

Welcome to

# QIS Program Tool Training



PRESENTED BY:  
**Jennifer Larsen**

DATE / TIME:  
**July 16th, 2013**  
**2:00 - 3:30 pm**

AUDIO OPTIONS:  
Use Telephone

Dial: 1-877-820-7831

Access Code: 982280

\*\* = click for animation

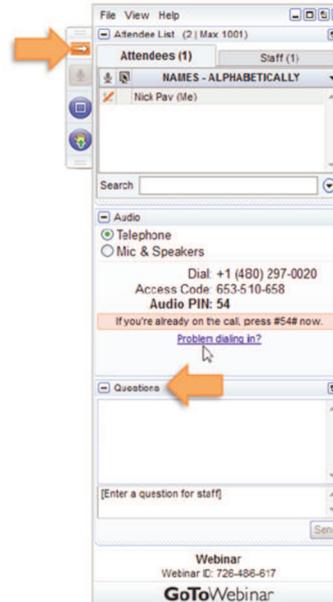
# How to Participate

## → Grab tab

- Open/close control panel

## → Questions panel

- Submit questions here
- View messages from organizer



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You should see a control panel on the right side of your screen - \*\*You can use the orange arrow tab to open and close the Control Panel as needed...

To ensure everyone can hear, we will place everyone on force mute to alleviate background noise.

\*\*As questions come up, please use the question field to enter any questions or comments. We will try to address them along the way.

This PowerPoint will be available online with the tools as well – we'll give you that information later in the presentation.

## Experience Level

- A** Rookie QIS Reviewer
- B** Veteran QIS Reviewer
- C** Just interested...

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**Poll question - Who's here?**

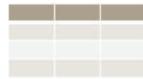
# Today's Objectives



Background  
Information



Tools of the  
Trade



Program Tool

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\*Construction: Photo by Ariel Eric; Images from The Noun Project



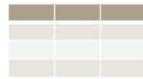
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Let's start with a little background information

## Why are we doing this?

- Ensure clients are receiving the services and supports they need
- CMS requirement
  - Annual and periodic reports
- Guide training development



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### Big picture

In order for states to gain CMS approval to have a waiver, each state must make certain assurances concerning the operation of its waiver(s). These assurances are spelled out in federal regulations and are the same for every state. The Department reports annually and periodically back to CMS that we're achieving what we set out to do with our waivers. And if we're not quite where we want to be, how we're going to get there. So analyzing the information you provide through these QIS reviews help us all to know where we stand.

Besides reporting to CMS, we're hoping to gain some information about what is working well and what areas challenge you the most. Information about those challenges can help us determine what additional information and training would be helpful.

## What are we looking for?

- Level of Care
- Service Plan
- Health and Welfare
- Qualified Provider
- Administrative Authority
- Financial Accountability

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These are Six federal assurances for each wavier – however this QIS review process only focuses on the first 3 – \*\*Level of Care, Service Plan and Health and Welfare

The others we look at through a variety of other processes.



Not what this process is about... This is something we hear every year that CMAs are worried they will be dinged for information found in this process.

I know this process feels invasive – and it may feel like we're out to catch and punish Case Management Agencies or Case Managers.

When in actuality it's about the clients – are they getting the waiver services and supports they need and what areas CMAs/case managers need more support from the Dept

## Role of the QIS Reviewer

- QIS Reviewers **cannot** review his or her own work
  - Okay if the client is or has been on the reviewer's caseload, as long as the reviewer is not case manager of record during the review period
- Review **only** the provided certification spans for the client
- QIS Reviewers should **not** make **any** changes to client records

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QIS Reviewers cannot review his or her own work during the certification span being reviewed

QIS Reviewers should review only the provided certification spans in the client sample

Already mentioned the QIS reviewers don't have the authority to make changes to the client records during the review

## What if I find something that needs to be changed?

- QIS Reviewers should **not** make **any** changes to client records
- Note **minor** changes, **wait** for CSR or remediation
- For **major** concerns or unmet needs identified, do full Service Plan **Revision**

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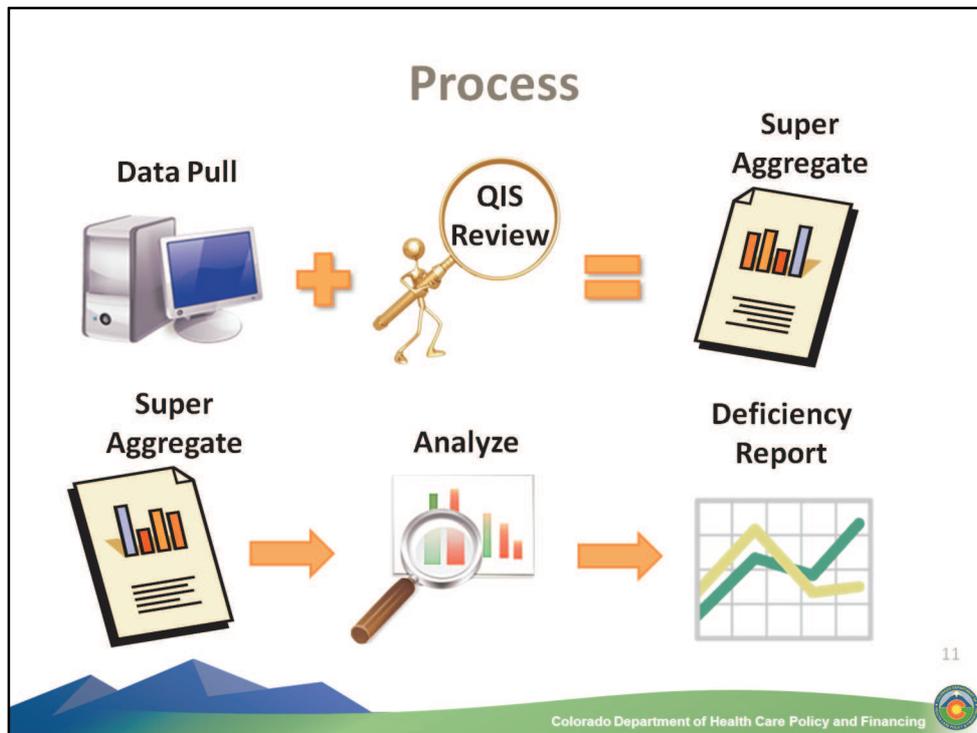
Often we get questions about changing information in the BUS as you are going through this review process.

