

MI CHOICE PROVIDER MONITORING TOOL

PROVIDER: _____

ADDRESS: _____

DIRECTOR: _____

PROGRAM/AGENCY PARTICIPANTS: _____

ASSESSMENT DATE: _____

CONTRACT PERIOD COVERED: FROM _____ TO _____

TYPE OF AGENCY: (Check all that apply)

_____ Private Duty	_____ Medicare Skilled
_____ Private for Profit	_____ Private Nonprofit
_____ Public	_____ Hospital-Based
_____ Hospice and/or Palliative Care Certified	_____ Other (explain): _____

SERVICE CATEGORY(S) BEING MONITORED:

_____ All listed	_____ Home delivered meals
_____ Community Living Supports	_____ Nursing Services
_____ In-home respite	_____ Adult day Health
_____ Chore Services	_____ Private duty nursing
_____ Transportation	_____ Counseling
_____ PERS	_____ Other _____

ASSESSMENT CONDUCTED BY: _____

DATE FEEDBACK SENT: _____

DATE REPORT SENT TO MDHHS: _____

MI CHOICE PROVIDER MONITORING TOOL

GENERAL INFORMATION

1. Purchase agreement current (updated)? Y_____ N_____
2. Have conditions of agreement been reviewed with local staff? Y_____ N_____
3. Does the provider agency maintain program books and records relevant to purchase agreement for at least ten years? Y_____ N_____
4. Is the provider agency aware of contract amendment and /or revised procedures as required by MDHHS that may have been implemented during the contract year? Have these been addressed? Y_____ N_____
5. Does the provider agency maintain the following insurance? (Visually verify)

Expiration Date

- | | | | |
|---|--------|--------|-------|
| a. Worker's Compensation | Y_____ | N_____ | _____ |
| b. Unemployment | Y_____ | N_____ | _____ |
| c. General Liability | Y_____ | N_____ | _____ |
| d. Facility/Property Insurance | Y_____ | N_____ | _____ |
| e. No-Fault Vehicle Insurance | Y_____ | N_____ | _____ |
| f. Fidelity Bonding (for persons handling cash) | Y_____ | N_____ | _____ |
| g. Malpractice/Liability | Y_____ | N_____ | _____ |
| h. Professional/Liability | Y_____ | N_____ | _____ |
| i. Other: _____ | Y_____ | N_____ | _____ |
| _____ | | | |
| _____ | | | |

PROGRAM SPECIFICATIONS

1. What are the agency's procedures for documenting hours of service provided by employees for billing purposes?

2. How does the agency verify that hours of service are actually provided? _____

3. Participant Records (Review 10 files or 10% whichever is greater) for the following contents.

% COMPLIANT

- | | |
|---|-------|
| a. Assessment/reassessments? | _____ |
| b. Service plan (work order)? | _____ |
| c. Service plan adjustments? | _____ |
| d. Progress Notes? | _____ |
| e. Release of information (if necessary)? | _____ |
| f. Accident reports (if necessary)? | _____ |
| g. Termination records (if necessary)? | _____ |
| h. Other (describe): _____ | |

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

4. Does the agency use the MI Choice assessment? Y_____ N_____
- a. If NO, does the agency conduct a supplemental assessment only? Y_____ N_____
- b. If NO, does the agency conduct a complete assessment? Y_____ N_____
5. Does the agency have its own service plan? Y_____ N_____
- If YES, does the agency service plan correspond to the waiver agency work order? Y_____ N_____
6. If the agency is a Medicare/Medicaid certified agency with a private duty component, does the agency bill either source for non-skilled services provided to waiver participants through "Management & Evaluation?" Y_____ N_____
7. How does the provider assure confidential participant files are kept secure? (Describe the methods of storing confidential information, controlled access to computer information) _____
- _____
- _____
8. Does the provider have policies and procedures for: (visual verification and review of policies required)
- a. Participant confidentiality? Y_____ N_____
- b. Participant appeals/grievances? Y_____ N_____
- c. Participant feedback/evaluation? Y_____ N_____
- d. Participant's rights and responsibilities? Y_____ N_____
- e. Reporting suspected abuse, neglect, exploitation or other critical incidents? Y_____ N_____
- f. Participant health, welfare, and safeguards? Y_____ N_____
- g. Emergencies in participant's home? Y_____ N_____
- h. Personnel? Y_____ N_____
- i. Recruitment, training, and supervision? Y_____ N_____
- j. Date of last revision of policy manual _____
9. Agency Documentation:
- a. Do provider records specifically identify participants being served through the agreement with the waiver agency? Y_____ N_____
- b. Does the documentation contain the state minimum requirements of "Date of Service," "Start and Stop Times" of service provision, and "Written Summary" of services and tasks performed? Y_____ N_____
- c. Is the signature of the employee providing the service included on the documentation? Y_____ N_____
- d. Does the provider use and maintain an "In-Home Journal" as required in the agreement? May include electronic system. Y_____ N_____
- i. If YES, is the in-home journal available for review in the participant's home by the supports coordination staff? Y_____ N_____
- ii. Does the in-home journal contain the minimum requirements of the "Date of Service," "Start and Stop Times" of service provision, and "Written Summary" of services and tasks performed, pertinent information regarding the participant's routine, health status, nutritional status, and changes or problems encountered? Y_____ N_____
- iii. Is the signature of the employee providing the service included on the documentation? Y_____ N_____
- If NO, explain: _____
- _____
- _____
- iv. Is the signature of the participant receiving the service included on the documentation? Y_____ N_____
- If NO, explain: _____
- _____
- _____

