases were not submitted to AHCCCS, confirming initial concerns about the data. Subsequently, those cases were appropriately referred to and documented by AHCCCS during the course of the audit.

Additionally widespread issues about the cases in general, were identified including:

- Inappropriate identification of allegation types, based on supplied documentation
- Non-compliance with Division policies and procedures, leading to inconsistent and incomplete documentation
- Inconsistency in QOC severity levels, including inconsistency with Division policies and procedures
- Mechanisms for tracking and trending were lacking; for example one member had 64 reported incidents but there was no evidence of a systemic review of the member's care/treatment and no evidence of referral for quality of care concerns and no identified trends
- Significant concerns about the data were noted, including the lack of a mechanism to clearly identify members (e.g. John Doe was identified on the spreadsheet as John D.; when records were requested, staff had to pull every John D. in their records because there was no singular identifier for John D.)
- Limited elevation to clinical leadership (medical director) for review of complex cases
- Delayed or untimely review of issues; cases were identified as still incomplete several months post incident date
- Requested documentation was not available for several incidents that were selected for review
- Inconsistent findings and concerning actions (e.g. an allegation of abuse was "unsubstantiated" yet the alleged perpetrator was fired)

Mortality Reviews:
AHCCCS selected a sample of 14 cases from a list of 150 mortality review cases submitted. The mortality review findings were complete and concise and compliant with Division policies. Cases were appropriately identified and referred as unexpected deaths.

Areas for process improvement include: 1) An abbreviated mortality review should be conducted for cases where death was clearly expected such as Hospice cases 2) Housing the mortality review process within the Quality Management Unit instead of outside the Unit as is current practice, would provide a more streamlined process for addressing those mortalities that require referral as a QOC.

STANDARD 2: The Contractor has a structure and process in place for quality-of-care, abuse/ complaint tracking and trending for system improvement.

This standard included the evaluation of cases submitted under Standard 1 as well as the processes surrounding the review and investigation of those concerns. An evaluation was conducted of the following: current referral processes for submission of QOC cases to the QM unit; use and effectiveness of correction actions when concerns were substantiated; the structure of the Unit in regards to confidentiality, and the occurrence of ongoing monitoring practices to ensure provider compliance with implemented corrective actions; relevant tracking and trending of cases, referrals to appropriate committee structures (e.g. Peer Review, Health and Safety, and/or Quality Management committees), and the engagement of and feedback to members/member representatives who are directly impacted by the QOCs.

Finding: Non-Compliant

Rationale: Refer to Standard 1 for a summary of findings specific to the casework. General observations about the Unit and related processes are provided below.

Numerous units outside of the QM Unit are responsible for aspects of traditional quality management work as evidenced by the following practices: Health Care Services staff investigate "clinical" cases; Compliance Monitoring staff implement and follow-up on corrective actions; and Contracts staff are responsible for network decisions related to adverse outcomes. Interviews with both Division QM staff as well executive leadership highlighted a lack of understanding of quality management operations and functions. A general theme that emerged was that "quality is everyone's responsibility"; however, the structure and processes required to support day-to-day quality functions were not evidenced in either staff feedback or in the review of materials submitted for the audit.

There was no evidence of appropriate Committee structures to support QM Unit functions. There was limited evidence of leadership engagement in quality management functions, including both clinical and non-clinical aspects. Interviews identified that QM staff at the Division-level were not able to speak to members directly about cases; only District staff could conduct that communication. When the referral process was assessed for QOCs referred into the unit, it was identified that there are limited internal Division referrals. Staff are inconsistently trained on the QOC referral process and there is limited general knowledge about who should or why someone should report a potential QOC internally.

Evidence was lacking that supported confidential quality management processes. Evidence was lacking for follow-up, consistent implementation of corrective actions, or ongoing monitoring to support quality management findings with providers. Additionally, there were numerous concerns about who is ultimately responsible for quality monitoring as well as significant concern about the Division's ability or willingness to implement corrective action and/or take compliance action against Division providers. Numerous instances were reviewed where significant provider concerns and non-compliance were identified without any evidence of actions notated other than "retraining provided". In some cases multiple years of similar findings and concerns were identified without any corrective action implemented by the Division. Additional findings regarding the investigation and monitoring processes are outlined in Standard 12.

