Quality Assurance Review

Consumer Name: Case Manager:

Prime: Reviewer:

Assessment Date: **Click on the ★ for additional instructions on a particular topic.**

Score

0=Comments do not reflect need level and/or answer all "three questions."

1=Comments address the "three questions". However, clarity or additional info. is needed.

2=Comments address the "three questions". All comment requirements are met.

Key (letters indicate an area not properly addressed)

A=Why is there a need? B=How frequent is the need? C=How is the assistance being received?

Assessment ★	Score	Key	Additional Comments
Ambulation			
Transfer			
Eating			
Bladder			
Bowel			
Toileting			
Self-Preservation			
Decision Making			
Making Self-Understood			
Challenging Behaviors			
Bathing			
Personal Hygiene			
Dressing			
Grooming			
Housekeeping			
Laundry			
Breakfast			
Lunch			
Dinner			
Med Management			
Shopping			
Transportation			

Percentage Score: 0.0%

☐ Check here if 4 ADL Assessment

Summary (Service Eligible? MED review needed?)

☐ Assessment/Functional Needs Review Only

Functional Needs Review ★

(Boxes that are checked indicate either it was addressed appropriately or it is N/A.)

Strengths/Preferences Addressed?

- ☐ *Selected Strengths and Preferences match the assessment needs.
- ☐ *The comment box indicates any specific Strengths or Preferences that are important to the individual.
- ☐ *The comment box indicates when the comments were last updated.

Goals Addressed?

- ☐ *The most recent goal was obtained at the last assessment.
- ☐ *The goal is in the individual's own words. If not possible, is there a goal that a representative can determine that would have been important to the individual?
- ☐ *If applicable, has the case manager provided support to the individual for this goal?

Risk Assessment Addressed (for in-home)?

- ☐ *Identifying in the comments any specific risk concern(s).
- ☐ *The individual's risks levels make sense (i.e. all areas marked as no risk, however concerns were noted in the assessment or narration).
- ☐ *If assessed at High/Medium risk, a mitigation plan has been documented to lower risk with agreement to plan.
- ☐ *Backup Plan in the event the provider is suddenly unavailable.

Service Plan Development ★

Alternative Medicaid/non-Medicaid Services

- [ ] *Are the natural supports identified in the service plan, along with any available contact information in Oregon ACCESS?
- [ ] *Were other non-Medicaid supports considered, such as VA benefits, OAA, community centers, etc?
- [ ] *Were other Medicaid supports considered, such as K-plan ancillary, DME options, HDM, BSS, ERS, etc?
- [ ] *For in-home services, if the individual appears to be unable to manage the consumer-employer duties, is there an identified representative?

Does the service plan address all needs?

- [ ] *Every need listed under Supports (in CAPS) identifies a need status and provider status
- [ ] *Service plan hours (if applicable) authorized and paid to match assessed needs?
- [ ] *Service plan hours appears to be justified?
- [ ] *For in-home cases, does the liability amount reported in ONE match SFMU (if not, is the calculation based upon cost of care)?
- [ ] *Does the service plan authorization match the payment systems (i.e. dates, amount)
- [ ] *If ICP, does the authorized amount match the payment in ONE?
- [ ] *For in-home cases, is the task list completed, matching the assessed needs?

Approved Special Needs

- [ ] *Do all Special Needs authorizations meet OAR 461-155-0500?

Assessment Completion and Timeliness (see OAR 411-015-0008(1)(e)) ★

Related to the last assessment completed, was the following criteria met:

- ☐ ***Completed appropriately (i.e. not simply copied the last assessment, appears to be completed properly).
- ☐ ***Completed in the last 12 months (unless permission was granted to extend this).
- ☐ ***Was an assessment completed as a result of a change of condition?
- ☐ ***Was an assessment completed as a result of a change in living situation?

Documentation and Forms ★

Narration Documentation should include the following:

- [ ] *Where the assessment was completed
- [ ] *Who participated in the assessment process (the individual must participate)
- [ ] *The SPL level and a determination if the individual is eligible
- [ ] *The decision is documented within 14 calendar days
- [ ] *Documentation of required forms is sent to the individual for review and signature

EDMS File

The EDMS file contains the following signed documents:

- [ ] *Service Plan Agreement (SPA portion of the SPAN)
- [ ] *Workers Compensation form (form 354, if applicable)
- [ ] *Representative Choice Form (form 737, if applicable)

Waivered Case Management ★

Direct and Indirect contacts must be completed timely and accurately. This includes the following:

- ☐ *For Risk related contacts, is there documentation that the risk mitigation plan (if applicable) was reviewed and followed up on as needed with the goal of lowering the risk?
- ☐ *Was the back-up plan reviewed?
- ☐ *For any Direct Contact, is there documentation showing the contact was made with the individual or appropriate representative (per OAR 411-028-0010(13) with a service that is allowed under OAR 411-028-0020(1).
- ☐ *Was a Direct Contact completed each quarter (or monthly for individuals assessed at high risk)?
- ☐ *Was an Indirect Contact service provided in every month that a Direct Contact service was not provided?
- ☐ *Was each Indirect Contact a service that is allowed under OAR 411-028-0020(2)?

