

Unit # 51				
Hospital Quality Activities				
Name of the Unit	Targeted Surveillance Team Activities			
Statutes and/or Regulations -- General Governance	Public Health Law Article 28 (http://public.leginfo.state.ny.us/menugetf.cgi) 10 NYCRR Part 405 http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm			
Description	Contractor staff will be responsible for statewide focused onsite surveillance activities including key program or policy issues such as Emergency Department overcrowding			
Type of Staff	Physician	Survey Nurse	Social worker	Life Safety Code
Minimum Qualifications	Currently licensed in NYS; Clinical experience in Emergency Department medicine and/or Hospital administration; Excellent telephone and written communication skills; Basic computer skills.	Currently registered in NYS; Bachelors degree or graduation from an approved nurse training program; Medical record and QA experience; Clinical background in acute care; Excellent telephone and written communication skills; Basic computer skills; Experience handling sensitive confidential information.	Currently registered in NYS; Clinical background in acute care; Excellent telephone and written communication skills; Basic computer skills; Experience with handling sensitive confidential information.	Bachelor's degree and 3 years of related experience; Excellent telephone and written communication skills; Basic computer skills; Experience with handling sensitive confidential information.
Preferred Qualifications		Master's Degree preferred	Medical record and QA experience	Experience in acute care settings
Required Certifications	No additional.			
Location(S) of Work	The team will be based out of Central Office, but will have statewide surveillance assignments.			
Reference Location to the Standard for the Unit	State Survey Manual. See Attachment 51 of this RFP.			
Additional Requirements	No additional.			
Staff Training Requirements	No additional.			
Unit is Complete When	The first of the following events occurs: (1) The facility is found to be in substantial compliance at the time of the survey; OR (2) An SOD not requiring a POC is issued to the facility; OR (3) An acceptable POC is received by the Department; OR (4) Thirty days have passed since an SOD requiring a POC was issued and the facility has not responded, or has failed to produce an acceptable POC. If a revisit survey is required, this Unit is complete when the revisit survey is scheduled.			
Historical Information	This is a new function. The Department estimates that approximately 100 surveys will be completed each year, each taking approximately 90 hours, and 3 team members. Department staff will provide supervision/support to the survey team. Approximately 90% will be hospital reviews and 10% D&TC Reviews.			

Attachment E

Data Chart with Additional Information for Bidders
On Components 1 and 2

Unit #	Survey Type	Average Total Hours Per Survey	FTEs Per Survey	Total Annual Surveys
ADULT CARE FACILITIES				
Facility Inspection				
5	Complete Inspection of ACF, ALR, SNALR	96.75	4.00	451
6	Complete Inspection EALR	104.50	5.00	89
7	Partial Inspection	41.00	2.00	233
8	ACF Complaint Intake	1.00	1.00	1058
9	Complaint Investigation	34.50	1.00	817
10	Pre-opening survey	134.50	5.00	16
Questionable Operations				
11	Complaint Investigation	22.50	1.00	38
Death Investigations				
12	Review or investigation	25.00	1.00	1012
Facility Closure				
13	Review and Monitor	81.00	1.00	43
ADULT DAY HEALTH CARE PROGRAMS				
Survey				
1	Desk Audit	10.00	1.00	168
2	Survey	75.00	1.00	60
Complaints				
3	Complaint Investigation	18.75	1.00	12
4	Complaint Intake	1.25	1.00	12
HOME CARE SERVICES AGENCIES				
Survey				
14	LHCSA Routine Operational Survey	30.00	2.00	200
16	Policy & Procedure Manual Review Initial	70.00	1.00	30
16	Policy & Procedure Manual Review Follow-up	47.50	1.00	50
15	Pre-opening Survey	37.00	2.00	40
Complaints				
17	Home Care and Hospice Complaint Intake	1.00	1.00	300
18	Home Care and Hospice Complaint Investigation Off-site	6.00	1.00	150
18	Home Care and Hospice Complaint Investigation On-site	12.00	1.00	150
HOSPITALS				
Survey				
45	D&TC Survey	37.50	2.00	51
51	Targeted Surveillance Team	37.50	3.00	100

