UTILIZATION REVIEW REPORT

INTRODUCTION

Under the provisions of the Multipurpose Senior Services Program's (MSSP) Home- and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home- and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement #01-15976 between Department of Health Care Services (DHCS) and California Department of Aging (CDA) and CDA policies.

The CDA conducts collaborative and independent URs to monitor the program at the site level for compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Currently, each site is scheduled to be reviewed every other year. The objectives of the CDA UR process are to:

1. Verify the medical necessity of services provided to eligible MSSP clients funded by the HCBS Waiver.
2. Ensure that available resources and services are being used efficiently and effectively.
3. Identify problem areas and to provide technical assistance (TA) as needed.
4. Initiate corrective action(s), if warranted.

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and a home visit to a client. The specific areas addressed by this report are:

1. NECESSITY OF SERVICES: Client Eligibility and Level of Care (LOC).
2. CLIENT ENROLLMENT, RIGHTS, AND INFORMATION: Application, Client Enrollment /Termination Information Form (CETIF), Notification of Rights, Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI), Institutionalization Form (IF).
3. APPROPRIATENESS OF SERVICES: Initial Health Assessment (IHA), Initial Psychosocial Assessment, Reassessment (IPSA), Care Plan, Assessing and Documenting Client Risk, Progress Notes, and Case Record.

4. AUTHORIZATION AND UTILIZATION OF SERVICES: Service Planning and Utilization Summary (SPUS), Tracking Cost Effectiveness, and Vendor Agreement Review.

5. QUALITY ASSURANCE ACTIVITIES: Peer/Internal Review, Client Satisfaction Survey and Home Visit.

METHODOLOGY

Review Date:	March 15, 2010 through March 18, 2010
Review Site:	Multipurpose Senior Services Program Institute on Aging 3626 Geary Boulevard San Francisco, California 94118
Record Review:	14 active and 6 terminated client records
Review Period:	August 2008 through September 2009
CDA-MSSP Review Team:	Joanne Miyao, Nurse Evaluator II Gloria Abernethy, Program Analyst II Alan O'Conner, Health Program Specialist Taffy Warner, Program Analyst II
Scheduled Conferences:	Entrance: March 15, 2010; Exit: March 18, 2010
Conference Participants:	Xanthe Wong, Director Kristina Lugo, Supervising Care Manager (SCM) Elisa Alarcon, SCM Mary Horrum, Nurse Care Manager (NCM) Caroline Schultz, NCM James Keys, Office Manager Yelenz Gasparyan, Fiscal Manager Lisa Wang, Account Payable Christine Ung, Receptionist Martha Jimenez, Intake Coordinator Joy Olshin, Administrative Assistant Natalie Barnett, Data Base Coordinator Athena Chien, Social Worker Care Manager (SWCM) Sara Dull, SWCM Cesar Smith-Diaz, SWCM Hyemee Park-Ahn, SWCM Victoria Tyryshkin, SWCM Julia Pasterl, SWCM Lileth De Guzman Rau, SWCM Rudy Armijo SWCM Tess Bowers, SWCM

Marillac Mayorga, CMA
Jenny Chang, Care Management Assistant (CMA)
Yefim Litvinov, CMA

DEFINITION OF TERMS

1. Findings:
   - Conclusions reached after the UR. Documents site practices during the review period. Compares what exists at the site with what is required.

2. Recommendations:
   - Actions necessary to correct existing conditions or improve operations and practices. The recommendations indicated in this report are requirements not suggestions.

3. Technical Assistance:
   - Documents information provided to site staff during UR. Includes consultation on specific client cases, printed information, online resources, policy references, etc. TA may also document subsequent research and responses provided to site staff following the UR.

4. Corrective Action:
   - Remediates problems found in site practices and ensures compliance to MSSP policies including the federal Waiver and the current Contract. A Corrective Action Plan (CAP) includes but is not limited to the following:

     - Revision of the site's existing procedures and practices or development of new ones. The site shall submit written documentation describing these changes.

     - Training of site staff necessary to implement the required CAP. Training documentation to be submitted to CDA may include, but is not limited to, the following:
       - Schedule of in-service sessions and dates;
       - Sign-up sheet or roster of session attendees;
       - Agenda or syllabi of sessions (topics covered);
       - Name of person(s) conducting the sessions;
       - Session hand-outs; and
       - Synopses of session results including specific problem areas addressed.

