



State of New Hampshire
Department of Health and Human Services
Division of Community Based Care Services
Bureau of Elderly and Adult Services

SFY 2011 Case Management
Program Evaluation

Pilot Health, LLC

April 2011

Prepared by:

Division of Community Based Care Services
Quality Management

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Executive Summary

The Division of Community Based Care Services (DCBCS,) in its commitment to the principles and activities of quality management established a division wide quality management philosophy and infrastructure which included a Quality Leadership Team, facilitated by the Deputy Director, and which is comprised of representatives from the DCBCS bureaus. A number of performance indicators were identified that address either system performance, safety, participant safeguards, participant outcomes and satisfaction, provider capacity, or effectiveness.

One of these performance indicators was to perform annual site visits of the independent case management agencies for the purposes of assuring that the home and community based care elderly and chronically ill waiver program participants' service plans were appropriate, person-centered, that the delivery of services was timely and that the case management agencies had the capacity and capability to deliver or access the services identified in the participants' service plans. This task was subsequently included in the 2007 application for the Home and Community Based Care – Elderly and Chronically Ill waiver as a component of the quality management section of the waiver and is identified as a performance measure for several quality management assurances.

The first annual program evaluation reviews for the five independent case management agencies were completed in May and June of 2009 and were based on the Targeted Case Management Services rule, He-E 805, which was adopted effective August 26, 2008. Program evaluation protocol and a review instrument were developed by a committee that included BEAS staff and which were shared and discussed with the five licensed case management agencies that served participants in the HCBC-ECI waiver program, also known as the Choices for Independence (CFI) program.

The 2009 program evaluation focused on the required case management services of (1) developing a comprehensive assessment, (2) developing a comprehensive care plan and (3) monitoring the services provided to the Elderly and Chronically Ill waiver program participants. A sample of cases was reviewed by a team comprised of staff from the Bureau of Elderly and Adult Services (BEAS) state office, the DCBCS Quality Leadership Team and BEAS Adult Protective Services field staff. The sample size for each agency was determined through the use of a statistical program used by the Bureau of Behavioral Health in its annual eligibility and quality assurance reviews.

Each case management agency received a report that included the results for each of the 38 questions and, when applicable, recommendations for improvement. The agencies were required to submit a quality improvement plan that addressed each recommendation within sixty days of the receipt of its program evaluation report.

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BEAS also committed itself to its own quality improvement activity by reviewing the 2009 case management program evaluation process, protocol and review instrument. The results were a reduced number of questions from 38 to 21, the use of a statistical application recommended by the National Quality Enterprise¹ consultants that identified a representative statewide sample for the SFY 2011 program evaluation, and the decision not to rate the timeliness and quality of initial assessments and initial care plans for those cases opened prior to the adoption of the rule, i.e., August 26, 2008, for the SFY 2011 program evaluations.

The protocol and instrument included a four point rating scale, as indicated below:

0	Not applicable, e.g., activity occurred prior to effective date of applicable rule
1	Does not meet minimal expectations, e.g., documentation is missing
2	Meets minimal expectations as established and described in rule
3	Exceeds minimal expectations, i.e., example of best practice

The goal for the initial case management program evaluation was to complete an evaluation on all five of the case management agencies within a few weeks in order to establish a baseline for each agency and for case management for the CFI waiver program as a whole. Going forward, it is anticipated that a complete case management program evaluation will be held annually with each agency that provides case management services to CFI participants. It is anticipated the program evaluation protocols will expand to address additional components of the Targeted Case Management rule, include other pertinent questions and a financial component. These are the goals of the 2010-2011 BEAS Case Management Program Evaluation scheduled bi-monthly from September 2010 through April 2011.

¹ The National Home and Community-Based Services Quality Enterprise (NQE) provides technical assistance on quality to state Medicaid home and community-based services programs (HCBS) and to federal government staff responsible for overseeing these programs.

The NQE is funded by the Centers for Medicare and Medicaid Services (CMS.) under a grant to the Healthcare Business of Thomson Reuters. Professionals from Thomson Reuters and the Human Services Research Institute staff the NQE, along with consultants from other organizations.

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Scope and Methodology

A report of participants in the Choices for Independence program as of the end of February 2011 was run which included cases that had been open for at least six months to allow time for a comprehensive assessment, a comprehensive case plan and for services to have been provided for at least a few months. Cases that were closed but had been closed for six months or less as of the end of February 2011 were also included.

A statistical application was used to identify a randomized and representative statewide sample that would yield a 5% confidence interval at the 95% confidence level. A proportionate sample was identified for each case management agency based on the statewide sample. See chart below:

	<u>CFI population</u> (as of the end of Feb. '11)	<u>Statewide</u> representative sample (5% confidence interval; 95% confidence level)	<u>Proportionate</u> sample of Pilot Health cases
Pilot Health (PH)	282		40 (Sample = 38; PH requested that 2 additional cases be reviewed)
Total population	2500	333	

The list of cases was distributed to Pilot Health approximately three weeks prior to its scheduled state fiscal year 2011 case management program evaluation. The program evaluation began with a brief meeting that included introductions, review of the evaluation schedule and an introduction to Pilot Health’s case record documentation system.

The program evaluation was completed within a week which included an exit meeting where reviewers’ observations regarding the cases they reviewed were shared along with informal consultation regarding the agency’s documentation system and case practice. The exit meeting included Pilot Health’s administrative team.