Unit #	Survey Type	Average Total Hours Per Survey	FTEs Per Survey	Total Annual Surveys
Complaints				
46	Hospital & DTC Complaint Intake Program	2.50	1.00	3500
47	Hospital & DTC Complaint Investigation / Survey	30.00	1.00	200
48	Hospital Complaint Resolution	8.00	1.00	1500
Other				
49	NYPORIS Reviews -- Central Office	5.00	1.00	2552
50	NYPORIS Reviews -- Regional Offices	6.00	1.00	1164
ICF/MRs				
Re-Survey				
19	Fed Standard	240.50	4.75	15
20	Life Safety Code Review	35.50	1.00	15
21	Extended Surveys (Additional Hrs)	121.75	3.00	2
Complaints				
22	On-site Complaint Surveys	36.00	1.00	10
24	Complaint Intake and Investigation	18.00	1.00	25
Follow-up				
23	Fed Revisit-Health	37.50	2.00	20
OMR/DD Reviews				
25	Off-site Survey Reviews	1.25	1.00	650
MEDICAID WAIVER PROGRAMS				
Complaint Intake				
26	Care At Home Waiver	1.00	1.00	200
27	Long Term Home Health Care Program	1.00	1.00	6750
28	Nursing Home Transition & Diversion Waiver	1.00	1.00	1250
29	Traumatic Brain Injury Waiver	1.00	1.00	750
NURSING HOMES				
Re-Survey				
30	Fed Standard	220.25	4.50	642
31	Extended Surveys (Additional Hrs)	121.75	4.50	31
32	Staggered Surveys (Premium Hrs)	14.25	4.50	63
Complaints				
33	On-site Complaint Surveys	18.75	2.00	3624
34	Partial Extended Surveys (Additional Hrs)	107.25	2.00	23
41	Complaint Intake	1.25	1.00	8800
Off-site Investigations				
35	Off-site Complaints	4.00	1.00	3000
Initial				
36	Fed Initial Survey	85.25	2.00	2
Follow-up				
37	Fed Revisit-Health	13.25	4.50	680
38	Fed Revisit Complaint	11.25	2.00	355

Unit #	Survey Type	Average Total Hours Per Survey	FTEs Per Survey	Total Annual Surveys
39	State Monitoring Visits	32.25	1.00	43
40	Fed Revisit-Life Safety Code	5.50	2.00	476
Other				
42	Informal Dispute Resolution - Regional Offices	7.50	1.00	75
42	Informal Dispute Resolution - Central Office	3.50	1.00	100
43	Random Quality Assurance Audits	5.50	1.00	180
44	Enforcements	6.00	1.00	100

**FORM TP-1-1
COMPONENT 1
DIRECT STAFFING SUMMARY**

For each activity, list all position titles that will be utilized for that activity including the percent of full time equivalent of each title and responsibilities and duties of each title. You may use this Word document as a form or use additional pages containing the information requested in a similar format, so long as complete information is provided and that staff titles, FTEs and responsibilities are associated with each of the individual Units listed.

ACTIVITY	UNIT #	TITLES	FTEs	RESPONSIBILITIES/DUTIES
ADULT DAY HEALTH CARE PROGRAM QUALITY ACTIVITIES				
Desk Audit	1			
Survey	2			
Complaint Investigation	3			
Complaint Intake	4			
ADULT CARE FACILITY QUALITY ACTIVITIES				
Complete Inspection – ACF, ALR, SNALR	5			
Complete Inspection EALR	6			