     - Periodic submittals to CDA, which may include examples of redacted case record documents, such as care plans, assessment forms, progress notes, etc., produced following the required training and remediation.

CORRECTIVE ACTION PLAN

A CAP is required as specified in the following UR Findings. A CAP is required to ensure compliance with the listed findings and recommendations. Please submit to CDA within 30 days. CDA reviewers may attend scheduled in-service training sessions developed in conjunction with the CAP without notice.

I. NECESSITY OF SERVICES

The objective of the MSSP is to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. At a cost lower than nursing facility placement, MSSP provides services to eligible clients and their families to enable clients to remain in or return to their homes. Case record documentation must support the client's need for these services.

Reference: MSSP Site Manual

I. A. Client Eligibility

Eligibility for the program is addressed initially at screening and confirmed throughout participation in the program. MSSP eligibility criteria include all of the following:

- Age 65 or older;
- Residence in the catchment area;
- Receiving Medi-Cal under an appropriate code;
- Certifiable for placement in a nursing facility (NF) (refer to the LOC section of this report for criteria requirements);
- Ability to be served within the cost limitations of MSSP and
- Appropriate for care management services.

Reference: MSSP Site Manual

Findings:

All twenty client records reviewed contained verification that clients met program eligibility requirements including being certifiable for NF placement, having the ability to be served within MSSP cost limitations, and being appropriate for care management services.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

I. B. Level of Care

The LOC determination is a clinical judgment made by the NCM. The LOC is a timely analysis of information gathered to determine and verify that the client is certifiable for placement in an Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF). The body of the client's case record must support the LOC determination.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

Seven client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) did not completely describe the client's functional limitations ensuring eligibility. Information was found elsewhere in the records that did establish eligibility for MSSP.

Client Record XXXX was missing the six-month XXXX XXXX LOC.

The XXXX XXXX and XXXX XXXX LOCs for Client Record XXXX did not describe the client's need for assistance to eat.

Client Records XXXX and XXXX did not fully describe either the IADLs or the ADLs. The LOC's did not address the IADLs of eating, dressing and grooming nor the client's functional abilities/deficits and specific assistance needed.

Recommendations:

Incorporate all TA provided during the exit conference and in this report. Conduct a training session within 60 days from the date of this report to ensure that all NCMs follow MSSP Site Manual LOC requirements. Submit to CDA the name of the instructor, materials used, and a sign-in sheet with names of attendees. Sixty (60) days following the training, the site will submit to CDA for review, two LOCs from each NCM. The LOCs will be reviewed by CDA and additional TA will be provided, as necessary.

Technical Assistance:

In order to be certified as functionally impaired to the extent of requiring the LOC provided in a nursing facility, a complete description of the client's functional deficits must be included in the LOC.

Although an LOC determination is a clinical judgment made by the NCM in conjunction with the California Code of Regulations, Title 22, Sections 51334 and 51335, MSSP Site Manual Section 3.110.3 Application of Title 22 Criteria recommends focusing analysis and judgment of the following elements:

- Cognition;
- Ambulation, including use of assistive devices and need for human help;

- Medication complexity, high-risk medications (e.g., coumadin, insulin, lanoxin), and compliance;
- Complexity of health issues and how medical diagnosis affect the client's ability to function; and
- Need for assistance (cueing, stand-by, hands-on, total) with ADL and IADL management.

CDA provided an LOC tool highlighting areas of focus with written example,

Corrective Action:

A CAP is required.

II. CLIENT ENROLLMENT, RIGHTS AND INFORMATION

II. A. Application

The application form is the vehicle for applying for services and summarizes what a client can expect from MSSP, alternatives regarding services and the rights of program participants. The application must be completed prior to conducting the LOC determination, and a copy of the application must be provided to the client.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. B. Client Enrollment/Termination Information Form

The CETIF records client demographic information. Data fields must be complete and accurate. As data is changed or updated, a new hard copy must be printed and filed chronologically in the record.

References: MSSP Site Manual and MSSP Contract.

Findings:

Client Record XXXX did not contain an updated CETIF form, handwritten notes were noted for XXXX of XXXX and the emergency contact information was incomplete.

