

Catherine A Cooper

Authorized Signature

Number: SPD-AR-04-052

Issue Date: 10/15/2004

Topic: Long Term Care

Due Date: 12/31/2004

Quality Assurance Home and Community Based Care Case Review 4th

Subject: Quarter 2004

Applies to (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input checked="" type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input type="checkbox"/> Other (please specify): |

Action Required: The sample of clients receiving waived services has been selected for review for the 4th quarter of 2004. The list of clients will be faxed separately to each office. If you have not received the list by October 19, 2004, please contact a staff member listed below. Be sure to use the Review Form attached. It accurately evaluates compliance with the 1915C Waiver and CMS Protocols. Please review the definitions for each question that accompany the form. If a template is preferred, contact a staff member listed to obtain the form.

Extra cases have been pulled in most areas to assure an adequate sample is reviewed. The number of reviews to be completed is noted on the faxed list of clients. The clients are listed by prime number to assure confidentiality.

Only Managers, Supervisors, Program Technicians or Technical Executive Assistants should complete reviews. Answer all questions relating to each client selected in the sample. To accurately assess the client's situation, a face-to-face interview with all clients in their living situation is strongly recommended. Any areas of non-compliance should be corrected immediately. The person reviewing the case and the person reviewing any corrections, are to sign the review form. If the client is no longer receiving waived services, note the client's name on the form and write, "no longer receiving services."

Return all completed Review Forms to:
 Judy Giggy, Performance Evaluation Unit Manager
 Department of Human Services
 Seniors and People with Disabilities
 Office of Licensing & Quality of Care
 500 Summer St NE E-13
 Salem OR 97301
 Fax: 503*378*8966

Reason for Action: In order to comply with quality assurance issues in the 1915C Waiver and CMS Protocol, a 1.5% statistically valid sample of clients receiving waived services must be reviewed at least annually. Specific quality assurance issues are identified on the attached Quality Assurance Case Review Form.

Field/Stakeholder review: Yes No

If yes, reviewed by:

If you have any questions about this action request, contact:

Contact(s):	Wendy Sampels: email: Wendy.Sampels@state.or.us; Phone: 503*947*5328 Kathi Kyes: email: Kathi.Kyes@state.or.us; Phone: 503*947*1190 Lynette Durst: email: Lynette.A.Durst@state.or.us; Phone: 503*947*1137 Angela Munkers: email: Angela.P.Munkers@state.or.us; Phone: 503*945*6985		
Phone:	Above	Fax:	503-378-8966
E-mail:	Above		

**Quality Assurance Home and Community Based Care
Case Review Checklist**

Local Office:		Branch #:		
Client Name:		Prime #:		
Case Manager:				
Living Situation (check appropriate box(es))				
<input type="checkbox"/> In-Home Alone <input type="checkbox"/> In-Home w/Spouse <input type="checkbox"/> Spousal Pay <input type="checkbox"/> In-Home w/Friends <input type="checkbox"/> In-Home w/other Family <input type="checkbox"/> In-home w/Live-in <input type="checkbox"/> Non-Relative AFH <input type="checkbox"/> Relative AFH <input type="checkbox"/> RCF <input type="checkbox"/> ALF <input type="checkbox"/> SLF				
Services Received (check appropriate box(es))				
<input type="checkbox"/> HCW Hourly <input type="checkbox"/> HCW Live-In <input type="checkbox"/> Spousal Provider <input type="checkbox"/> Contracted In-Home Care <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Adult Day Health <input type="checkbox"/> PACE <input type="checkbox"/> Medical Transport <input type="checkbox"/> Non-Medical Transport <input type="checkbox"/> Environmental Adaptations <input type="checkbox"/> HDM <input type="checkbox"/> CRN Name of RN:				
Box	Question	Yes	No	Notes
1	Is the Client Assessment Current?			
2	If not, are there notes indicating why?			<input type="checkbox"/> N/A
3	Does the client meet survivability levels 1-13?			
4	Does the information in the CAPS Comments, Dropdowns and OACCESS Case Narration match?			
5	Are client Preferences indicated in the Client Assessment or is there documentation the client has no preferences or cannot provide info?			
6	Are client Goals entered or is there documentation the client cannot articulate goals?			
7	If service(s) have been refused, and no informal supports were in place to provide the service(s), were available alternative options offered?			<input type="checkbox"/> N/A

8	Were risks associated with declining services discussed with the client and documented?			<input type="checkbox"/> N/A
9	Are contingency plans in place for emergent situations or is there documentation there are no concerns?			
10	If the lack of immediate care would pose a serious threat to health and welfare, is there a documented back-up plan in place when usual care is unavailable?			<input type="checkbox"/> N/A
11	Is the Client Plan complete, indicating how all needs are addressed (including those not provided under the Waiver)?			
12	Is the Client Plan signature page on file and signed by the client and/or guardian?			
13	If applicable, is the Client Plan signature page on file signed by the facility CBC provider?			<input type="checkbox"/> N/A
14	Is there narrative reflecting discussions with the client and/or client rep regarding care needs and proposed plans?			
15	Is there narration indicating ongoing monitoring is occurring?			
16	Is the SPD 914 (Client Choice) form signed by the client or legal rep for the current care setting?			
17	Is the SPD 539R (Rights & Responsibilities) form signed by the client or guardian?			
18	Does the AFH provider have a valid contract?			<input type="checkbox"/> N/A

Box	Question	Yes	No	Notes
19	Were payments made only to AFH providers with valid contracts?			<input type="checkbox"/> N/A
20	For In-Home care (HCW, Spousal Pay or contracted services) is a CA 546 completed?			<input type="checkbox"/> N/A
21	Was there a complaint of abuse or neglect?			
22	Was appropriate action taken in regards to the issue?			<input type="checkbox"/> N/A