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

STAFFING

1. Is the following information in paid staff employee files:
 - a. Reference checks? Y_____ N_____
 - b. TB test results (card)? Y_____ N_____
 - c. Copy of certification/license/registration for professional employees? Y_____ N_____
 - d. Copy of a valid driver's license and automobile insurance, if applicable? Y_____ N_____
2. Does the provider conduct a criminal history review on new employees? Y_____ N_____
- If yes, are these conducted prior to the employee entering the participant's home? Y_____ N_____
3. Does the provider conduct reference checks prior to paid staff entering the participant's home? Y_____ N_____
4. Describe the agency's procedures for introducing the caregiver staff to participants: _____

5. Do caregivers wear pictured identification? Y_____ N_____
- If NO, what form of agency identification is presented to participants? _____

6. What type of orientation program is set up for new staff? (Ask for outline or copy of training program) _____

7. The following applies for private duty nursing/respiratory care and nursing services:
 - a. Are licenses and registrations for RNs, LPNs and RTs from the State of Michigan current and available for viewing? (visually verify) Y_____ N_____
 - b. Are LPNs supervised by RNs? Y_____ N_____
 - c. Are there written procedures to govern administering of medications? Y_____ N_____If YES, describe these procedures _____

[illegible]

MI CHOICE PROVIDER MONITORING TOOL

8. The following applies to in-home workers (caregivers) including those delivering community living supports, respite, and chore services:

- a. Describe the typical tasks performed in the participant's home: _____

- b. Do any of the workers have certification? Y_____ N_____
- i. If YES, how many? _____
- ii. Are copies of the certification on file? Y_____ N_____
- c. Is in-service training provided to workers at least two times per year? Y_____ N_____
- d. Is there an annual in-service training plan? (review this plan) Y_____ N_____
- e. What types of training topics have been covered in the last 12 months? _____

- f. Is an aide training course provided as recommended by MDHHS? Y_____ N_____
- g. Does a qualified professional supervise workers? Y_____ N_____
- If YES, what are the credentials of the supervisor? _____

- h. Does the supervisor review the MI Choice work order with the in-home workers before the initial home visit? Y_____ N_____
- i. Is the supervisor available to workers at all times by telephone? Y_____ N_____
- j. Are supervisory in-home evaluations of workers conducted at least two times per calendar year? Y_____ N_____
- k. Do participant records reflect documentation of on-site supervisory visits including the following: Y_____ N_____
- i. Name and title of person doing the supervising? Y_____ N_____
- ii. Staff person being supervised? Y_____ N_____
- iii. Location of on-site supervision (participant ID number only, no names) Y_____ N_____
- (Note last monitoring date and findings)
- l. Is there a policy on dispensing of nonprescription medications? Y_____ N_____
- m. Is there a procedure to govern the dispensing or administering of prescription medications? Y_____ N_____

SERVICE COORDINATION

1. Describe how the agency coordinates with the waiver agency supports coordinators:
- a. What is the procedure for notifying the waiver agency supports coordinators of participant changes in condition or status? _____

- b. What is the agency's policy/procedure for notifying the supports coordinator of discontinued services due to participant not at home, death, institutionalization, hospitalization, personal choices, etc.? _____

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

- c. What is the agency's policy/procedure for notifying the supports coordinator of upcoming appointments the participant may have that the agency becomes aware of? _____

- d. What is the agency's policy/procedure for notifying the supports coordinator when paid staff fails to show up at the participant's home? _____

OTHER

1. Are the agency services available to the general public? Y_____ N_____

If YES, how does the public rate compare to the unit rate waiver agency pays?

