



OFFERING A LIFELONG ALLIANCE TO PEOPLE
CROTCHED MOUNTAIN WITH DISABILITIES

April 25, 2012

State of New Hampshire
Department of Health and Human Services
Division of Community Based Care Services
Quality Management
129 Pleasant St.
Concord, NH 03301

To Division of Community Based Care Services:

Crotched Mountain Community Care has revised our Response to Recommendations as requested in the email from Sally Varney dated April 9, 2012.

Please find enclosed CMCC's Response to Recommendations from the Case Management Program Evaluation report dated January 2012.

Sincerely,


Ann Schwartzwalder, LICSW
Program Director

RESPONSE TO RECOMMENDATIONS
Crotched Mountain Community Care
April 25, 2012

CMCC recommendation #1:

CMCC should provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its initial comprehensive assessments to ensure the legal status and community participation of each client are addressed.

Of the 26 charts reviewed (80 charts were eliminated from these 2 review areas due to the date of assessment being before the rule was in effect) for legal status and community involvement, 4 did not meet the standard for documentation of legal status and 3 did not meet the standard for community participation.

CMCC Quality Improvement Plan:

Action taken by CMCC is as follows:

- **Documentation:** add two sections to the formal progress note that is completed every other month following the client visit; legal/financial and family/community/social supports section. This ensures that this area gets addressed not only at the time of the initial assessment but ongoing - **DONE**
- **Supervision:** as part of CMCC's Quality Assurance process, supervisors will review these two areas of the initial assessment and the formal progress notes when reviewing charts and discussing client's during monthly individual supervision – **IN PROCESS**

CMCC recommendation #2:

CMCC should review its policy and practice regarding developing care plans, provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its care plans to ensure that care plans:

1. *contain client-specific, measurable objectives and goals with timeframes*
2. *contain comprehensive contingency plans that address alternative staffing and special evacuation needs.*

1. Of the 105 charts reviewed 85 did not meet standards in this area. These numbers do speak to a problem in the area. As discussed at our exit interview and again with BEAS

and the directors of the care management agencies on March 15, 2012 the development of measurable goals is an area all providers struggle with. There is a need for training across all care management providers and clarity from BEAS at to what exactly is expected here.

CMCC Quality Improvement Plan:

Action CMCC will take after training by BEAS, as requested, of all care management agencies:

- **make the necessary changes to client's care plans**
- **provide ongoing support and monthly individual supervision to our staff in regards to development of the care plans and specifically, measurable goals with time frames**
- **closely monitor our plans of care through supervision and our established QA process.**

2. Of the charts 105 charts reviewed 19 did not meet the standard for documentation of contingency planning addressing alternative staffing and special evacuation needs.

CMCC Quality Improvement Plan:

Action taken by CMCC:

- **developed an emergency assessment completed on every client at the time of assessment - DONE.**
- **add a contingency plan section to our formal progress note completed every two months - DONE**
- **ongoing monitoring of the contingency plans and discussion/training of staff through monthly supervision - ONGOING**

*** please find attached, a copy of our formal progress note format, a copy of our monthly supervision form and a copy of our Emergency Assessment.**

QUALITY ASSURANCE/SUPERVISION REVIEW

Date: _____
Client: _____
Care Manager: _____

1. Is the current care plan adequate to meet the needs of the client? Yes No

Explain: _____

2. Identified Best Practices:

- Excellent collaboration with community and state providers (ie: BEAS, APS) assuring safety and well being of the client
- Excellent communication and problem solving with the client, family and providers
- Creative utilization of resources and available grants/funding sources
- Other _____

3. Identified Deficiencies/Unmet Needs:

- Needed in-home service is unavailable Transportation unavailable for medical needs
- Client/Family non-compliance No access to mental health treatment
- Unsafe Environment No access to appropriate waiver program
- Loss of informal supports
- Other _____

