MI CHOICE PROVIDER MONITORING TOOL

PROVIDER:

ADDRESS: Click or tap here to enter text.

DIRECTOR: Click or tap here to enter text.

PROGRAM/AGENCY PARTICIPANTS: Click or tap here to enter text.

ASSESSMENT DATE: Click or tap to enter a date.

CONTRACT PERIOD COVERED: FROM Click or tap to enter a date. TO Click or tap to enter a date.

TYPE OF AGENCY: (Check all that apply)

☐ Private Duty

☐ Private for Profit

☐ Public

☐ Hospice and/or Palliative Care Certified

☐ Medicare Skilled

☐ Private Nonprofit

☐ Hospital-Based

☐Other (explain): Click or tap here to enter text.

SERVICE CATEGORY(S) BEING MONITERED:

☐All listed

☐Community Living Supports

☐In-Home Respite

☐Chore Services

☐Transportation

☐PERS

☐ Home Delivered Meals

☐ Nursing Services

☐ Adult Day Health

☐ Private Duty Nursing

☐ Counseling

☐ Other *Click or tap here to enter text.*

ASSESSSMENT CONDUCTED BY: Click or tap here to enter text.

DATE FEEDBACK SENT: Click or tap to enter a date.

DATE REPORT SENT TO MDHHS: Click or tap to enter a date.

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GENERAL INFORMATION

1. Purchase agreement current (updated)? YES☐ NO☐
2. Have the conditions of the 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 be implemented during the contract year? YES☐ NO☐
5. Have above (#4) been addressed? YES☐ NO☐

6. Does the provider agency maintain the following insurance? (Visually verify)

		EXPIRATION DATE
A.	Worker's Compensation YES☐ NO☐	Click or tap to enter a date.
B.	Unemployment YES☐ NO☐	Click or tap to enter a date.
C.	General Liability YES☐ NO☐	Click or tap to enter a date.
D.	Facility/Property Insurance YES☐ NO☐	Click or tap to enter a date.
E.	No-Fault Vehicle Insurance YES☐ NO☐	Click or tap to enter a date.
F.	Fidelity Bonding (for persons handling cash) YES☐ NO☐	Click or tap to enter a date.
G.	Malpractice/Liability YES☐ NO☐	Click or tap to enter a date.
H.	Professional /liability YES☐ NO☐	Click or tap to enter a date.
I.	Other:Click or tap here to enter text.	

PROGRAM SPECIFICATIONS

1. **What are the agency's procedures for documenting hours of service provided by employees for billing purposes?**
   Click or tap here to enter text.

2. **How does the agency verify that hours of service are actually provided?**
   Click or tap here to enter text.
3. **Participant Records (Review 10 files or 10% whichever is greater)**

		PERCENT COMPLIANT
A.	Assessment/Reassessments	Click or tap here to enter text.
B.	Service Plan (work Order)	Click or tap here to enter text.
C.	Service Plan Adjustments	Click or tap here to enter text.
D.	Progress Notes	Click or tap here to enter text.
E.	Release of Information (if necessary)	Click or tap here to enter text.
F.	Accident Reports (if necessary)	Click or tap here to enter text.
G.	Termination Records (if necessary)	Click or tap here to enter text.
H.	**Other (describe) :** Click or tap here to enter text.	

COMMENTS: Click or tap here to enter text.

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☐
    If YES , does the agency 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 methods of storing confidential information, controlled access to computer information)**
    Click or tap here to enter text.

8. **Does the Provider have policies and procedures for the following ? (visual verification and review of policies is 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☐
    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 : Click or tap here to enter text.

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 performed? YES☐ NO☐
    C. Is the signature of the employee providing the service included on the documentation? YES☐ NO☐
    D. Does the provider maintain an " in-home journal" as required in the agreement? YES☐ NO☐
        i. **If YES**, is the in-home journal available for review in the participant's home by the supports coordination staff? YES☐ NO☐

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? YES☐ NO☐

iii. Is the signature of the employee providing the service included in the documentation ? YES☐ NO☐
If NO, explain: Click or tap here to enter text.

iv. Is the signature of the participant receiving the service included on the documentation? YES☐ NO☐
If NO, explain: Click or tap here to enter text.