ACTIVITY	UNIT #	TITLES	FTEs	RESPONSIBILITIES/DUTIES
Partial Inspection, including ALR, EALR, SNALR	7			
Complaint Intake, including ALR, EALR, SNALR, ALP	8			
Complaint Investigation Survey, including ALR, EALR, SNALR, ALP	9			
Pre-opening Survey, including ALR and ALP	10			
Questionable Operations (Q-Op) Investigation	11			
ACF Death Investigations	12			
Monitoring Facility Closure	13			
HOME CARE SERVICES AGENCY QUALITY ACTIVITIES				
LHCSA Routine Operational Survey	14			
LHCSA Pre-opening Survey	15			

ACTIVITY	UNIT #	TITLES	FTEs	RESPONSIBILITIES/DUTIES
LHCSA Policy and Procedure Manual Review	16			
Home Care and Hospice Complaint Intake	17			
Home Care Complaint Investigation	18			
ICF/MR QUALITY ACTIVITIES				
ICF/MR Federal Standard Survey	19			
ICF/MR Life Safety Code Review	20			
ICF/MR Extended Survey	21			
On-Site Complaint Survey	22			
Federal Revisit – Health	23			
ICF/MR Complaint Intake and Investigation	24			
ICF/DD Certification Review	25			

ACTIVITY	UNIT #	TITLES	FTEs	RESPONSIBILITIES/DUTIES
MEDICAID WAIVER RELATED QUALITY ACTIVITIES				
Complaint Intake Related to Care At Home Waivers	26			
Complaint Intake Related to Long Term Home Health Care Waiver Program	27			
Complaint Intake Related to Nursing Home Transition and Diversion Waiver	28			
Complaint Intake Related to Traumatic Brain Injury Waiver	29			
NURSING HOME QUALITY ACTIVITIES				
Federal Standard Survey	30			
Extended Survey	31			
Staggered Survey	32			
On-site Complaint Survey	33			

ACTIVITY	UNIT #	TITLES	FTEs	RESPONSIBILITIES/DUTIES
Partial Extended Survey	34			
Off-site Complaint Investigation	35			
Federal Initial Survey	36			
Federal Revisit -- Health	37			
Federal Revisit - Complaint	38			
State Monitoring Visit	39			
Federal Revisit -- Life Safety Code	40			
Complaint Intake	41			
Informal Dispute Resolution	42			
Random Quality Assurance Audits	43			
Enforcements	44			

SPECIAL PRICING UNITS				
Adult Day Health Care Information and Referral	1-Ea			
Adult Care Facility Information and Referral	1-Eb			
Home Care Information Hotline	1-Ec			
Medicaid Waiver Information and Referral	1-Ed			
Nursing Home Information and Referral	1-Ee			

REVISED BIDDERS' CHECKLIST

<input checked="" type="checkbox"/>	Technical Proposal	Part of RFP
<input type="checkbox"/>	Transmittal Letter	D.2.a
<input type="checkbox"/>	Subcontractor Letters of Intent, if any	E.1.c
<input type="checkbox"/>	Table of Contents	D.2.b
<input type="checkbox"/>	Executive Summary	D.2.c
<input type="checkbox"/>	Bidder's Assurances	Attachment D
<input type="checkbox"/>	HIPAA and Medicaid Confidentiality Assurances	D.2.k; Attachments O and P
<input type="checkbox"/>	Statement of Understanding of Department's Goals and Objectives	D.2.d
<input type="checkbox"/>	Statement of Understanding Scope of Work	D.2.e
<input type="checkbox"/>	Bidder's Technical Processes, Policies and Procedures	D.2.f
<input type="checkbox"/>	Bidder's Personnel Organization	D.2.g; Attachment F, Forms TP-1 and TP-2
<input type="checkbox"/>	Bidder's Organization, Experience and Capability	D.2.f
<input type="checkbox"/>	Statement of Data Security Measures	D.2.i
<input type="checkbox"/>	Work Plan and Deliverable Schedule	D.2.f
<input type="checkbox"/>	Units Proposal	D.2.f, D.2.h, C.3 or C.4, Attachment 7, Form TP-4
<input type="checkbox"/>	Quality Assurance Plan	D.2.j; Attachment 7, Form TP-3
General Documentation & Vendor Responsibility		
<input type="checkbox"/>	Curricula Vitae, Licenses and Certifications for Staff Managing the Contract and Assigned to Contract Functions	D.2.l
<input type="checkbox"/>	Audited Financial Statements 2005, 2006 and 2007	D.2.m
<input type="checkbox"/>	Vendor Responsibility Questionnaire, if applicable	E.1.i, F.11
<input type="checkbox"/>	Vendor Responsibility Attestation	E.1.i, F.11, Attachment H
<input type="checkbox"/>	Proof of Incorporation, Copy of Partnership Agreement, DBA, or Authority to Do Business in New York	D.3
<input type="checkbox"/>	NYS DTF Contractor Certification Forms	F.16; Attachments J and K
<input type="checkbox"/>	Any Other Relevant Financial Information	D.3
<input type="checkbox"/>	References	D.2.n
Cost Proposal		
<input type="checkbox"/>	Bid Form	Attachment B
<input type="checkbox"/>	Price Schedule – Unit Bids	Attachment G, Form CP-1
<input type="checkbox"/>	Additional Work Units and Hourly Fees	Attachment G, Form CP-2
<input type="checkbox"/>	Consultant Services Form A	F.12; Attachment I