First of all, the QIS reviewers are not authorized to make any changes to the client records. They are just reviewing.

If the reviewer finds minor changes, we ask that you leave it alone and wait either for the next CSR or the remediation process to fix it. Find a way to make note of those either through your own process, or we have an optional tool that you can use – we'll talk about that next.

If the reviewer finds major concerns or unmet needs that are effecting the client, we ask that you go ahead do a full Service Plan Revision to address those concerns. We don't want those to go unaddressed – but need to do a Service Plan revision and all that goes with that.

Handling changes this way will ensure that we get cleaner data and it will be more clear what needs to be done at remediation time. We hope to develop a new tool that will collect more information and will allow for remediation on the spot, but for now this is how we need to you address minor and major changes.



Here is a general overview of the process:

Anything that is comparing dates or pulling basic client information – we have our data team doing that piece

\*\*Anything that takes a human being to review for content and understanding – we have the QIS reviewer providing data through this process

\*\*The Dept then puts those two pieces together to create the super aggregate which combines all the samples statewide

\*\*Once the super aggregate has been compiled state staff review all the data from the data pull and from the QIS reviewers and \*\*analyze it to look for trends and identify areas where additional actions need to be taken.

\*\*After analysis is complete, we will then provide each CMA with a deficiency report which begins the remediation process. This step happens several months after the QIS Tools were initially completed. In many cases the deficiencies will already have been corrected through the natural process of the of the client’s CSR or through a service plan revision. If the deficiency has not been corrected the CMA will be asked to correct it at this time.



Questions about the Process?

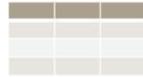
## Today's Objectives



Background  
Information



Tools of the  
Trade



Program Tool

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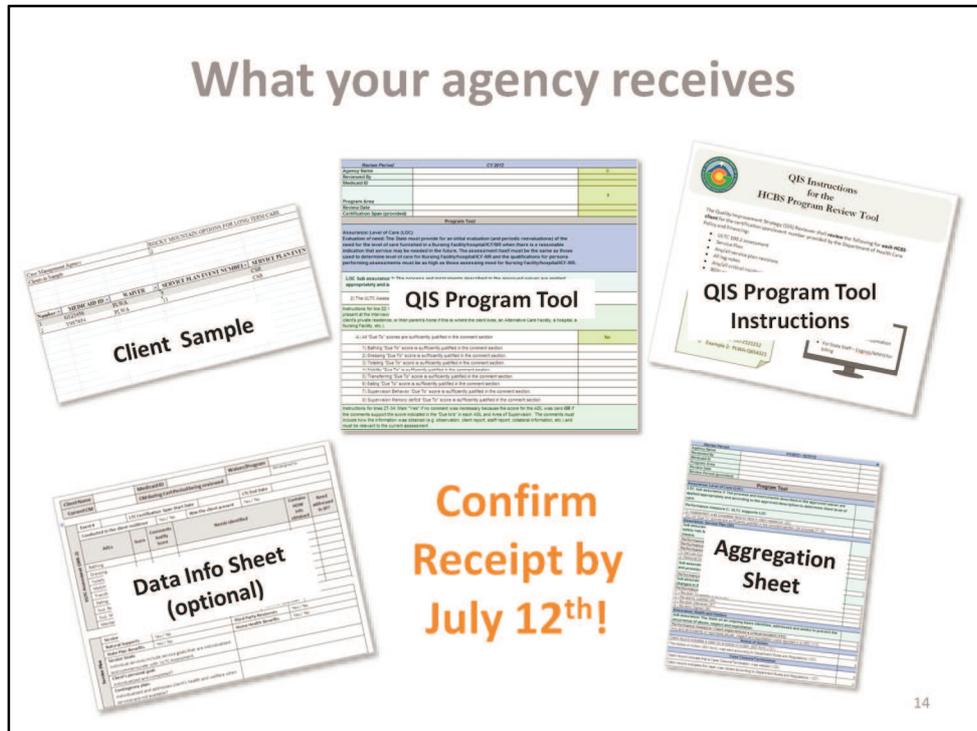
\*Construction: Pahl by Ariel Eric; Images from The Noun Project

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Let's talk about the tools we have sent you and the timeline...

## What your agency receives



Your agency should have received an email with your sample several attachments today, Wednesday, July 10<sup>th</sup>.