Client Record XXXX contained discrepancies of the address/street number on the CETIF, and the referral form on XXXX, XXXX. It is unclear which address was correct.

Recommendations:

Incorporate the following TA into site policies and procedure.

Technical Assistance:

Review MSSP Site Manual Section 7.210 Client Enrollment/Termination Information Form (CETIF) which states, "As data is changed or updated, a new hard copy is printed and filed chronologically in the record."

Review MSSP Site Manual Section 3.1700 Termination which states, "The case record will contain documentation of the relevant actions and decisions leading up to the termination of a client's participation in MSSP. Termination plans should include how services will be provided after MSSP departs."

Corrective Action:

The findings did not constitute a trend; therefore, a CAP is not required.

II. C. Notification of Rights

MSSP sites must inform clients and/or their designees of their right to be informed of MSSP components which are material to a client's participation (or lack of participation) in the MSSP. Program components include:

1. Processes on registering complaints, termination and appeal;
2. The safeguarding of client information (including application, care plan and termination form) through proper use of the AUDPHI Form and storage of client records;
3. Services that may be provided by MSSP as well as alternatives to participation in the program;
4. Potential outcomes of refusing offered services; and
5. Client participation in MSSP care planning and service satisfaction surveys.

Notices of Action (Termination and Change):

- State law and Medi-Cal regulations require that a Notice of Action (NOA) be sent to an applicant who is denied eligibility at point of application or to a MSSP client who has a change in service or who is terminated (for codes specified in the Site Manual) from the program. Timeframes for mailing NOAs are specified in the Site Manual. The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP. A copy of the NOA will be filed in the client's case record.

Client Rights/Right to State Hearing:

- Clients will be informed in writing and in a timely manner of their right to request a State Medi-Cal hearing when they indicate disagreement with any decision, which would result in a discontinuance, termination, suspension, cancellation or decrease of services under the program.

Reference: MSSP Site Manual and California Welfare and Institutions Code

Findings:

Client Record XXXX XXXX NOA was dated XXXX, XXXX; however, the effective date was documented as XXXX, XXXX. The NOA was not issued in a timely manner.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review Site Manual Section 6.400 Notice of Action for Terminations which states, "The NOA must be mailed in sufficient time for the client to receive it ten days prior to termination from the program." Review Section 3.640.8 Changes to the Care Plan that states, "Clients will receive the following notices of action regarding changes to their care plan."

1. Increases, Additions or Augmentation of waived services. The Client will be sent either a copy of the care plan that has been revised to include the new service, or a separate letter that fully identifies and describes the new service that has been agreed upon. Either of these written notices will also include the State Hearing Notice (Appendix 5).

2. Decreases, Reductions or Termination of previously authorized waived services. The client will be sent either a copy of the care plan that has been revised to reflect the decrease, reduction or termination, or a separate letter that fully identifies and describes the action that has changed."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

II. D. Authorization for Use and Disclosure of Protected Health Information Form

MSSP sites must comply with contract requirements regarding client confidentiality. Sharing and obtaining information requires specific client consent as provided in the AUDPHI. This form must:

- Address only one individual or agency;
- Be specific as to the particular information (such as diagnosis, treatment, or financial information) that is requested from/to that entity; and
- Include an expiration date which cannot exceed two years from the date of the client's signature.

References: MSSP Site Manual and MSSP Contract

Findings:

Ten client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) lacked AUDHPI forms for family members.

Recommendations:

Incorporate all TA provided during the exit conference and in this report. Conduct a training session within 60 days from the date of this report to ensure that all care managers (CMs) and NCMs follow MSSP Site Manual AUDPHI requirements. Submit to CDA the name of the instructor, materials used, and a sign-in sheet with names of attendees.

Technical Assistance:

Review MSSP Site Manual Section 3.510 Confidentiality, which states, "...sharing and obtaining information requires the specific consent of the client. In all cases (including family members) the client must sign a written consent to obtain or release such information."

Corrective Action:

A CAP is required.

II. E. Institutionalization Form

Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the IF. MSSP sites are responsible for the inclusion of the IF in the client case record. The IF provides a chronology of the client's hospitalizations and admitting diagnoses.

Reference: MSSP Site Manual

Findings:

Client Records XXXX, XXXX, and XXXX were missing emergency room visits on the IF as documented in progress notes.