STANDARD 3: The Contractor has a structure and process in place to identify and investigate adverse outcomes, including mortalities, for member/system improvement.

This standard evaluated the investigative processes associated with adverse outcomes for medication concerns and mortalities, including monitoring of the Controlled Substance Prescription Monitoring Program (CSPMP) database and implementation of related improvement opportunities post review. This standard also assessed the role of the Peer Review Committee and documentation of findings and related corrective actions.

Finding: Compliant

Rationale: Policies were provided to support compliance with this standard; however, policies were out of date with the most recent policy review documented as occurring in 2016. There was limited evidence of compliance with the policies, as indicated above.

STANDARD 4: Contractor ensures that the staff providing attendant care, personal care, homemaker services, and habilitation services are monitored as outlined in Chapter 900.

This standard evaluated the quality monitoring and oversight of HCBS services including the annual review process of attendant care, personal care, homemaker, and habilitation services.

Finding: Compliant

Rationale: All review materials presented were complete and thorough for the service types specifically reviewed under this standard. There was evidence of corrective actions implemented in response to historical monitoring efforts as well as follow-up during the most recent annual monitoring review. Broader concerns identified regarding the monitoring process are detailed under Standard 5.

STANDARD 5: The Contractor ensures that Home Community Based Services (HCBS) and residential settings are monitored by qualified staff.

This standard evaluated Division compliance with annual HCBS monitoring in regard to appropriate staff conducting the monitoring efforts. This standard included evaluation of the Division's response to immediate jeopardy/health and safety concerns and related onsite monitoring and follow-up monitoring of facilities or service sites where quality of care concerns have been

identified.

Finding: Non-Compliant

Rationale: In reviewing submitted documentation and conducting staff interviews, it was discovered that staff with the clinical knowledge and expertise are not utilized to complete annual monitoring reviews. The Division is unclear about which facilities/service sites required annual monitoring review. There is no evidence that all required residential monitoring is completed as outlined in AMPM Chapter 900 requirements.

The Division utilizes District-level staff without the clinical knowledge and expertise (non-clinical) to respond to immediate jeopardy/health and safety concerns. Staff interviews indicate that if the non-clinical staff feel that a clinical review is needed, they contact Health Care Services to have a nurse come onsite to the provider. There was limited evidence of communication with Health Services and/or an onsite review by a nurse.

The evaluation found limited evidence of ongoing monitoring or evaluation of facilities post immediate reviews. Referrals are made to the Compliance Monitoring and/or Contract teams for further action; however, there was no documentation supporting a completed feedback loop into Quality Assurance or Quality Management for any actions taken.

STANDARD 6: The governing body and the Contractor are accountable for all Quality Management (QM) program functions.

This standard evaluated a number of quality management functions including the involvement of Division's governing body in the overall QM structure/program, engagement of the Medical Director, the structure and effectiveness of the Quality Management Committee, the communication and coordination with other functional areas (such as Health Care Services, Support Coordination, and Behavioral Health), the organizational structure of quality management at both the central and district levels, and the monitoring and oversight of group homes and other Division-licensed facilities.

Finding: Non-Compliant

Rationale: There was limited evidence to support DES/DDD leadership engagement in or oversight of quality management functions. While leadership is present for some of the committee meetings as evidenced by minutes and documentation of attendance, documentation in meeting minutes is limited and staff interviews indicated that supported active engagement or understanding of big picture concepts and specific issues or barriers by leadership is limited.

Staff interviews indicated concerns of staff regarding the overall process flow as well as the accountability structure for significant quality of care concerns. It was indicated that the Contract Compliance team is responsible for addressing provider (vendor) issues that are identified. However, interviews of both QM and Contract Compliance staff identified concerns, including the limited employment of corrective actions, monitoring, or other interventions. There was evidence

of repeated findings and concerns year over year for providers with no change to oversight or regulatory action. All quality monitoring activities specific to providers occur outside of the QM Unit and there is no documentation to identify who is responsible or what actually occurs once referrals are made to other work units.