- \*\*Client Sample
- \*\*QIS Program Review Tool
- \*\*Revised Program Tool Instructions
- \*\*Data Info Sheet (optional to use if you want)
- \*\*and the Aggregation sheet

We will need you to confirm that your agency has received the \*\*email by July 12<sup>th</sup>. The Email will ask you to confirm receipt when you open it, just click Yes and we'll know you have received the email. If you don't get that little message when you first open the email, please email Elaine Osbment by July 12<sup>th</sup> to let her know that your agency has received the email. We'll have her email on the next slide.

Each of the tools are also available on our website – except for the client samples of course which contain PHI!

This PowerPoint will be available online a few of the tools as well. We'll give you that website in just a minute, first let's go over the tools.

# Client Sample

Case Management Agency	ROCKY MOUNTAIN OPTIONS FOR LONG TERM CARE					
Clients in Sample	2					
Number	MEDICAID ID	WAIVER	SERVICE PLAN EVENT NUMBER	SERVICE PLAN EVENT TYPI	100.2 EVENT NUMBER	100.2 EVENT TYPI
1	Y123456	PLWA	5	CSR	12	CSR
2	G654321	PLWA	11	CSR	16	CSR

→ Check for:

- are the clients listed with our agency during selected review period
- are the clients listed on the correct waiver

→ If not, notify [elaine.osbment@state.co.us](mailto:elaine.osbment@state.co.us) immediately

→ Confirm you have completed this basic review by **July 19th**

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Client Sample – first thing your Agency needs to check is – are these clients yours? AND Are they on the correct waiver? If not – email Elaine Osbment immediately  
The clients must have been with your agency on the designated waiver during the certification span selected for review. These cases could have moved to another agency, waiver, or closed since that time period.

We’re asking that you complete this basic review by July 19<sup>th</sup>.

This will help us make sure that the right clients get to the right agencies, so everyone has enough time to complete the review.

# Program Tool and Instructions

Review Period	CY 2012	
Agency Name		6
Reviewed By		
Medicaid ID		
Program Area		6
Reviewer Date		
Certification Span (provided)		
Program Tool		
<p><b>Assurance Level of Care (LOC)</b>                      Evaluation of need: The State must provide for an initial evaluation (and periodic re-evaluations) of the need for the level of care furnished in a Nursing Facility/hospital/CF-MR when there is a reasonable indication that service may be needed in the future. The assessment itself must be the same as those used to determine level of care for Nursing Facility/hospital/CF-MR and the qualifications for persons performing assessments must be as high as those assessing need for Nursing Facility/hospital/CF-MR.</p>		
<p>LOC Sub assurance 3: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine client level of care.</p>		
<p>2) The ULTC Assessment was completed face-to-face in the client's residence.</p>		
<p>Instructions for line 22: Mark "Yes" if 1) the assessment was completed in the client's residence and 2) the client was present at the interview. The client's residence is defined as where the client currently resides (this may include the client's private residence, or their parents home if this is where the client lives, an Alternative Care Facility, a hospital, a Nursing Facility, etc.).</p>		
A) All "Due To" scores are sufficiently justified in the comment section.		No
1) Bathing "Due To" score is sufficiently justified in the comment section.		
2) Dressing "Due To" score is sufficiently justified in the comment section.		
3) Toileting "Due To" score is sufficiently justified in the comment section.		
4) Mobility "Due To" is sufficiently justified in the comment section.		
5) Transferring "Due To" score is sufficiently justified in the comment section.		
6) Eating "Due To" score is sufficiently justified in the comment section.		
7) Supervision Behavior "Due To" score is sufficiently justified in the comment section.		
8) Supervision History Detail "Due To" score is sufficiently justified in the comment section.		
<p>Instructions for lines 27,34: Mark "Yes" if no comment was necessary because the score for the ADL was zero OR if the comments support the score indicated in the "Due To" in each ADL and Area of Supervision. The comments must include how the information was obtained (e.g. observation, client report, staff report, collateral information, etc.) and must be relevant to the current assessment.</p>		



### QIS Instructions for the HCBS Program Review Tool

The Quality Improvement Strategy (QIS) Reviewer shall review the following for each HCBS client for the certification span/event number provided by the Department of Health Care Policy and Financing:

- ULTC 100.2 assessment
- Service Plan
- Any/all service plan revisions
- All log notes
- Any/all critical incident reports
- BQs provided due to a reduction, termination or suspension of services

**Before You Begin**

- Open the QIS Program Review Tool Template
- Select **Save As**
- Name file by: **waiver-Medicaid ID**
  - Example 1: DD-Z121212
  - Example 2: PLWA-QS4321

**Systems you will need:**

- Benefits Utilization System (BUS)
- For CCNs – DDD Web Application Portal
- For State Staff – Cognos/MMS for billing

Newly Revised for 2013

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Program Review Tool – similar to last year, Excel document that you fill out for each client in your sample. We're going to go through it step by step in the next section

And Updated Instructions – similar to previous versions, with a little bit of a new look and hopefully it will provide some helpful guidance as you're doing the review

## Data Information Sheet (Optional)

Client Name		Medicaid ID		Waiver/Program		
Current CM		CM during Cert Period being reviewed			QIS assigned to:	
ULTC Assessment (100.2)	Event #	LTC Certification Span Start Date		LTC End Date		
	Conducted in the client residence		Yes / No	Was the client present		Yes / No
	ADLs	Score	Comments Justify Score	Needs Identified		Contains HOW info obtained
	Bathing					
	Dressing					
	Toileting					
	Mobility					
	Transfers					
	Eating					
	Sup. Behavioral					
Sup. Memory						
Mental Health Diagnosis:						

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Data Information Sheet – It’s new and it’s optional. You don’t HAVE to use this.