Client Records XXXX and XXXX were missing hospital admissions on the IF, as documented in progress notes.

Client Record XXXXX was missing a hospitalization from XXXX, XXXX to XXXX, XXXX then admitted to a XX, as documented in progress notes.

Recommendations:

Incorporate the following TA and into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.1220 Institutionalization Form which states, "Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the Institutionalization Form (Appendix 23). This form is designed to consolidate information regarding institutionalizations in order to facilitate identification of health issues and events for care management purposes."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

III. APPROPRIATENESS OF SERVICES

The criteria for Appropriateness of Services address the client's need for and ability and willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services (whatever the funding source); maintain or effectively utilize available services; or manage serious health conditions.

- "Ability and willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the care plan. The term "client" includes a client's significant support person when the client is cognitively unable to participate independently.

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client and the CM must be identified, acknowledged and addressed in the initial assessments.

References: MSSP Site Manual and MSSP Contract

III. A. Initial Health Assessment, Initial Psychosocial Assessment, and Reassessment

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive IHA and IPSAs to determine specific problems, resources, strengths, needs and preferences and to confirm LOC.

Reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to LOC and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant.

Assessment instruments and forms include but are not limited to:

- IHA and IPSA
- Reassessments
- Summaries and Problem Lists
- Client's Medication List
- Client's Physicians and Other Health Professionals
- Initial Psychosocial Functioning
- CDA Approved Cognitive Screening Tool
- Functional Needs Assessment Grid (FNAG)

References: MSSP Site Manual and MSSP Contract

Findings:

The prescribing physician's name was missing for each medication listed on two client records (XXXX and XXXX).

Client Record XXXX, contained blanks on the FNAG in the "current help section."

The reassessment medication list for Client Record XXXX was missing the physician's name. The reassessment summary indicated this client may be taking XXXX, however this was not listed on the medication list. It was unclear whether XXXX should have been listed on the medication list.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.620 Assessment/Initial Assessments which states, "All sections are to be completed. If information is unobtainable for some reason, the situation should be noted on the form. On occasion, completion of an item may be deferred. Deferring an entry means that it will be completed later; it does not mean eliminating or not attempting to get the information at all. If completion of an item is deferred, the reason will be noted along with any plans for obtaining the information at a later time."

Corrective Action:

Three findings do not represent a trend; therefore, a CAP is not required.

III. B. Care Plan

Care planning is the process of developing an agreement between the client and CM regarding identified client problems and resources, outcomes to be achieved and services to be pursued in support of goal achievement. The care plan must reflect services and supports necessary to sustain the client's ability to live in their community. The care plan provides a focus for the needs identified in the functional assessments, organizes the service delivery system to the client and helps to assure that the service being delivered is appropriate to the client's needs/problem.

The MSSP interdisciplinary care management team will develop a client-centered written comprehensive care plan for each client. It will be based on the IHA and IPSA or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services and will be written within two weeks of the latest assessment or reassessment.

The MSSP Care Plan includes:

- Statements of problems and needs determined upon assessment;
- Strategies to address the problems and needs; and
- Measurable goals or outcomes used to demonstrate resolution based upon the problem and need, the time frame, the resources available, and the desires and the motivation of the client and/or family.

References: MSSP Site Manual and MSSP Contract

Findings:

There were significant findings in the care plans of all the records reviewed. The findings are listed in the areas of the problem statements, goals, interventions, service provider/type and the resolution or comment section.

Problem Statements

Thirteen of the twenty client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) contained problem statements that were either not
descriptive, contained interventions, not client centered, contained more than one issue in one statement or did not address issues identified in the assessment.

Eleven client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) contained problem statements that did not describe how or why the issue was a problem for the client or how the need related to a functional deficit.

Two client records (XXXX and XXXX) contained interventions within the problem statement.

Three client records (XXXX, XXXX, and XXXX) contained problem statements that were not client centered.

A single care plan problem statement included more than one issue in Client Record XXXX.

The problem statements for Client Records XXXX and XXXX did not specify the functional deficit.

Three client records (XXXX, XXXX, and XXXX) did not address important health issues on the care plan that were identified in the assessment.

Goals

Ten client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) contained goals that were not measurable.