No deficiencies or unmet needs

4. Remedial Action Already Taken or Planned:

- Risk Management meeting with BEAS _____
- Team meeting with client and providers _____

Referral to Adult Protective Services _____

Revising care plan to meet clients needs _____

Explore alternative resources _____

No action required currently _____

Other _____

4. Documentation Review:

Current authorization to release medical information: Yes No

Advanced Directives Form: Yes No Copies: Yes No N/A

Contingency Planning reviewed Yes No Emergency Plan Completed Yes No

Annual reassessment completed Yes No

Every two month visit and call documented Yes No

Initial Assessment – legal status and community participation filled completely Yes No

Legal status and community participation sections completed on formal progress notes Yes No

Plan of Action: _____

No Action Required:

Additional Information Relevant to Supervisory Meeting:

Supervisor: _____

Care Manager: _____

Save New Note

cancel

1. Living Environment/Mobility/Accessibility/Safety:
2. Informal supports: Family/Community/Social Support:
3. Ability for Self Care/ Self Direction:
4. Coping Abilities/ Strengths:
5. Understanding of Medical Condition / Cognitive Changes:
6. Risk for Abuse/Neglect/Exploitation:
7. Satisfied with Current Supports:
8. Transportation / Accompaniment Needs:
9. Back-up/Contingency Plan:
10. Legal/Financial:
11. Other:

Client Goals: (as voiced or expressed by client or legal representative)

- To remain living independently in my own home/community
- In home supports
- Nutrition
- Equipment/Home modification
- Financial/Benefits
- Transportation
- Community Participation
- other _____

CM Plan/Timeframe

GAPS IN SERVICE/
UNMET NEEDS

- None
- Lack of transportation affecting health and safety
- Unsafe Housing
- No access to appropriate waiver program - DD or ABD
- Other _____
- No provider available
- Loss of informal supports
- No Physician
- No access to mental health services

EMERGENCY ASSESSMENT

Client Name: _____ Date: _____

CM: _____

TOWN: _____ Street Address: _____

Phone: _____

Lives: __ *alone* __ with family/friends __ Senior Housing __ Res Care/Assisted Liv**Emergency Contact(s):** _____**Phone:** _____ Emergency Response System: _____ When is it worn: _____ Submitted Supplemental Automatic Location Information (S-ALI for NH 911) Pets _____ Back-up caregiver and phone if needed: _____Personal/Medical Emergency Updated medical & Rx info on: _____ 'fridge _____ Wallet Availability of key for Emergency (optional) _____ City/Municipal Housing Housing Management: _____ Lock Box with Key _____ Neighbor: _____

Personal plan:

○ _____

Fire Emergency Familiar with fire safety procedures _____

Extinguisher _____ Updated? _____ Know how to use? _____

 Oxygen _____ Fire Dept alerted to use of Oxygen/tanks? _____ Gas/kerosene _____ Fire exit plan _____ Barriers to exiting in an emergency: _____ Smoke detectors/ carbon monoxide detectors _____

Client Name: _____

Storm/Electrical Loss

- Phone (hard wire or cable?) _____
- Cell phone: Y N Kept charged? ____ Need one that can only dial 911? ____
- Generator (Has it been inspected?) _____
- Alternative heat source/ Is it safe? _____
- Medical equipment that requires electricity (including oxygen) _____
- Utility phone and electricity PRIORITY need notification (Note from MD for Priority re-connect/call then Mail to utility) _____
- Do you have the recommended 3 day supply of food, water, medication to shelter in place? _____
- If weather prevents your worker from getting to you, what is your back-up plan?

Disaster/Evacuation

- Transportation options: _____
- Place (s) to go _____
- Seabrook Power Plant Evacuation form (Seacoast area only) submitted (date)
_____ (_____)
- Do family/neighbors/friends know your plan? _____
- Do you have a dedicated support person who will evacuate you? (Who is nearby?)
_____ (_____)
- Medical equipment needed/location:

- Medication needed/location: _____