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 valid driver's license and automobile insurance, if applicable YES☐ NO☐
2. **Does the provider conduct a criminal background history review on new employees?** YES☐ NO☐
   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 procedure for introducing the caregiver staff to participants**
   Click or tap here to enter text.
5. **Do caregivers wear picture identification?** YES☐ NO☐
   If NO, what form of identification is presented to participants? Click or tap here to enter text.
6. **What kind of orientation program is set up for new staff? (Ask for outline or copy of training program)**
   Click or tap here to enter text.
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 medications? YES ☐ NO ☐
If YES, describe : Click or tap here to enter text.

COMMENTS: Click or tap here to enter text.

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:
   Click or tap here to enter text.

   B. Do any of the workers have certification ? YES ☐ NO ☐
      i. If yes, how many? Click or tap here to enter text.
      ii. Are there 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 plan) YES ☐ NO ☐
   E. What type of training topics have been covered in the last 12 months?
   Click or tap here to enter text.
   F. Is an aid training course provided as recommended by MDHHS? YES ☐ NO ☐
   G. Does a qualified professional supervise workers? YES ☐ NO ☐
   If YES, what are the credentials of the supervisor? Click or tap here to enter text.
   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?
      i. Name and title of the person supervising YES ☐ NO ☐
      ii. Staff person being supervised YES ☐ NO ☐
      iii. Location of the on -site supervision (participant ID number only, no names) YES ☐ NO ☐ (Note last monitoring date and findings?)

   L. **Is there a medication policy on dispensing nonprescription medications?** YES ☐ NO ☐
   M. **Is there a medication procedure to govern the dispensing or administration of prescription medications?** YES ☐ NO ☐

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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**
   Click or tap here to enter text.
   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?**
   Click or tap here to enter text.

   COMMENTS: Click or tap here to enter text.

   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?**
   Click or tap here to enter text.

   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?**
   Click or tap here to enter text.

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 the waiver agency pays?

   Private Pay Rate: Click or tap here to enter text.
   Waiver Agency Rate: Click or tap here to enter text.

2. **Does the provider have any need for technical assistance or training?**
   YES ☐ NO ☐
   If YES, in what areas? Click or tap here to enter text.

3. **How are the agency services publicized?**
   Click or tap here to enter text.

4. **Were there any problems encountered in the past 12 months?** YES ☐ NO ☐
   If YES, describe: Click or tap here to enter text.

5. **Is the agency an assisted living setting ? (ie licensed or non-licensed AFC or HFA)**
   YES ☐ NO ☐
6. **If YES to #5, has this setting been evaluated regarding the Home ans Community Based Setting requirements?** 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 Setting Assessment.*
9. **If NO, to #7, describe the steps that need to occur 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 03/17/2018.**
   Click or tap here to enter text.

COMMENTS: Click or tap here to enter text.

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VALLEY AREA AGENCY ON AGING
CLIENT RECORDS CHECKLIST
PROVIDER NAME :

CLIENT NAME	INTAKE	ASSESSMENT/ REASSESSMENT	SERVICE AUTH	CLIENT NOTES	RELEASE OF INFORMATION	PCSP	SUPERVISORY VISITS	OTHER	OTHER

MI CHOICE PROVIDER MONITORING TOOL

VALLEY AREA AGENCY ON AGING
STAFF RECORDS CHECKLIST
PROVIDER NAME : Click or tap here to enter text.

EMPLOYEE NAME	TITLE	REFERENCE CHECKS	COPY OF PROF. LICENSE	COPY OF DRIVERS LICENSE	COPY OF AUTO INSURANCE	ANNUAL CRIMINAL BACKGROUND CHECK	SUPERVISORY VISIT (2X ANNUALLY)	TRAINING (2XANNUAL	TB Test	SANCTION LIST REVIEW (STATE AND FED.)