Six client records (XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) contained interventions in the goals. For example "Client will XXXX through XXXX."

Two client records (XXXX and XXXX) contained goals that were not client centered. For example "Clients XXXX will have access XXXX."

Interventions

Nine client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) contained interventions that did not address the problem statement.

Signatures

Four client records (XXXX, XXXX, XXXX, and XXXX) contained care plans with late or missing client signatures.

Other Care Plan Findings

Two client records (XXXX and XXXX) contained inaccurate numerical sequencing.

Three client records (XXXX, XXXX, and XXXX) lacked a complete list of service provider names and/or types.

No client records utilized the Outcome/Resolution column to document the outcome or resolution of problem statements.

Recommendations:

Incorporate all TA provided during the exit conference and in this report to ensure CMs follow MSSP Site Manual care plan requirements. CDA will conduct care plan training, at your site, on June 17, 2010. Sixty (60) days following the care plan training, the site will submit to CDA for review, one care plan from each CM along with the associated reassessment summary. The care plans will be reviewed by CDA and additional TA will be provided, as necessary.

Technical Assistance:

Problem Statements

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states that problem statements must describe areas of concern identified in the reassessment. They must define the problem and substantiate the need for the service. Problem statements are derived from problem lists, written in complete statements, are client centered and relate to the client's functional status. If there are problem areas identified that will not be addressed in the care plan, an explanation should be documented in the progress notes.

Problem statements must describe areas of concern identified in the reassessment. They must define the problem and substantiate the need for the service. Problem statements are derived from problem lists, written in one sentence and relate to the client's functional status. Problem statements do not include interventions.

Goals

Review MSSP Site Manual Section 3.640 Care Planning which states, "The MSSP care plan includes measurable goals or outcomes used to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client/family."

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, "The goal is the desired end result to be achieved. The goal will specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met. The outcome identifies the anticipated result or benefit to be obtained from the service provided."

Goals must be specific, measurable, attainable and realistic. Goals do not contain interventions.

Interventions

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, "The Plan/Intervention section lists information pertinent to the problem and outlines possible actions, plans or solutions to solve the problem."

Interventions address the client's needs and relate specifically to accomplishing the goal. Language must imply some action such as "refer," "assist," "arrange," "purchase," "advocate," "obtain" or "monitor."

Signatures

Review MSSP Site Manual Section 3.640.4 Care Plan Approval which states, "The client will also sign and date the care plan. The client's signature should be obtained within thirty days, recognizing that it may take some time to either mail the form to the client with a return envelope or take the form to the client on the next scheduled home visit. When the client is late in returning the signed form or refuses to sign it, the circumstances will be documented in the progress notes. Reference to the date of this entry will be entered on the file copy of the care plan on the line where the client's signature would have been written."

Other

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states,

B. "Service Provider and Type
The Service Provider and Type section will list the service provider for all services (purchased and referred). The type of provider(s) for each service will also be entered:

I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers.

R = Referred: a service provided without cost through referral to a formal organized program or agency.

P = Purchased: a service purchased by MSSP through Waived Services funds.

C = Care Management: specific activities or interventions carried out by the CM

More than one provider type may be entered for an individual service."

Review MSSP Site Manual Section 3.640.1 General Guidelines which states, "The care plan will address all appropriate needs of the client, including general health and welfare issues. Any needs or services deferred must have appropriate justification for the deferral documented in the client record."

The final care plan document will be written by the PCM within two weeks of the latest assessment or reassessment.

Suggested Problem Statements and Goals

1. Problem Statement:
   - The client is at risk for falls due to poor balance and unsteady gait.

   Goal:
   - The client will report no injury from falls over the next year.

     Interventions:
     - Purchase ERS
     - Provide bathroom safety equipment – specify – hand-held shower (HHS), grab bars, non-slip bath mat, rugs
     - Obtain ramp
     - Obtain lift chair (with prescription)
     - Perform Fall Risk Assessment (Appendix 21g)
     - Educate fall prevention measures
     - Coordinate PT/OT consult (with prescription)

2. Problem Statement:
   - The client is at risk for gaps in care due to high level of need.

   Goal:
   - The client will report zero gaps in care during monthly contact.