It was identified through interviews that QM staff responsible for QOC investigations do not participate in Compliance Action Committee meetings and while QM and Division leadership may participate, there is no evidence of a feedback loop between the Units to ensure coordinated efforts and complete documentation. Additionally there are no processes to ensure checks and balances between QOC findings and necessary compliance/contract actions with vendors. Interviews indicated that there is limited support from leadership to take stronger actions (e.g. terminations) in response to provider noncompliance and /or quality of care concerns and/or guidance on how to address the most egregious findings that staff encounter.

STANDARD 7: The Contractor has the appropriate staff employed to carry out Quality Management (QM) Program administrative requirements.

This standard evaluated the appropriateness of staff that the Division has in place to carry out the quality management functions and responsibilities, including the review of qualifications and expertise and well as ongoing training provided to staff within quality management and staff outside of the unit, specific to the referral of quality of care concerns to the Quality Management Unit.

Finding: Non-Compliant

Rationale: The review of the staffing structure identified a lack of centralized quality management functions and an ineffective quality management program dispersed throughout the Division and inconsistently down to each of the Districts. Documentation and staff feedback failed to indicate a clear understanding of quality management requirements or direct responsibility for quality management functions. There was no evidence of clinical oversight in regard to the quality program and limited evidence of clinical expertise in regard to the evaluation of member health, well-being and safety.

STANDARD 8: The Contractor has a structured Quality Management Program that includes administrative requirements related to policy development.

This standard evaluated current quality management policies and procedures, the annual review/revision of policies and oversight and approval of Medical Director and Division leadership.

Finding: Compliant

Rationale: The review of Division policies indicates alignment with AHCCCS AMPM Chapter 900. The Division's 900 series (QM) policies were reviewed by the Division in November 2017. Required changes were not consistently incorporated into the policies submitted for review. Documentation supplied indicated that the Division review of the policies occurred in 2017; however, sign off on the policies by the QM Administrator and Chief Medical Officer was not

documented until February 2018.

STANDARD 9: The Contractor has implemented a structured peer review process that includes administrative requirements related to the peer review process.

This standard evaluated the Division's Peer Review Committee and related processes for peer review. The standard assessed Peer Review structure, confidentiality protocols, case documentation, ongoing follow-up when significant concerns were notated, and general compliance with all Peer Review requirements outlined in AMPM Chapter 900.

Finding: Non-Compliant

Rationale: Review of the Peer Review Committee structure identified that there are not peers on the committee (e.g. providers, therapists) as required. Review of meeting minutes and attendance identified meetings where a clinician (e.g. Medical Director) was not present as required. It was identified that numerous clinical functions are conducted outside of the Quality Unit (e.g within Health Care Services) and are not included into Peer Review as required, forgoing a comprehensive review by qualified peers as well as the level of confidentiality afforded under the peer review process. Documentation was lacking of any follow-up back to the Peer Review Committee in instances where recommendations were made regarding quality of care concerns.

In at least one instance, the Peer Review Committee minutes reflected specific guidance given by the Medical Director; however, the minutes indicated that the guidance would not be followed unless the staff received written direction from AHCCCS that supported the guidance given. This is a concerning practice and indicates a lack of understanding by staff of the role and responsibility of the Medical Director and collaboration between QM Unit staff and clinical leadership.

STANDARD 10: The Contractor has mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

This standard evaluated how the Division ensures that its members have individualized clinical and behavioral treatment plans as appropriate. This standard evaluated the Division's process for multi-disciplinary staffings for members with complex healthcare needs, how the members and members' family/guardians, and/or caregivers are involved in the care planning process, the degree to which providers who are caring for members have appropriate knowledge and expertise to serve individuals with DD diagnoses, and the degree to which the Division appropriately engages stakeholders (e.g. sub-contracted acute plans, Regional Behavioral Health Authorities (RBHAs), and/or CMDP) in members' care.

Finding: Compliant

Rationale: A policy review identified that most elements of this standard (summarized above) were thoroughly outlined, with the exception of family involvement. No documentation was supplied that supported implementation of or compliance with the policies. The policies reviewed were out of date, with the last date of Division revision documented as January 2013. Case review and interviews of staff indicated that stakeholder engagement is not always present, especially with the RBHAs for complex behavioral needs.

