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
________	Public	________	Nonprofit 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 ______________________________

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GENERAL INFORMATION

1. Purchase agreement current (updated)? Yes ______ No ______
2. Have conditions of agreement been reviewed with local staff? Yes ______ No ______
3. Does the provider agency maintain program books and records relevant to purchase agreement for at least **ten** years? Yes ______ No ______
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? Yes ______ No ______
5. Does the provider agency maintain the following insurance? (Visually verify)

		Yes	No	Expiration Date
a.	Worker's Compensation	Yes ______	No ______	____________
b.	Unemployment	Yes ______	No ______	____________
c.	General Liability	Yes ______	No ______	____________
d.	Facility/Property Insurance	Yes ______	No ______	____________
e.	No-Fault Vehicle Insurance	Yes ______	No ______	____________
f.	Fidelity Bonding (for persons handling cash)	Yes ______	No ______	____________
g.	Malpractice/Liability	Yes ______	No ______	____________
h.	Professional/Liability	Yes ______	No ______	____________
i.	Other: ______________	Yes ______	No ______	____________

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? __________

____

____

____

____

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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 ________

4. Does the agency use the MI Choice assessment? Yes ______ No ______
   a. If NO, does the agency conduct a supplemental assessment only? Yes ______ No ______
   b. If NO, does the agency conduct a complete assessment? Yes ______ No ______

5. Does the agency have its own service plan? Yes ______ No ______
   a. If YES, does the agency service plan correspond to the waiver agency work order? Yes ______ No ______

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?" Yes ______ No ______

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 & review of policies required)
   a. Participant confidentiality? Yes ______ No ______
   b. Participant appeals/grievances? Yes ______ No ______
   c. Participant feedback/evaluation? Yes ______ No ______
   d. Participant's rights and responsibilities? Yes ______ No ______

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e. Reporting suspected abuse, neglect, exploitation or other critical incidents? Yes ______ No _______
f. Participant health, welfare, and safeguards? Yes ______ No _______
g. Emergencies in participant's home? Yes ______ No _______
h. Personnel? Yes ______ No _______
i. Recruitment, training, and supervision? Yes ______ No _______
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? Yes ______ No _______
   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? Yes ______ No _______
   c. Is the signature of the employee providing the service included on the documentation? Yes ______ No _______
   d. Does the provider use and maintain an "In-Home Journal" as required in the agreement? May include electronic system. Yes ______ No _______
      1. If YES, is the in-home journal available for review in the participant's home by the supports coordination staff? Yes ______ No _______
      2. 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? Yes ______ No _______
      3. Is the signature of the employee providing the service included on the documentation? Yes ______ No _______
         If NO, explain ____
         ____
         ____
      4. Is the signature of the participant receiving the service included on the documentation? Yes ______ No _______
         If NO, explain ____
         ____
         ____

COMMENTS ____
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STAFFING

1. Is the following information in paid staff employee files
   a. Reference checks? Yes _____ No _____
   b. TB test results (card)? Yes _____ No _____
   c. Copy of certification/license/registration for professional employees? Yes _____ No _____
   d. Copy of a valid driver's license and automobile insurance, if applicable? Yes _____ No _____

2. Does the provider conduct a criminal history review on new employees? Yes _____ No _____
   a. If yes, are these conducted prior to the employee entering the participant's home Yes _____ No _____

3. Does the provider conduct reference checks prior to paid staff entering the participant's home? Yes _____ No _____

4. Describe the agency's procedures for introducing the caregiver staff to participants

____
____
____
____

5. Do caregivers wear pictured identification? Yes _____ No _____
   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) Yes _____ No _____
   b. Are LPNs supervised by RNs? Yes _____ No _____
   c. Are there written procedures to govern administering of medications? Yes _____ No _____
      If YES, describe these procedures ________________________________

   ____
   ____
   ____
   ____
   ____

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COMMENTS ____

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? Yes ______ No ______
      1. If YES, how many? ____________
      2. Are copies of the certification on file? Yes ______ No ______
   c. Is in-service training provided to workers at least two times per year? Yes ______ No ______
   d. Is there an annual in-service training plan? (review this plan) Yes ______ No ______
   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? Yes ______ No ______
   g. Does a qualified professional supervise workers? Yes ______ No ______
      1. 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? Yes ______ No ______
   i. Is the supervisor available to workers at all times by telephone? Yes ______ No ______
   j. Are supervisory in-home evaluations of workers conducted at least two times per calendar year? Yes ______ No ______
   k. Do participant records reflect documentation of on-site supervisory visits including the following Yes ______ No ______
      1. Name and title of person doing the supervising? Yes ______ No ______
      2. Staff person being supervised? Yes ______ No ______

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3. Location of on-site supervision (participant ID number only, no names (Note last monitoring date and findings) Yes ______ No ______

l. Is there a policy on dispensing of nonprescription medications? Yes ______ No ______

m. Is there a procedure to govern the dispensing or administering of prescription medications? Yes ______ No ______

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 ______________________________

   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? Yes _____ No _____
   If YES, how does the public rate compare to the unit rate waiver agency pays?
   Private Pay rate $ ____________ Waiver Agency rate $ ____________

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2. Does the provider have any need for technical assistance or training? Yes _____ No _____

   If YES, in what areas? ______________________________

3. How are the agency services publicized? ______________________________

4. Were there any problems encountered during the last 12 months? Yes _____ No _____

   If YES, please describe: ______________________________

5. Is the agency an assisted living setting (i.e. licensed or non-licensed assisted living, AFC or HFA)? Yes _____ No _____
6. If yes to #5, has this setting been evaluated regarding the Home and Community Based Settings requirement? Yes _____ No _____
7. If yes to #6, does this setting meet the Federal Home and Community Based Settings requirements? Yes _____ No _____
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 ______________________________

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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?
   Yes _____ No _____

   Findings of visual review ____________________

2. Did monitoring reveal any areas of participant needs not being addressed adequately through provider's provision of service? Yes _____ No _____

   If YES, explain: ____________________

FINDINGS ____________________