Additional Comments

Additional Resources

Press ★ to return

Assessment Criteria (page 1)

The main service eligibility requirement is for an individual to meet a Service Priority Level between 1-13. Here is a link for some general information on the topic.

The assessment comments should reflect the assessed level and include:

-Answers to "the three questions":

1. Why is there a need?
2. How frequent is the need?
3. How is the assistance being received?

-In Cognition, an example of how the need is tied to health and safety

-Address any changes from the previous assessment.

For additional information and comment examples, the document called "Examples of Good Comments in CA/PS" may be helpful.

Service eligibility is considered questionable if one of the 4 ADLs does not have comments that appropriately support the need level.

Individuals between the ages of 18-64 must have a primary physical need to qualify. See MED information for additional details.

Functional Needs Review (page 2)

Press ★ to return

Strengths/Preferences/Goals

It is very important to complete assessments and a review of an individual's functional needs (in CA/PS, it is referred to as "Client Details") in a person-centered manner. It is easy to focus on limitations when assessing an individual's needs. However, understanding the individual's strengths, preferences, and goals can help guide how services should be delivered for the individual.

Here is some training information on Strengths/Preferences/Goals.

Risk Assessment

Assessing an individual's risk level in various categories is a central part to ensuring that an individual's care needs can be safely met.

The Risk Assessment page provides the expectations on how to properly assess an individual's risk level. The page includes the following tools:

-Risk Assessment Policy

-Template

-FAQ

-Definitions

-Other Risk related information

Service Plan Development (page 3)

Press ★ to return

Alternative Medicaid/non-Medicaid Services

It is important to identify any natural supports that are a part of the service plan. Natural supports are identified on the "contacts" page in OA. The names of the natural supports (if available) should be listed in the service plan. For more information on assessing natural supports and how to add them in OA, please see the service planning page in CM tools.

There many other service options besides authorizing a service provider to assist with personal care needs. This includes Medicaid and non-Medicaid resources. For example, home delivered meals, Adult Day Services, K-plan Ancillary Services, or an –Emergency Response System may be an important part of the service plan. The individual may have access to other resources such as a veteran benefit, an Older Americans Act program, or perhaps other community resources.

Service Plan Needs Addressed:

It is important to document if and how the service plan needs are met. In CA/PS, under the Supports selection, each need status and provider status should reflect the status of the individual.

In-home hours should reasonably match the needs of the individual. Examples: If the hours have been reduced, is there a reasonable explanation? Are all the hours assigned, yet a natural support is providing care? Any possible exceptional needs that are not reflected in the service plan?

The service plan provider should match the authorization found in the payment systems. For example, HCW (hours and mileage) and HDM authorization should match what is in the HINQ screen.

For in-home services, the liability amount in ONE should match what is authorized in SFMU (unless there is a cost of care calculation).

For the Independent Choices Program, the calculation on form 546IC must match the MRP in ONE.

Special Needs

Here is a worker guide on the Special Needs program in general.

Here is the special Needs program worker guide for PIFs and Room and Board allowances. It is important to note that any service option under K-plan Ancillary Services should be utilized prior to using any benefit under the Special Needs program.

Assessment Completion and Timeliness (page 4) Press ★ to return

It is important to make sure that a new assessment record reflects an actual assessment that was fully completed. For example, if an assessment was copied from the previous year, and the comments were minimally changed, it may be a concern.

Assessments are required to be completed at least annually. An assessment should be completed more frequently than this when there is a significant change in care needs, a change in living situation, or whenever the individual requests a new assessment.

Documentation and Forms (page 5) Press ★ to return

Narration Documentation

Documentation of the assessment process and outcome is required.

Forms that must be sent to the individual (and in some cases, signed and returned) after the result of the assessment is found in the document "APD LTC Services Form Requirements". This and other related information can be found here in CM tools.

EDMS File

The following forms must be signed, returned, and saved in EDMS. Please note, other forms may be required to be saved in EDMS as well.

Service Plan Agreement (SPA): All individuals receiving services should know about all the possible program options that APD provides. The Service Plan Agreement (SPA portion of the SPAN, form 2780) provides a list of these options. Having individuals understand and choose the services they wish is important. This form must be signed and returned to the case manager.

Worker's Compensation form (354): This is required for any individual that is receiving in-home services by employing a home care worker.

Representative Choice form (737): The first part of the form, which is for Consumer Employer duties, is required for individuals receiving in-home services with a home care worker. This part goes over the consumer-employer responsibilities and who is managing these duties.

The second part of the form is to name a Client Representative. This should be completed by all individuals. It provides information on how a representative may be appointed if one is needed in the event the individual is unable to make their own decision. It also gives the individual the ability to specifically name someone to act on their behalf if needed.

Waivered Case Management (page 6) Press ★ to return

(Direct/Indirect Contacts)

Waivered case management services supports individual service plans. For most individuals, a direct contact is needed every quarter. Individuals assessed at having a high risk require a direct contact every month.
When completing a direct contact, a review of the previously assessed risk is required. The "risk focused template" on the Risk Assessment page provides guidance on how this contact should be completed.
All Direct and Indirect contacts should provide some level of value to the individual.
The Waivered Case Management page has additional information on this topic. This page includes the following:

-Rule reference to OAR 411-028

-Definition and examples of the different kinds of Direct and Indirect Contacts

-Tracking spreadsheet

-Training information