This is just a snapshot of part of the sheet, but it is a full page. What we thought it might be helpful for the QIS reviewer as they go through the client’s records looking for information, to use this sheet for notes. It’s just a way to keep internal notes or information that you would then transfer to the QIS Program Review tool. You may also find it handy when it comes to remediation time to look back at what the QIS reviewer found as a deficiency and why.

Again, it’s completely optional – something you can use if you want. If your agency has their own process or if you as the QIS reviewer have your own method for keeping track of notes, do what works for you.

Also, these notes whether on this sheet or another method are NEVER collected by the Department. They are for your agency’s use only.

We want to thank DDRC and Jenny Jordan for sharing their agency’s sheet which this is largely based on.

# Aggregation Sheet

Review Period		1/1/2012 - 12/31/12
Agency Name		
Reviewed By		
Medicaid ID		
Program Area		
Review Date		

Case Closure/Termination		
36	Client record indicate that a Case Closure/Termination was needed (125)	0
37	Client record indicates the case was closed according to Department Rules and Regulations. (127)	0
38		
39		
40		
41		

EBD Waiver Scoring Aggregation		BI Waiver Scoring Aggregation
Sub assurance 1: Service Plans address all client's assessed needs (including health and safety risk factors) and personal goals, either by provision of waiver services or through other means.		
Performance measure A: SP aligns with ULTC (40)		0
Performance measure B: Needs addressed through non-waiver services (43 includes 45-48)		0
Performance measure C: SP addresses Personal Goals (49 includes 51-53)		0
1) Service Goals under "HCBS Services" have been achieved (54)		0
2) Personal Goal (client's goal for this year) has been achieved (53)		0
Sub assurance 2: The State monitors Service Plan development in accordance with its policies and procedures.		
Performance measure B: SP addresses health and safety risk factors (1, 6)		0
Sub assurance 3: Service Plan is completed at least annually or revised when warranted by changes in the client's needs.		
Performance measure B: SP required revision (81)		0
1.) Revision Completed in BUS (83)		0
2.) Revisions Justified (85)		0
3.) Revision Delivered (87)		0
4.) Revision Signed (89)		0

Aggregation sheet – After you complete the individual QIS Program Tools, you will copy the summary information from the scoring page of each QIS Program Tool and paste it into your CMAs Aggregation Workbook.

This will be the piece that you will need to return to the Department – specific instructions and some tips and tricks about copying information into the Aggregation sheet were provided in the July 10<sup>th</sup> email.

**\*\*Also, you will need to rename the tabs at the bottom for each waiver you are reviewing. \*\***Some agencies may only have one or two waivers, some will have more.

This piece is due back to the Department by September 3<sup>rd</sup>. For those agencies with DD waivers, or a mix of waivers should also send a copy of their aggregation sheet to Lisa Neveu at DDD.

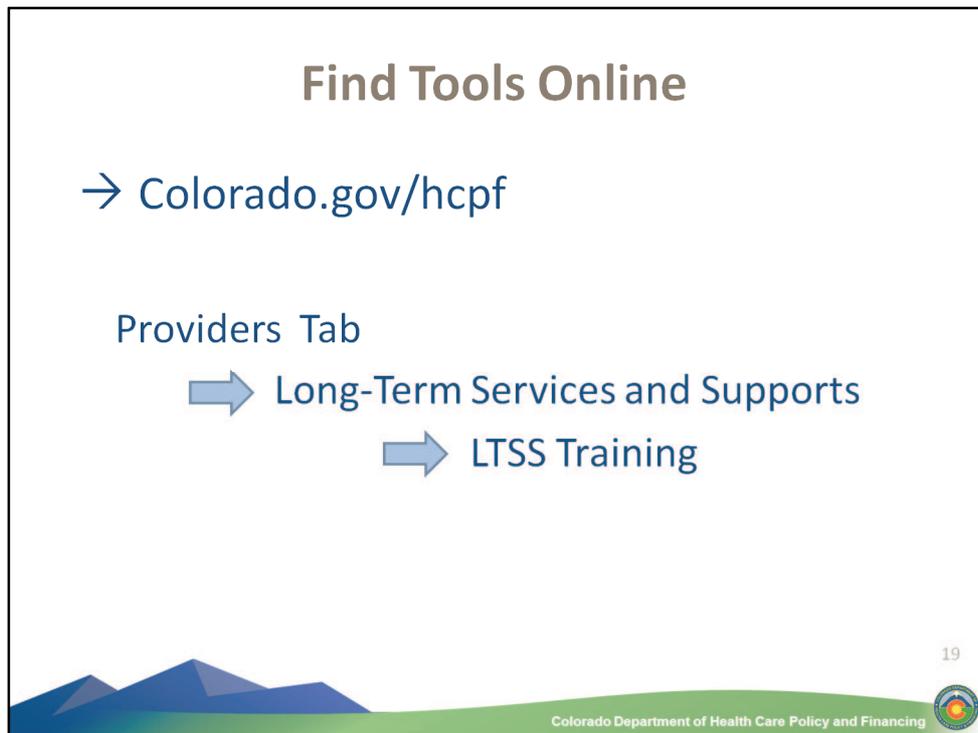
## Find Tools Online

→ [Colorado.gov/hcpf](https://colorado.gov/hcpf)