**FORM CP-1-1
COMPONENT 1
ANNUAL PRICE SCHEDULE**

UNIT #		PROJECTED # OF ANNUAL SURVEYS	UNIT PRICE	COLUMN "C"
	SURVEY TYPE			
	Adult Day Health Care Program Quality Activities			
1	Desk Audit	168		
2	Survey	60		
3	Complaint Investigation	12		
4	Complaint Intake	12		
	Adult Care Facility Quality Activities			
5	Complete Inspection – ACF, ALR, SNALR	451		
6	Complete Inspection EALR	89		
7	Partial Inspection, including ALR, EALR, SNALR	233		
8	Complaint Intake, including ALR, EALR, SNALR, ALP	1058		
9	Complaint Investigation Survey, including ALR, EALR, SNALR, ALP	817		
10	Pre-opening Survey, including ALR and ALP	16		
11	Questionable Operations (Q-Op) Investigation	38		
12	ACF Death Investigations	1012		
13	Monitoring Facility Closure	43		
	Home Care Services Agency Quality Activities			
14	LHCSA Routine Operational Survey	200		
15	LHCSA Pre-opening Survey	40		
16	LHCSA Policy and Procedure Manual Review Initial	30		
16	LHCSA Policy and Procedure Manual Review Follow-up	50		
17	Home Care and Hospice Complaint Intake	300		

UNIT #		PROJECTED # OF ANNUAL SURVEYS	UNIT PRICE	COLUMN "C"
	SURVEY TYPE			
18	Home Care Complaint Investigation	300		
	ICF/MR Quality Activities			
19	ICF/MR Federal Standard Survey	15		
20	ICF/MR Life Safety Code Review	15		
21	ICF/MR Extended Survey	2		
22	On-Site Complaint Survey	10		
23	Federal Revisit – Health	20		
24	ICF/MR Complaint Intake and Investigation	25		
25	ICF/DD Certification Review	650		
	Medicaid Waiver Related Quality Activities			
26	Complaint Intake Related to Care At Home Waivers	200		
27	Complaint Intake Related to Long Term Home Health Care Waiver Program	6750		
28	Complaint Intake Related to Nursing Home Transition and Diversion Waiver	1250		
29	Complaint Intake Related to Traumatic Brain Injury Waiver	750		
	Nursing Home Quality Activities			
30	Federal Standard Survey	642		
31	Extended Survey	31		
32	Staggered Survey	63		
33	On-site Complaint Survey	3624		
	Nursing Home Quality Activities (con't.)			
34	Partial Extended Survey	23		
35	Off-site Complaint Investigation	3000		
36	Federal Initial Survey	2		
37	Federal Revisit -- Health	680		
38	Federal Revisit - Complaint	355		
39	State Monitoring Visit	43		
40	Federal Revisit -- Life Safety Code	476		
41	Complaint Intake	8800		
42	Informal Dispute Resolution	175		