STANDARD 11: The Contractor ensures care is coordinated between the Primary Care Provider (PCP), specialists, behavioral health, service organizations and community supports.

This standard evaluated care coordination between the Division and the RBHAs and members physical and behavioral health providers. The standard assessed if behavioral health needs were appropriately documented and included in service plans and the degree to which coordination occurred with entities responsible for other aspects of member care.

Finding: Compliant

Rationale: The Division submitted policies from their subcontracted Acute health plans. One policy had not been updated in the past year; however, the policies submitted did support compliance with this standard. There was no evidence of actual implementation of or compliance with the submitted policies such as the execution of care coordination activities.

STANDARD 12: The Contractor has implemented a process to complete on-site quality management monitoring and investigations.

This standard evaluated all of the onsite monitoring conducted during the previous year (from June 1, 2017 to the time of the audit) to ensure that all service sites were monitored in accordance with AMPM Chapter 900, that appropriate corrective actions were implemented upon the identification of deficiencies, that the Quality Management Unit participates in unscheduled monitoring of placement settings or service sites when appropriate/necessary, and that appropriate action is taken with providers when significant concerns are found or members are at risk (e.g. practice closure, unsafe environment).

Finding: Non-Compliant

Rationale: Please refer to the findings documented under Standards 1 and 2. Health and Safety checks are not conducted by staff with necessary clinical expertise and knowledge. Non-clinician Quality Assurance staff at the District level conduct these checks. No consistent process exists for feedback to the QM Unit resulting in incomplete case investigations. No effective mechanisms for corrective action were identified and corrective actions were executed on only a limited basis.

CORRECTIVE ACTIONS

Due to the severity of the audit findings, AHCCCS is implementing the following immediate actions:

Beginning on July 23, 2018, AHCCCS located its QM Manager onsite at the Division. The AHCCCS QM Manager will remain at the Division for a minimum of 90 days and be directly responsible for the management and oversight of the Division's Quality Management Unit. The QM manager is charged with implementing a work plan to address the following:

- Centralization of all quality functions
- Securing appropriate staffing resources and expertise as well as securing consultant resources to support restructuring efforts

- Development of comprehensive policies, processes, and desk aids
- Development of comprehensive quality and compliance education and training curriculum as well as a schedule for ongoing training throughout the next year

The DES/DDD, under the direction of AHCCCS, has been tasked with immediately implementing the following actions in order to come into compliance with quality management requirements and expectations.

- Evaluate all medication errors reported over the last year (on or after June 1, 2017) and document all quality of care concerns; track and trend the medication errors and determine systemic concerns as well as appropriate corrective actions
    - Educate all staff on medication errors as potential QOCs and have all medication errors documented and assessed and opened as QOCs as appropriate
- Evaluate all outstanding recommended contract compliance actions against providers/vendors for potential QOC concerns and refer significant concerns to appropriate committees for review and determination of corrective actions; implement a clear process for corrective action implementation and follow-up
- Hire temporary clinical staff (e.g. Registered Nurses or Behavioral Health Professionals) that can address the backlog of potential QOCs that have not previously been assessed and to provide clinical insight on current QOC investigations until an appropriate staffing model can be implemented at the Division
- Procure consultant services with expertise and experience specific to quality management that can support AHCCCS and the Division in development and restructuring of a sound quality management unit and program
- Actively participate in technical assistance sessions with AHCCCS and provide frequent and ongoing updates of the Division's progress towards compliance with these findings

In addition to the immediate actions being taken, AHCCCS will issue a Notice to Cure, specifically related to the Division's quality management structure and functions.

In response, the Division will be placed under intensive monitoring until AHCCCS determines that the Division can demonstrate compliance and effectively conduct and sustain the management of required quality functions.

In summary, the Division must commit to the development and maintenance of a sound and effective Quality Management program that incorporates a streamlined Quality Management Unit as well as the effective, holistic evaluation of member concerns. Furthermore, the Division must staff the Quality Management Unit with appropriate clinical expertise and knowledge and develop/maintain sustainable quality management functions, while ensuring effective, ongoing leadership and oversight of the program.