Providers Tab

→ Long-Term Services and Supports

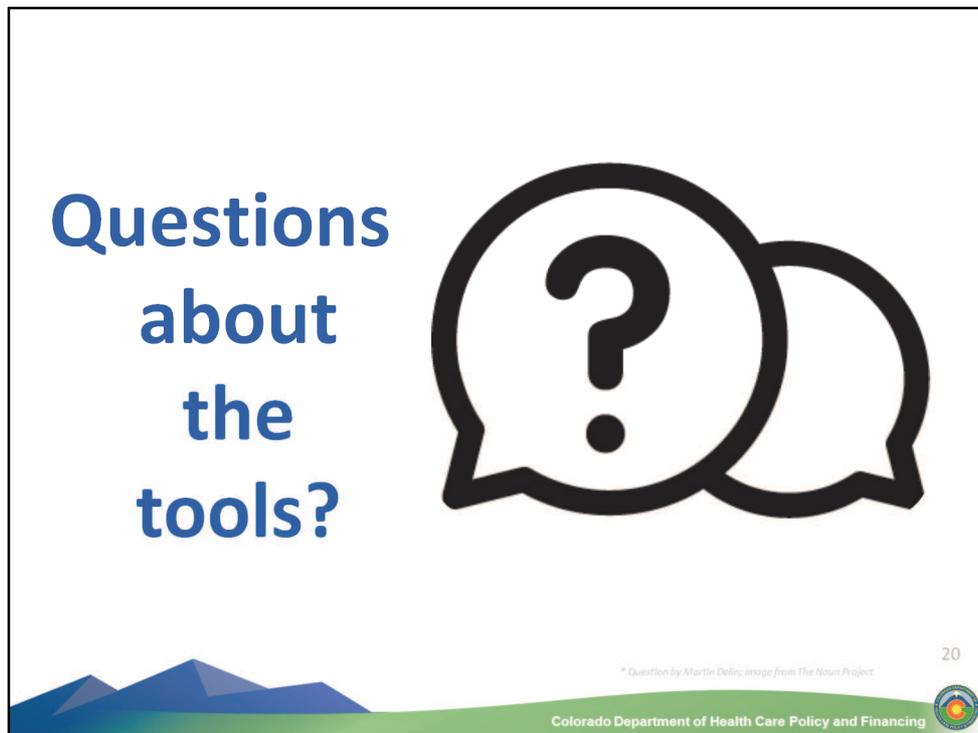
→ LTSS Training



Here is where you can find some of the tools and today's presentation online.

It's the Long-Term Services and Supports training page which you will find under the Provider Tab and then Long-Term Services and Supports

Our website does not get along with Excel, so most likely I won't be able to post the program tool itself and the aggregate tool, but if something changes I will let you know.



Questions about the tools and the timeline?

Other than the program tool – because we’re going to jump into that next...

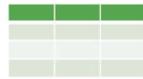
## Today's Objectives



Background  
Information



Tools of the  
Trade



Program Tool

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Let's dive in to the Program Tool!

# Program Tool Template

Review Period		CY 2012
Agency Name		0
Reviewed By		
Medicaid ID		0
Program Area		
Review Date		
Certification Span (provided)		
Program Tool		
<p><b>Assurance: Level of Care (LOC)</b>                      Evaluation of need: The State must provide for an initial evaluation (and periodic reevaluations) of the need for the level of care furnished in a Nursing Facility/hospital/CF/MR when there is a reasonable indication that service may be needed in the future. The assessment itself must be the same as those used to determine level of care for Nursing Facility/hospital/CF-MR and the qualifications for persons performing assessments must be as high as those assessing need for Nursing Facility/hospital/CF-MR.</p> <p>LOC Sub assurance 3: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine client level of care.</p> <p>2) The ULTC Assessment was completed face-to-face in the client's residence.</p> <p>Instructions for line 22: Mark "Yes" if 1) the assessment was completed in the client's residence and 2) the client was present at the interview. The client's residence is defined as where the client currently resides (this may include the client's private residence, or their parents' home if this is where the client lives, an Alternative Care Facility, a hospital, a Nursing Facility, etc.).</p>		
A) All "Due To" scores are sufficiently justified in the comment section.		No
1) Bathing "Due To" score is sufficiently justified in the comment section.		
2) Dressing "Due To" score is sufficiently justified in the comment section.		
3) Toileting "Due To" score is sufficiently justified in the comment section.		
4) Mobility "Due To" score is sufficiently justified in the comment section.		
5) Transferring "Due To" score is sufficiently justified in the comment section.		
6) Eating "Due To" score is sufficiently justified in the comment section.		
7) Supervision Behavior "Due To" score is sufficiently justified in the comment section.		
8) Supervision Memory deficit "Due To" score is sufficiently justified in the comment section.		
<p>Instructions for lines 27-34: Mark "Yes" if no comment was necessary because the score for the ADL was zero OR if the comments support the score indicated in the "Due to's" in each ADL and Area of Supervision. The comments must include how the information was obtained (e.g. observation, client report, staff report, collateral information, etc.) and must be relevant to the current assessment.</p>		