UNIT #		PROJECTED # OF ANNUAL SURVEYS	UNIT PRICE	COLUMN "C"
	SURVEY TYPE			
43	Random Quality Assurance Audits	180		
44	Enforcements	100		
	TOTAL COLUMN C			

**FORM CP-1-2
COMPONENT 2
ANNUAL PRICE SCHEDULE**

UNIT #		PROJECTED # OF ANNUAL SURVEYS	UNIT PRICE	COLUMN "C"
	SURVEY TYPE			
	Diagnostic and Treatment Center Quality Activities			
45	D&TC Survey	51		
	Hospital Quality Activities			
46	Hospital and D&TC Complaint Intake	3500		
47	Hospital and D&TC Complaint Investigation / Survey	200		
48	Hospital Complaint Resolution	1500		
49	NYPORIS Reviews – Central Office	2552		
50	NYPORIS Reviews – Regional Offices	1164		
51	Targeted Surveillance Team	100		
	TOTAL COLUMN C			

This page should be inserted after page 122 of 566 in Attachments Part 2 .pdf file.

**ARTICLE 36 and ARTICLE 40
Statement of Deficiencies and Plan of Correction**

PROVIDER INSTRUCTIONS: Describe in the plan of correction the corrective actions taken to resolve each deficiency cited. This plan should also indicate the steps taken to prevent future occurrence of the cited deficiency and the person, identified by position, who will be responsible for implementation of the corrective action(s). Fill in the anticipated completion date for each corrective action. Attach additional sheets as needed. Return to area office within 10 days of receipt. Retain a copy for your files.

Name of Agency/Program		Provider Number	Certificate/License Number	Date Survey Completed
Street Address, City, State, Zip Code		Type of Agency/Program <input type="checkbox"/> CHHA <input type="checkbox"/> LTHHCP <input type="checkbox"/> LHCSA <input type="checkbox"/> Hospice		Date
Provider Representative Signature and Title				

NOTE: The following deficiencies were identified by Health Department representatives during the survey of your agency/program. Correction of these deficiencies is required in order to bring your agency/program into compliance with the State of New York Official Compilation of Codes, Rules and Regulations (10 NYCRR).

Item No.	Deficiencies and 10 NYCRR Citations	Provider's Plan of Correction with Timetable	Completion date

This page should be inserted after page 127 of 566 in Attachments Part 2 .pdf file.

ARTICLE 36 AND 40
POST-CERTIFICATION/APPROVAL REVISIT REPORT

Instructions: Refer to Survey
Process Guide prior to
filling out this form.

Name of Agency/Program		Provider Number	Certificate/License Number	Date of Revisit
Street Address, City, State, Zip Code		Type of Agency/Program		
Signature of Surveyor and Title		<input type="checkbox"/> CHHA	<input type="checkbox"/> LTHHCP	<input type="checkbox"/> LHCSA <input type="checkbox"/> Hospice

Item No.	Present Status
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This page should be inserted after page 128 of 566 in Attachments Part 2 .pdf file.

Log Number:

New York State Department of Health
Division of Home & Community Based Care
Licensed Home Care Service Agency Transaction Notice

A. Type of Transaction

New

New Lic # _____
Application Number:
Effective Date:

B. Type of Ownership

C. Agency Information

Corporate Name:

DBA:

Address:

City:

County:

Federal I.D. Number:

State: N.Y. ZIP:

Phone Number: Ext.

Fax Number:

E-Mail:

D. Revisions

Revision to:

Existing

New

Corporate Name:

DBA:

Address:

City:

County:

Zip Code:

Phone Number:

Fax Number:

E-Mail:

Federal I.D. Number:

Services:

Add

Delete

Counties:

Add:

Delete:

E. Authorization:

Name:

Location: **Area Office**

Date sent: **08/05/2008**

BPM Only: _____