Corrections	Yes	No	Notes
Corrections Required?			Which box(es) require correction(s)? <input type="checkbox"/> 1 <input type="checkbox"/> 7 <input type="checkbox"/> 13 <input type="checkbox"/> 19 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 14 <input type="checkbox"/> 20 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/> 15 <input type="checkbox"/> 21 <input type="checkbox"/> 4 <input type="checkbox"/> 10 <input type="checkbox"/> 16 <input type="checkbox"/> 22 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> 17 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 18
Return for correction to:	Date due:		
Corrections completed by:	Date returned:		
Case File Review Completed by:			
Print Name: _____		Title: _____	
Signature: _____		Date: _____	
Corrections Reviewed by:			
Print Name: _____		Title: _____	
Signature: _____		Date: _____	

Definitions for the Quality Assurance Home and Community Based Care Services Review Checklist

1. Client assessments are completed in Oregon ACCESS, Client Assessment and Planning System (CAPS), at least annually. Note the date of last assessment.
2. Note the date of the narration indicating why assessment is overdue. **Check NA if the assessment is not overdue.**
3. If the client does not meet levels 1-13, why not? Enter notes to explain. (May be Aid Paid Pending, etc.)
4. Review and compare the information entered in CAPS Comments with information in Dropdowns and Case Narration. Are there discrepancies noted?
5. Client Preferences are a description of the individual's choice of how care is provided. Preferences are listed on ADL/IADL pages in CAPS. Examples are: Bathing, morning or evening? Male or Female caregiver? Special soap? etc.
6. Are the client's goals listed in CAPS, Care Planning leaf, Goals tab? If the client cannot express any goals, that should be noted. The information entered in the Goals will print on the Client Plan.
7. If services for an identified need are declined, it should be indicated on the CAPS screen where that need is being assessed. The Assessment Status for that ADL/IADL should be Declined and the alternatives discussed should be in CAPS Comments. (See 8.) **Check NA if no service was declined.**
8. The risks associated with declining services for identified needs must be discussed with the client. This discussion and the client's response should also be indicated in the CAPS Comments. (See 7.) **Check NA if no service was declined.**
9. For in-home clients or those living in R-AFHs, are there concerns about the client's environment or access to emergency services identified in the CAPS Environmental Leaf, Physical and Community Alerts tab? Specific information about the type of intervention the client would

need and why should be noted in Comments on that screen. These Concerns will print on the Emergency Concerns Report. If there are no concerns for a specific client, “None” should be noted in Comments on that screen. (Does the office have a current report printed for all clients with Community Alerts? Is there a plan of action? Do all workers know where the list is posted and how to implement the plan of action?)

10. If a lack of immediate care would pose a risk to a client living in the home or in a R-AFH, it must be documented. It should be entered in CAPS in Environment Leaf, Community Alerts tab, with a Concern of Emergency Services, and the Issue of Threat to health and safety. What poses the threat and any resources available to help the client in the event care is not immediately available should be documented in Comments. This Concern would then print on the Emergency Concerns Report. If the client’s health and safety would not be jeopardized if care were not provided as scheduled, “Not in jeopardy” should be entered in Comments.
11. The Client Plan, SPD CA001, lists all the needs identified through the assessment. To be complete, the Plan must list the Provider Type and Frequency for all needs for which the client has agreed to accept help, whether through paid or informal support. The plan also lists those needs for which the client has declined assistance.
12. The client, or their guardian, must sign the Client Plan. If the client has no guardian and is unable to sign because of physical or cognitive limitations, indicate this on the signature page of the Plan. If a person signs who is not the guardian, the relationship between the client and the signer must be noted. Only the signature page needs to be in the client file, the client keeps the Plan and one signature page.
13. If the client resides in a community based (CBC) facility, the provider is also required to sign the Client Plan. The facility must have a copy of the Client Plan and the Assessment Summary. **Check NA if the client is not in a CBC facility.**
14. Narration should indicate who participated in the assessment and planning process. Clients and any representatives must be involved.

15. Monitoring ensures client needs and provider standards are being met. This can be done through phone calls to or from clients and providers; reports from the CRN; care conferences etc. These contacts must be noted in Case Narration.
16. The Client Choice form, SPD 914, needs to be signed at intake and whenever a client moves between nursing facility and community based care. If the client is unable to sign because of physical or cognitive limitations, indicate this on the form. If a person signs who is not the guardian, the relationship between the client and the signer must be noted.
17. Only the client or their legal representative may sign the Rights & Responsibilities form (SPD539R). If the client is unable to sign because of physical or cognitive limitations, indicate this on the form. If a person signs who is not the guardian, the relationship between the client and the signer must be noted.
- 18 & 19. No payments can be made to providers without a valid contract. Verify that AFH or RAFH licenses are not issued before the last signature on the contract. The contract cannot be in effect until the date of the last signature on the contract. Check the signature dates on the current contract in the provider file. Go to PESM, p, provider # to determine if payments were made before that date. (All other contracts are done through SPD Central Office.) **Check NA if the client is not an AFH or RAFH.**
20. The In-Home Service Plan, CA 546, can be found in Oregon ACCESS. Click the printer icon from any screen in ACCESS, type CA and all CA forms will be available. Check the preview box for the 546 form, select a worker and click on preview. **Check NA if the client lives in a CBC facility.**
- 21 & 22. Review Abuse/Protective service to determine whether a report was made and whether appropriate action was taken. **Check NA if no abuse or protective service complaints have been made.**