Interventions:
- Purchase respite for caregiver daughter
- Coordinate schedules for church and other family members to visit client
- Advocate for increased IHSS hours

3. Problem Statement:
   - The client is at risk for skin breakdown related to urinary incontinence.

   Goal:
   - The client/caregiver will report intact skin during monthly contacts.

   Interventions:
   - Coordinate incontinence supplies (TAR for supplies covered by Medi-Cal)
   - Purchase wipes, gloves, creams
   - Purchase sheets, towels
   - Purchase new bed mattress
   - Coordinate wound care via home health agency

4. Problem Statement:
   - The client is at risk for malnutrition due to inability to prepare her own meals.

   Goal:
   - The client will report maintaining a body weight between 120 - 130 pounds during the quarterly visits.

   Interventions:
   - Obtain oral nutritional supplements (ONS) (with prescription)
   - Arrange Meals on Wheels (MOW) or Home Delivered Meals (HDM)
   - Coordinate nutrition consult (with prescription)
   - Provide adaptive utensils
   - Purchase microwave

Outcome Resolution

When an issue has been resolved an agreement is formed with the client to remove the Problem Statement from the Care Plan. An entry is then made on the care Plan in the comment/outcome section. Documentation of the problem resolution is then noted in the progress notes and a NOA must be sent to the client regarding the change to the care plan. The Problem statement number can be "re-activated" if the issue resurfaces.

This column can also be used to indicate when items have been provided.

Corrective Action:

A CAP is required.

III. C Assessing and Documenting Client Risk

The goal of risk assessment is informed by the fact that MSSP clients have the right to refuse specific services and interventions. When a client refuses a service or intervention, the site must have a process of assuring that the risks associated with the refusal are addressed to the extent possible.

Assessing a client's ability to assume risk includes whether or not the client can:

- Make and communicate choices;
- Provide sensible reasons why choices were made;
- Understand the implications of choices; and
- Consider the consequences of choices.

A risk management plan will be developed when a situation arises where the client has chosen a course of action that may place the client at risk. This process allows for the systematic exploration of situations with a high possibility of an adverse outcome.

The status of the risk management plan must be monitored during regular monthly contacts by the CM. It must be formally reviewed or renewed at intervals mutually agreeable to the client and CM.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

III. D. Progress Notes

Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- The date and type of MSSP staff contact with the client;
- A record of all events that affect the client and the status or validity of the care plan;

- Actions taken when there are discrepancies between the care plan and services delivered;
- Any education or counseling support provided to either the client or caregiver;
- Evaluative subjective and/or objective comments on all services delivered and client outcomes in relation to needed services; and
- A reflection of the relationship between identified problems and services delivered or not delivered.

Progress notes must include any significant information regarding the client's relationship with family, community or any other information which would impact the established goals for the client's independent living.

Reference: MSSP Site Manual

Findings:

Nine client records (XXXX, XXXX, XXXX, XXXX, and XXXX, XXXX, XXXX, XXXX, and XXXX) did not address the care plan problems during the month of reassessment.

Ten client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX) lacked complete care management activity documentation.

Eight client records (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX and XXXX) lacked monthly documentation of care plan problem statement status.

Two client records (XXXX and XXXX) were missing progress notes. Client Record XXXX was missing progress notes for July and August of XXXX and Client Record XXXX was missing a progress note for October of XXXX.

The incomplete or missing progress notes can result in recovery of funds.

Recommendations:

Incorporate all TA provided during the exit conference and in this report to ensure CMs follow MSSP Site Manual requirements. Review MSSP Site Manual Sections 3.640.6 Care Plan Monitoring, 3.800 Progress Notes, 3.810 General Requirements, and 3.820 What Progress Notes Include. Conduct a training session within 60 days from the date of this report to ensure future progress notes are written according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Technical Assistance:

Progress notes must document the status of each care plan problem monthly and provide evidence of all care management activity. Progress notes must be client centered and provide a clear sequence of events, actions and outcomes.

CDA reviewers provided site staff with a handout on the importance of progress note documentation, including the DHCS Audits and Investigations Medi-Cal Payment Error Study of 2006, which cited a MSSP site for less than comprehensive documentation. DHCS found that the progress note in question warranted the lower social reassurance (8.3) reimbursement rate and not the higher and usual reimbursement rates for Case Management (50) and Administration (60).

Corrective Action:

A CAP is required.