Private pay rate: \$_____ waiver agency rate: \$_____

2. Does the provider have any need for technical assistance or training? Y_____ N_____

If YES, in what areas? _____

3. How are the agency services publicized? _____

4. Were there any problems encountered during the last 12 months? Y_____ N_____

If YES, please describe: _____

5. Is the agency an assisted living setting (i.e. licensed or non-licensed assisted living, AFC or HFA)?

Y_____ N_____

6. If yes to #5, has this setting been evaluated regarding the Home and Community Based Settings requirements?

Y_____ N_____

7. If yes to #6, does this setting meet the Federal Home and Community Based Settings requirements?

Y_____ N_____

8. If no to #6, complete the Home and Community Based Settings assessment.

9. If no to #7, describe steps that need to be taken to become compliant. If the provider does not wish to become compliant, discuss a plan for transferring MI Choice participants to another setting as of 3/17/2018.

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

BILLING AUDIT

NOTE: A complete audit of the participant case records is to be conducted for those cases being reviewed. The waiver agency must verify billing dates and units of service submitted by the provider agency and paid by the waiver agency with dates and units of service found in office participant case records.

1. Do progress notes correspond with billing dates of service? Y_____ N_____

[illegible]

2. Did monitoring reveal any areas of participant needs not being addressed adequately through provider's provision of service? Y_____ N_____

[illegible][illegible]

**MI CHOICE IN-HOME PARTICIPANT VISIT
(CONDUCTED IN CONJUNCTION WITH PROVIDER MONITORING)**

PROVIDER AGENCY MONITORED: _____

REVIEWER: _____ SIGNATURE: _____

PARTICIPANT'S NAME: _____ DATE: _____

SOCIAL SECURITY #: _____ D.O.B.: _____

CURRENT CLIENT TYPE: **WA** ☐ **CM** ☐ **OTHER (specify):** _____

CLIENT STATUS: **ACTIVE** ☐ **MAINTENANCE** ☐

OTHER (Check all that apply): Chose SD option ☐ NFT ☐ MFP ☐ SMOU ☐ MOU ☐

Dates of WA: _____ **Dates of CM/other program:** _____

Participant Meets NFLOC: Yes ☐ Door: _____ No ☐ Unable to Determine ☐

	PERSONAL GOALS, FUNCTIONAL ABILITY, DIAGNOSES, SOCIAL/OTHER CONCERNS	COMMENTS
Per Chart Review:		
Per Participant:		
Per Primary Caregiver:		

Current Services	<u>Frequency</u>	
	Per Person Centered Service Plan (PCSP) Authorizations	Per Participant
☐ ADULT DAY CARE		
☐ COMMUNITY LIVING SUPPORTS		
☐ RESPITE SERVICES		
☐ COUNSELING		
☐ HOME MODIFICATIONS		
☐ HOME DELIVERED MEALS		
☐ NURSING SERVICES		
☐ SUPPORTS COORDINATION		
☐ TRAINING		
☐ PERS		
☐ TRANSPORTATION		
☐ PRIVATE DUTY NURSING/RESPIRATORY CARE		
☐ CHORE		
☐ FISCAL INTERMEDIARY		
☐ GOODS AND SERVICES		
☐ COMMUNITY HEALTH WORKER		
☐ OTHER		

☐ SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES:

☐ HOSPITAL BED ☐ COMMODE ☐ WALKER ☐ WHEELCHAIR ☐ RAISED TOILET SEAT
☐ OXYGEN ☐ HUMIDIFIER ☐ DIAPERS ☐ BLUE PADS ☐ SYRINGES ☐ DRESSINGS

