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? Y______ N______ 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 ____
      ____
      ____
      ____
      ____
      ____

COMMENTS: ____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

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: ____
____
____
____

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______

   Findings of visual review: ____________________

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

   If YES, explain: ____________________

FINDINGS: ____________________

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	Frequency	
	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 NURSINGRESPIRATORY 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.**	**File review N/A for these questions**		**1. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A**
	2. Providers arrive as scheduled.			**2. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A**
	3. Providers complete all tasks specified in PCSP.			**3. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A**
	4. Providers treat participant with respect and dignity.			**4. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A**
	5. Participant is pleased with services and supports.			**5. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A**
	6. Other services needed.			**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 adaptions (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.