

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 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\_\_\_\_\_
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: \_\_\_\_\_  
 \_\_\_\_\_  
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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 \_\_\_\_\_  
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COMMENTS: \_\_\_\_\_  
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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.? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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COMMENTS: \_\_\_\_\_  
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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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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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: \_\_\_\_\_  
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2. Did monitoring reveal any areas of participant needs not being addressed adequately through provider's provision of service? Y\_\_\_\_\_ N\_\_\_\_\_

If YES, explain: \_\_\_\_\_  
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FINDINGS: \_\_\_\_\_  
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