→ One template...  
...many clients

→ Rename file by  
waiver and  
Medicaid ID

- DD-Z121212
- PLWA-Q654321



Important to rename the template for each client – with their **Waiver Acronym** and **Medicaid ID number**

## Why are there lines missing?

9	<b>Assurance: Level of Care (LOC)</b> <b>Evaluation of need: The State must provide for an initial evaluation (and periodic re-evaluation) of the need for the level of care furnished in a Nursing Facility/hospital/ICF/MR when there is an indication that service may be needed in the future. The assessment itself used to determine level of care for Nursing Facility/hospital/ICF-MR and the performance of assessments must be as high as those assessing need for Nursing Facility/hospital/ICF/MR.</b>
13	<b>LOC Sub assurance 3: The process and instruments described in the approved description of the assessment must be used appropriately and according to the approved description to determine client's level of care.</b>
22	2) The ULTC Assessment was completed face-to-face in the client's residence.
23	Instructions for line 22: Mark "Yes" if 1) the assessment was completed in the client's presence at the interview. The client's residence is defined as where the client currently resides, their private residence, or their parent's home if this is where the client lives, an Alternate Care Facility, or a Nursing Facility, etc.).
26	A) All "Due To" scores are sufficiently justified in the comment section.

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There are hidden lines in the tool – because the tool used to be longer and ask more questions of you. Over the years we have been able to phase out some of those questions that are now collected by data team.

Easier to Hide – deleting would affect the integrity of the tool

Color coding - The white rows will be the questions the reviewers will need to enter a response. The blue rows give you some information about the Assurances and the green rows will give you instructions about how to answer the question ABOVE the green row.

## Client/Agency Information Lines 1-7

1	<i>Review Period</i>	<i>FY 2012-13</i>	
2	Agency Name		0
3	Reviewed By		
4	Medicaid ID		
5	Program Area		0
6	Review Date		
7	Certification Span (provided)		

MM/DD/YY – MM/DD/YY
  
ex. 03/01/12 – 02/28/13

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**The first section of the form is for Client and Agency information**

**\*\*Ensure you are using the correct template – it should say FY 2012-13 at the top**

This section is pretty straight forward – entering basic agency and client information

**\*\*When entering the cert span dates – make sure you use the provided cert span dates using two digits to display the month day and year**

**\*\*Ignore the Yellow section in these rows – you won't need to enter anything there.**

## Level of Care Lines 22-34

22	2) The ULTC Assessment was completed face-to-face in the client's residence.	[v]
23	Instructions for line 22: Mark "Yes" if 1) the assessment was completed in the client's residence and 2) the client was present at the interview. The client's residence is defined as where the client currently resides (this may include the client's private residence, or their parent's home if this is where the client lives, an Alternative Care Facility, a hospital, a Nursing Facility, etc.).	
26	A) All "Due To" scores are sufficiently justified in the comment section.	No
27	1) Bathing "Due To" score is sufficiently justified in the comment section.	
28	2) Dressing "Due To" score is sufficiently justified in the comment section.	
29	3) Toileting "Due To" score is sufficiently justified in the comment section.	
30	4) Mobility "Due To" is sufficiently justified in the comment section.	
31	5) Transferring "Due To" score is sufficiently justified in the comment section.	
32	6) Eating "Due To" score is sufficiently justified in the comment section.	
33	7) Supervision Behavior "Due To" score is sufficiently justified in the comment section.	
34	8) Supervision Memory deficit "Due To" score is sufficiently justified in the comment section.	

**Client's Residence** = where the client currently resides, which may include: the client's private home or their parent's home if this is where the client lives; an Alternative Care Facility; a Hospital; a Nursing Facility; etc.

**0 score = YES**

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**\*\***Many of the cells have drop-down menus in each cell to answer the questions. Just hover over to get the little drop-down arrow.

We get a lot of questions about line 22 – “for this question to be a yes, the record must reflect that the client was present for the interview AND that the interview took place in the client’s residence. **\*\*Client’s Residence** is defined as where the client currently resides, which may include: the client’s private home or their parent’s home if this is where the client lives; an Alternative Care Facility; a Hospital; a Nursing Facility; etc.

**\*\***In the Due To scoring section... the QIS reviewer needs to ensure that each ADL Due To score is sufficiently justified in the comments section and that the comment includes how the information was obtained. Look for wording like, “the client reports,” or “staff member reports,” or “family member reports.”

We also get a lot of questions in this section about what if the client scored 0 on any of these, what do I put? Because a score of 0 on an ADL means the client is independent on that skill. **\*\***As long as that zero score appears justified, then you would mark Yes.

The yellow Auto-populate fields correspond to a selection of rows below it.... So in this case if you put Yes on all of these, the yellow square will change to yes. If you put No on just one of the lines (or More) then the yellow square will change to No.