III. E. Case Record

MSSP sites must maintain up-to-date, centralized, confidential and secured case file records for each MSSP client, utilizing mandatory CDA forms. Sites are to implement case documentation, date and signature requirements, revisions and corrections according to the MSSP Site Manual specifications and time frames.

Case record documentation is a tangible part of the care management process which must be clear, timely, accurate, legible, appropriate and complete, providing the CM with working documents that are effective and efficient. The site shall also maintain and make available records for inspection and audit by the State.

Reference: MSSP Site Manual

Findings:

Three letters of correspondence were not translated from XXXX to English, in Client Record XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 5.600 which states "Entries in a language other than English will be translated into English. Translation is not required for standardized casework forms (e.g., Application forms, State Hearing Notice, Request for a State Hearing Form, Client Rights in MSSP, and Authorization for Use/Disclosure of Information). Other forms (e.g., Care Plan, Notices of Action, and Negotiated Risk Agreement) that contain individualized information written in another language will be

translated into English. Correspondence written in a language other than English must be addressed in the record."

Corrective Action:

One finding does not represent a trend; therefore a CAP is not required.

IV. AUTHORIZATION AND UTILIZATION OF SERVICES

MSSP sites are responsible for maintaining complete records for funds received under the MSSP contract, including the tracking for purchased and referred services. Sites are required to cooperate with the State in the monitoring, assessment and evaluation of site processes. Sites must provide the CDA any relevant information requested through ad hoc reports that are related to administrative procedures.

The Department's Audit Branch will review the reconciliation process between service authorization and disbursement of payments to ascertain whether services authorized and provided were:

- Consistent with the care plan,
- Verified by the site, and
- Differences between authorized and verified services noted.

CDA MSSP staff will review selected client records to verify that correct procedures were followed in authorizing services for clients.

In authorizing services for a client, the CM will use the following prescribed order of priorities:

1. All services available through the informal support of family, friends, and etc., must be used.

2. Existing Title XVIII Medicare, Title XIX Medi-Cal, Title XX Social Services, Title III Older Americans Acts, the Special Circumstances Program, and other publicly-funded services for which the client is eligible, and which are available in the community, must be relied upon, coordinated and recorded in developing a care plan. Within MSSP these services are called "Referred" services.

3. Only after the client's informal support and the existing public and private services are reviewed and optimally used, can the CM request the use of MSSP funds to purchase Waived Services. Within MSSP, these services are also called "Purchased" services.

CMs must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of a piece of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

References: MSSP Site Manual and Contract

IV. A. Service Planning and Utilization Summary

The SPUS is an element of the client's care plan. The SPUS sets forth specific service information: who is the provider, what service is provided, how much it will cost, and what is the source of payment.

The SPUS is to be completed for each client for each month they are enrolled in the program. The services tracked on the SPUS are those purchased with waived services funds and certain categories of services obtained by referral to other funding sources.

The primary CM signs each client's verified SPUS each month. If the client's tracked costs are more than 95%, but less than 120%, of the site's benchmark, the Supervising CM must also sign; if costs exceed 120%, the Site Director must sign the SPUS, too.

References: MSSP Site Manual and Contract

Findings:

In all twenty records reviewed, the primary care managers (PCM) did not sign the final verified SPUS for the client's month of service. In addition, SPUSs found in client records did not indicate final costs of delivered services. The data field for these entries always indicated "DELIVERED - $0.00."

As discussed in the Progress Note section of this UR report, Client Record XXXX had no entries for July 2008 and August 2008. Client Record XXXX had no progress note entries for October 2008. Since no care management activity was documented during these months, reimbursed care management and administrative claims for these clients may be subject to recovery.

Recommendations:

The site must conduct training within 60 days of the date of this report to correct SPUS documentation and verification. Incorporate the following TA and provide to CDA-MSSP training curricula, agenda, dated sign-in sheets, and the names of staff who provided the training.

Technical Assistance:

Review and revise site practices with the following sections of the MSSP Site Manual:

- Chapter 3, Sections 3.640 – Care Planning; 3.640.1 – General Guidelines; 3.640.6 – Care Plan Monitoring; 3.640.8 – Changes To The Care Plan; 3.930 – Authorization And Utilization Of Services.
- Chapter 5, Sections 5.800 – Case Documents; 5.810 – Staff Signatures And Signature Requirements.
- Chapter 7, Section 7.220 – Service Planning And Utilization Summary (SPUS).
- Chapter 9, Section 9.100 – Claims Reimbursement/Billing
- Appendix 25 and Form Ap 25 - Service Planning And Utilization Summary; the form shows required data fields.

