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: _____

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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 six 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_____ 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: _____
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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: _____

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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 _____

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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: _____

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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? 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: _____