## Service Plan Lines 40-48

40	Performance measure A: The Service Plan appropriately aligns with the level of care as identified in the ULTC Assessment.	
41	Instructions for line 40: Mark "Yes" only if all needs identified in the ADLs, Supervision, IADL's (EBD, BI, PLWA, and MI only) and Medical sections of the ULTC Assessment are addressed through the services listed in the Service Plan. Example: if a client scores one or more on the ULTC Assessment the client's need must be addressed through a waiver/state plan service or by a third party (i.e. natural supports, other state program, private health insurance or private pay). Mark "No" if any area on the ULTC Assessment identifies a need not supported in the Service Plan regardless of funding source.	
43	Performance measure B: Identified needs are addressed through non-waiver services including natural supports, third party payers and/or State Plan benefits prior to accessing waiver services. (Resources were reviewed to ensure that HCBS is the payer of last resort.)	No
44	Instructions for line 43: The response will auto populate with "Yes" if at least one of the following four non-waiver services has been identified and/or completed in the Service Plan, otherwise the response will auto populate "No"	
45	1) Natural Supports	
46	2) Third Party Resources	
47	3) State Plan Benefits	
48	4) Home Health Benefits	

No supports = No



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### Service Plan section

**\*\*Line 40 –** The first performance measure for the Service Plan section is ensuring that all needs identified on the ULTC Assessment have been addressed in some part of the Service Plan.

In general, HCBS waivers are should be used as the “payer of last resort.” Therefore, QIS Reviewers should see if any other non-waiver services have been accessed. This would indicate that the Inter-Disciplinary team looked for other resources to meet the individual’s needs prior to accessing the waiver services.

**\*\* A common question we get in this sections is – what if the client doesn’t have a natural support, for example, would I put yes or no?... \*\*You would answer NO to indicate that the client does **not** have a Natural Support in their plan**

**At least one of these should be Yes however because that is a condition of the HCBS waiver that clients are accessing the HCBS services.**

Again, line 43 will auto-populate based on your answers in lines 45-48 below it.

## Goals and Contingency Plan Lines 49-66

49	Performance measure C: All Service Plan(s) applicable during the review period appropriately address personal goals as identified in the Service Goals and Personal Goals section of the Service Plan. (Service Plans adequately addresses the client's desired outcomes as identified in the HCBS Service Section and Personal Goals sections.)	No
50	Instructions for line 49: The reviewer is to look at the Annual Service Plan and any amendments/revisions during the certification period provided. The response will auto populate with "Yes" only if the response to 1) and 2) below are also marked "Yes". The response will auto populate with "No" if the response to 1) or 2) is "No".	
51	1) Service Goals under "HCBS Services" have been completed.	
52	Instructions for line 51: Mark "Yes" only if each authorized service has a Service Goal that is individualized and commensurate with the information obtained from the ULTC Assessment including ADLs, Supervision, IADL's (EBD, BI, PLWA, and MI only) and Medical sections.	
53	2) Personal Goal (client's goal for this certification span) has been documented.	
54	Instructions for line 53: Mark "Yes" only if the Personal Goal section is completed and the narrative is individualized.	
55	Sub assurance 2: The State monitors Service Plan development in accordance with its policies and procedures.	
56	Performance measure B: The Service Plan addresses health and safety risks through the Contingency Plan.	

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Next section is goals and contingency plan. Line 49 will again auto-populate based on your next two answers, so don't need to do anything there.

**\*\*Look to see if the client's service goals are complete.** They should match the service definition and be reasonable for the client.

**\*\*Personal Goals** – look to see that a goal has been documented and is individualized.

We often get the question – **what if the client refuses** to have a Personal Goal – that's ok as long as the case manager has documented the client's refusal to have a goal.

**\*\*Look at the Contingency plan to see that it is individualized and provides details of what the client will do in the event of an emergency.** Need to have more than just call 911.

## Service Plan Revisions Lines 81-89

81	<b>Performance Measure B: Review of record indicated the Service Plan required revision.</b>	<b>KEY</b>
	Instructions for line 81: Mark "Yes" if documentation indicated a client's changing needs or any significant event (hospitalization, injury, change in cognitive capacity, change in functional ability, critical incident, loss of natural support, etc.) should have prompted a Service Plan Revision. If more than one revision was needed, for questions 1-4 below, the QIS Reviewer should mark "No" if any one of the Service Plan Revisions did not meet the requirement. Mark "No" if the client record does not indicate a Service Plan Revision was needed, and mark "N/A" for questions 1-4 below (lines 83, 85, 87 and 89).	
82		
83	1) Revisions to the Service Plan were completed in the BUS.	
	Instructions for line 83: Mark "Yes" if a Service Plan Revision was completed on the BUS. Mark "No" if documentation review indicated a Service Plan Revision was needed but the revision was not completed on the BUS. Mark "N/A" if a Service Plan Revision was not needed.	
84		
85	2) Revisions are justified by documentation and address all service changes in accordance with Department policy.	
	Instructions for line 85: Mark "Yes" if the following two statements are true 1) changes to the Service Plan are supported by documentation in the applicable areas of the ULTC Assessment including ADL's, IADL's, PMIP, log notes or CIRS and 2) the "Service Goals" section of the Service Plan Revision includes documentation to justify the need for a revision. Mark "No" if the changes in the Service Plan were not justified by documentation or if the "Service Goals" section of the revision does not include justification for the revision. Mark "N/A" if a Service Plan Revision was not needed.	
86		
87	3) Service Plan Revision was delivered to client/representative/legal guardian.	
	Instructions for line 87: Mark "Yes" if the box is checked indicating that a copy of the revised Service Plan was delivered/mailed to the client/representative/legal guardian. Mark "No" if the box is not checked. Mark "N/A" if a revision to the Service Plan was not needed.	
88		
89	4) Service Plan Revision is signed by client or legal guardian as appropriate for each waiver.	