☐ OTHER: _____

☐ ADDITIONAL DME'S NEEDED: _____

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Cultural sensitivity	*Direct service providers speak same language as participant. *Plan of service reflects specific cultural practices.			
Timeliness of purchased services	*Time between service authorization and services in place in home. *Provider delivers services at times specified on plan of service or otherwise acceptable to participant.			
Choice of service providers	*Participant approval of plan of service *Participant satisfied with provider and/or workers.			
Responsiveness to changes in person centered service plan (PCSP)	*Provider implemented requested service change. *Provider responsive to participant requests and instruction.			
Participant can contact provider with issues	*Participant able to name provider, locate phone number for provider, etc.			
Participant has materials on complaint, appeals process	*Participant aware of right to complain and/or appeal. *Participant knows process.			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Evidence of PCP	*Participant satisfied with current service delivery. *Worker knows participant preferences. *Participants preferences honored during delivery of services.			
Services are delivered as ordered	*Gaps in services are documented. *Agency notifies waiver agency if unable to provide services.			
Emergency/ contingency plans	*Emergency plan in place. *Emergency plan followed when needed. *Services delivered according to ER plan during emergency or when unable to staff with regular worker.			
PCSP sufficient to assure health and safety of participant	*Plan of service reflects assurance of health and safety and risk planning. *Provider/caregivers assure health & safety while in home. *Provider reports health/safety issues to supports coordinator.			
Provider facilitates delivery of needed arranged services/supports	*Provider staff contact supports coordinator to notify of unmet need. *Provider staff assists with advocating for participant.			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Quality of care outcomes	*Participant satisfied with quality of service. *Provider completes all tasks as specified.			
Evidence of effort to prevent excess disability	*Caregivers encourage participant to maintain and/or improve function.			
Evidence of under-service to participant	*Provider consistently delivers services and supports according to plan of service and participant preferences. *Reasons for non-provision of service are documented and valid.			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Consumer satisfaction	1. Service and support needs met by direct care workers. 2. Providers arrive as scheduled. 3. Providers complete all tasks specified in PCSP. 4. Providers treat participant with respect and dignity. 5. Participant is pleased with services and supports. 6. Other services needed.	File review N/A for these questions		1. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A 2. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A 3. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A 4. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A 5. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A 6. List other services:

OTHER COMMENTS:

For participants who reside in a provider-owned setting, please also complete the following:

Question	Yes	No	Comments (Explain all “NO” answers)
1. Can you close and lock your bedroom door?			
2. Do individuals have keys to your bedroom door?			
3. Does your bedroom door have doorknobs that may be unlocked from the inside with one motion (automatically unlocks with one turn of the knob)?			
4. Can you close and lock your bathroom door			
5. Does your bathroom door have doorknobs that may be unlocked from inside with one motion (automatically unlocks with one turn of the knob)?			
6. Do staff members have a key or keypad access to your bedroom doors?			
7. Do staff members have a key or keypad access to your bathroom doors?			
8. Do staff members respect your privacy when entering your personal space?			
9. Are you allowed to have meals/snacks at the time and place you choose?			
10. Can you choose what you eat, as appropriate?			
11. Can you choose to eat alone or with other housemates?			
12. Can you choose what clothes to wear?			
13. Can you receive assistance with dressing if necessary?			
14. If you have access to a personal communications device (e.g., cell phone, landline phone, personal			

Question	Yes	No	Comments (Explain all "NO" answers)
computer, tablet), can you use this device in private at any time?			
15. If you have access to a shared communication device (e.g., cell phone, landline phone, personal computer, tablet), can you use the device in a location that allows for private communication?			
16. Does your bedroom offer a telephone jack, wireless internet, or an Ethernet jack?			
17. If there are cameras and visual/audio monitors present in the individual's bedroom or bathroom, was the equipment installed to meet an assessed or documented need for the individual?			
18. Do you have privacy when receiving support with your personal care needs?			
19. Did you have a choice of roommate(s)?			
20. Can you furnish or decorate your bedroom?			
21. Do you arrange and control your personal schedule of daily appointments and activities?			
22. Do you have full access to the following common areas?			
a. Kitchen			
b. Dining Area			
c. Laundry Room			
d. Comfortable Seating Area			
e. Bathroom			
23. Is there space for you to meet with visitors to have private conversations?			
24. Are you free to come and go from the home setting?			
25. Can you freely move about the inside space of the home setting?			
26. Can you freely move about the outside space of the home setting?			

Question	Yes	No	Comments (Explain all “NO” answers)
27. Is the residence physically accessible to you?			
28. Are there environmental adaptations (grab bars, shower chairs, wheelchair ramps) within the setting to enhance the physical accessibility of the setting?			
29. Are the household appliances within the setting physically accessible to you?			
30. Is the furniture at a height and location that is accessible and comfortable to you?			
31. Does the home have gates, locked doors, or other barriers preventing entrance or exit from common areas of the home (i.e. kitchen, dining area, laundry, comfortable seating area, and bathroom)?			
32. If available, do you have the same access to features of the housing community (e.g. pool, gym) as other housemates?			
33. Is accessible transportation available for you to make trips within the community?			
34. Do you have access to nearby public transportation?			
35. If public transit is available, do you receive training or assistance with using public transit?			
36. If public transit is limited or unavailable, do you have other resources to access the broader community?			
Additional Information:			

In addition to explaining all “No” answers provided by the participant, the waiver agency should also follow up with the provider for their explanation to assure the setting is compliant with home and community based services setting requirement.