Corrective Action:

A CAP is required.

IV. B. Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waived Services. MSSP CMs are required to follow service authorization procedures which maximize the use of the informal support system and existing community service delivery systems (including use of the Medi-Cal Treatment Authorization Request [TAR] process) prior to the use of Waived Services.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. C. Vendor Agreement Review

Sites are responsible for arranging for the provision of client services. In addition to the MSSP Site Manual, there are two documents that must be consulted in this regard: the current MSSP Waiver and the individual site contract with CDA. Both the Waiver and the contract set forth policy and procedures which must be followed in structuring the terms and conditions of agreements with local service providers. In the contract, the site agrees to directly provide or arrange for the continuous availability and accessibility of all services identified in each client's care plan. In addition, the site agrees to maintain sufficient written vendor agreements for the following minimum array of Waived Services at all times.

(a) Adult Day Support Center (ADSC) and Adult Day Care (ADC)
(b) Housing Assistance
(c) Domestic Chore and Personal Care Services
(d) Care Management
(e) Respite Care
(f) Transportation
(g) Meal Services
(h) Protective Services
(i) Special Communications

Sites are required to maintain specific information and documents on each vendor of services. Sites must maintain copies of current license and insurance documents, and establish a tickler file or other system to ensure timely updating of this information. The Vendor Record Review Tool can assist sites with maintaining service provider compliance to MSSP requirements.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. QUALITY ASSURANCE ACTIVITIES

Quality assurance (QA) is characterized by a focus on systems, processes and outcomes, rewarding excellence, and working in a collaborative or partnership environment. It is ongoing, with each element continuously informing and supporting

the entire process. Rather than replacing traditional program evaluation activities, quality assurance builds on and integrates them into an organized system.

MSSP sites are required to deliver quality services to clients through the continual demonstration of best practices in clinical care management. Sites will have a written policy describing their QA activities that includes a vision/mission statement, which ensures that staff fully support the mission and specifies the elements employed to secure this vision. QA elements include, but are not restricted to, a process of peer/internal review and a means to solicit client satisfaction with MSSP services.

V. A. Peer/Internal Review

Peer/Internal Review activities focus awareness on care management activities practiced within the program. Driven by the needs and abilities of the care management staff, this review process offers CMs an opportunity to learn from each other through the critical examination of professional practices.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. B. Client Satisfaction

Client Satisfaction Surveys, or other methods of obtaining information regarding client satisfaction, are instrumental to program operation analysis and the provision of quality client services.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. C. Home Visit

A home visit to a client ensures that clients are informed of their rights and receive quality services that meet their needs.

References: MSSP Site Manual and MSSP Contract

Home Visit Summary:

The CDA Nurse Evaluator and site NCM made a home visit to Client XXXX on XXXX, XXXX. The client is a very alert and articulate XX-year old XXXX who lives alone in a two story building. Her medical history includes XXXX, XXXX, pancreatitis, XXXX, XXXX, and XXXX. XXX is a XXXX, XXXX, XXX client dependent for XXXX. The client's XXXX was present during our visit.

The client was sitting up in XXX XXXX in expectation of our arrival. The bedroom was a bit cluttered but clean. The client was wearing XXX XXXX XXXX XXXX and demonstrated XXX ability to use it.

The client stated XXX was aware of XXX rights as a participant in the program. XXX is pleased to be living at home with the services provided through MSSP and is very satisfied with XXX CM. When asked if XXX could think of anything that could make the program better, XXX replied, "More money."

VI. BEST PRACTICES

Best Practices are those processes, policies, procedures and methods of casework that demonstrate exemplary work in the field of care management. Examples of Best Practices include, but are not limited to, administrative processes, the work done within an individual case, and general practices developed and applied to the work of all site care management staff.

VII. SUMMARY

The site is acknowledged for its hospitality and for being receptive to the recommendations made and the TA provided during the UR process. This review team is available to provide continued technical support regarding the findings identified in this report.