With this section the first question is the **\*\*Key** to whether you will need to complete the other 4 questions in this section.

That Key question is – in your review did you see anything that indicated that the Service Plan required revision.

**Did the client's needs change OR did a significant event occur like (hospitalization, injury, change in functional ability, etc.)** that would cause you to think that a service plan revision was necessary. Whether it was done or not is the next question. So if a revision appeared necessary – mark 81 yes and then continue answering the next four questions.

HOWEVER, if a revision did not appear to be necessary – you can answer No on line 81 and **\*\*mark N/A** for lines 83, 85, 87 and 89.

Other things to point out – It is not enough to put justification for the revision in the service goal alone, it must be documented elsewhere too.

Line 89 asks about a signature on the revision – DD waivers must have a signature on the revision. For other waivers a signature is not required.

## Critical Incidents Lines 113-115

113	<b>Performance Measure:</b> Review indicates the client experienced a Critical Incident during the certification span provided.	 <b>KEY</b>
114	Instructions for line 113: Mark "Yes" if documentation review (e.g. log notes, ULTC Assessment, Service Plan, etc.) indicated the client experienced a reportable Critical Incident. Mark "No" if the client's record does not indicate a reportable Critical Incident, and mark "N/A" for the next question (line 115).	
115	Any and all Critical Incidents involving abuse, neglect or exploitation were reported in CIRS.	
116	Instructions for line 115: Mark "Yes" if there is an indication that a reportable event involving abuse, neglect or exploitation occurred and the case manager submitted a formal report through CIRS. Mark "No" if there is an indication that an abuse, neglect or exploitation event occurred and the case manager DID NOT submit a formal report through CIRS. Mark "N/A" if there is no indication a Critical Incident involving abuse, neglect or	

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Lines 113 and 115 deal with Critical incidents

**\*\***Again, 113 is the key question of this section – if anything in your review prompts you to believe that a Critical Incident either was or should have been reported – answer Yes and move on to question 115.

However, if there was no need for a critical incident report during the review period, then you can answer No for 113 and N/A for line 115

NOA and Case Closure Lines 121-128	
121	Does the client record indicate a Notice of Action (803 form) was sent or should have been sent during the certification span provided due to a reduction, termination or suspension of services?
122	Instructions for line 121: Mark "Yes" if the client record indicated that a Notice of Action (803 form) should have been sent due to a reduction, termination or suspension of services during the certification span provided. Mark "No" if a Notice of Action (803 form) was not needed during the certification span provided, and mark "N/A" for the next question on line 123. Note: QIS Reviewers are not required to review Notice of Action (803 forms) for actions that increased services and should Mark "No" if the only Notice of Action (803 forms) are for actions that increased services.
123	If record review indicated a Notice of Action (803 form) was needed due to a reduction, termination or suspension of services, was it completed on the BUS and in accordance with Department Rules and Regulations?
124	Instructions for line 123: Mark "Yes" if the client record indicated that a Notice of Action (803 form) was needed due to a reduction, termination or suspension of services and was completed correctly. Mark "No" if a Notice of Action (803 form) was needed due to a reduction, termination or suspension of services during the certification span provided but was not completed correctly. Mark "N/A" if a Notice of Action (803 form) was not needed or if the Notice of Action (803 form) was provided for actions that increased services. See the instruction packet for detailed information regarding Department Rules and Regulations regarding Notice of Action (803 form) requirements.
<b>Case Closure/Termination</b>	
125	Does the client record indicate that a Case Closure/Termination was needed during the certification span being reviewed?
126	Instructions for line 126: Mark "Yes" if the client record indicates that Case Closure/Termination was needed during the certification span being reviewed. Mark "No" if the client record indicates that Case Closure/Termination was NOT needed, and mark "N/A" for the next question on line 128.
127	Documentation in the client record indicates the case was closed according to Department Rules and Regulations.
128	

Lines 121 and 123 refer to Notice of Action or 803 forms

**\*\*121 is the key question of this section – if anything in your review prompts you to believe that a Notice of Action due to a reduction, suspension or termination of services was sent or should have been sent – Answer Yes. And then continue on to line 123.**

**\*\*However, if there was no need for a Notice of Action to be sent during the review period, then answer No on line 121 and N/A for line 123.**

**\*\*The last two questions are about Case Closure and Termination – which is an important step that can often get missed. Not closing out cases can cause issues with clients showing up incorrectly in the system. Important to finish the process.**

Line 126 is the key question here – if the review indicated that a Case Closure/Termination was needed during the Certification Span provided, answer Yes to line 126 and move on to 128.

**\*\*However, if case closure or termination was not needed, answer No to line 126 and answer N/A for line 128.**



**Questions?**

**Comments?**



## Timeline

- **July 10** – receive sample and tools via email
- **July 12** – confirm receipt of the sample and tools via email
- **July 19** – confirm that all clients in your sample belong to your agency and are on correct waiver – contact Elaine either way
- **September 3** – Completed Aggregate Due back to [elaine.osbment@state.co.us](mailto:elaine.osbment@state.co.us)

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Colorado Department of Health Care Policy and Financing



Reminder of Timeline



Just another reminder... we're not looking to ding you, we want to learn how we can better support you.

# Contacts

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June 2013

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This PowerPoint will be available online with some of the tools as well.

**Thank you for  
attending!**

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