The program evaluation instrument was based on the three sections of the Targeted Case Management rule, i.e., He-E 805, as discussed in the Executive Summary. The program evaluation process, as was emphasized, is a quality management / quality improvement process with the expectation that each agency would produce a quality improvement plan that includes “the remedial action taken and/or planned including the date(s) action was taken or will be taken.”²

² He-M 805.10(b)(4)

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Findings and Observations

Preliminary observations were shared with Pilot Health at the exit meeting held at the end of the program evaluation.

It was not possible to have gathered and assessed the data from all the case reviews for the exit meeting; the observations shared with the agency staff were a result of the daily and final wrap-up conversations with the program evaluation reviewers.

The ratings for each of the 20³ questions are presented within the appropriate section of the report. Four questions⁴ were rated for timeliness with one rated for both timeliness and quality (question #22) for a grand total of 21 ratings for each of the 40 cases.

Below are two charts that illustrate the rating results with the majority of questions (64%) (540) being rated as meeting minimal expectations (rating of “2”), regarding the items in the He-E 805 Targeted Case Management rule. Nine percent (76), of the total questions were rated as not meeting minimal expectations (rating of “1”), e.g., documentation is incomplete. Zero percent (0) of the total questions were rated as exceeding minimal expectations (rating of “3”), e.g. best practice.

total # of "0" ratings		224
total # of "1" ratings		76
total # of "2" ratings		540
total # of "3" ratings		0
Total		840

percent of "0" ratings		27%
percent of "1" ratings		9%
percent of "2" ratings		64%
percent of "3" ratings		0%
Total		100%

³ The Case Management Program Evaluation instrument was revised with several questions combined for a total of 21 questions for SFY 2011; there were 38 questions in the CY 2009's program evaluations.

⁴ Questions #1, 11, 19 and 22.

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Two questions addressing timeliness were rated as zero, indicating not applicable, when the items in question were developed prior to the August 2008 adoption of the Targeted Case Management Rule, He-E 805, and thus could not legitimately be rated. Ratings of zero were recorded for the following questions when a Choices for Independence case was opened prior to August 2008:

#	BEAS Case Management Program Evaluation
1	Comprehensive Assessment is conducted within 15 working days of assignment
11	Initial Care Plan is developed within 20 working days of assignment

The majority (22 or 55%) of the 40 cases reviewed were opened prior to the adoption of the He-E 805 rule with 18 (45%) opened after the adoption of the rule.

A zero rating was recorded for questions related to the initial comprehensive assessment (#2-9) for cases opened prior to August 2008. Question #19⁵ was rated as zero for cases open less than one year at the time of the review; there were three.

The team leader recorded a zero rating when it was impossible to determine the reviewer’s intent when an item was not rated or the rating appeared to be grossly inconsistent with ratings on related questions.

Reviewers were encouraged to include explanatory and helpful comments as they reviewed the cases; a table of their comments, categorized as indicators of “challenges/concerns” and “positive practices” are included in the appendix of this report.

Comparison with CY 2009 Program Evaluation

The June 2009 Pilot Health program evaluation results were similar to the April 2011 program evaluation results except for the number of questions, which is explained below, and percent of “0” ratings which, of course, effected the other ratings.

	CY 09	SFY 11
count of 0 ratings	328	224
count of 1 ratings	226	76
count of 2 ratings	2382	540
count of 3 ratings	102	0
totals	3038	840

⁵ Question #19: Care is updated

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	CY 09	SFY 11
% of 0 ratings	11%	27%
% of 1 ratings	7%	9%
% of 2 ratings	78%	64%
% of 3 ratings	3%	0%
totals	100%	100%

The CY 09 program evaluation reviewed 62 cases; the SFY 11 program evaluation sample was 40 cases.

The CY 09 program evaluation included 39 questions; the SFY 11 program evaluation included 21 questions by combining related questions and eliminating others that were determined not to be necessary.

The CY 09 program evaluation included 11 questions that were rated for both timeliness and quality (#19, 20, 21, 29, 30, 31, 33, 35, 36, 37, 38); the SFY 11 program evaluation included 1 question that rated both timeliness and quality (# 22).

The change in the SFY 11 program evaluation to not rate the comprehensive assessment questions (#1, 2, 3, 4, 5, 6, 7, 8 and 9) when cases were opened before the approval of the Targeted Case Management rule (He-E 805) resulted in more questions rated as zero and fewer rated as two.

The SFY 11 questions included five that were a combination of two or more questions from the CY 09 program evaluation and seven that were removed. See the appendix for the SFY 2011 program evaluation instrument.

	SFY 2011
1	Same question as CY 09
2	Same
3	Same
4	Same
5	Same
6	Same
7	Same
8	Same
9	Combined with #10
10	See #9
11	Same
12	Removed
13	Same
14	Combined with #15 and #33
15	See #14

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	SFY 2011
16	Combined with #17
17	See #16
18	Same
19	Same
20	See #24
21	See #22
22	Combined with #21, 23, 32 and 38
23	See #21
24	Combined with # 20, 27 and 35
25	Same
26	Removed
27	See #24
28	Misnumbering; no #28
29	Same
30	Same
31	Removed
32	See #22
33	See #14
34	Removed
35	See #24
36	Removed
37	Removed
38	See #22
39	Removed

The SFY 2011 program evaluation included a review of the status of each agency's recommendations from its CY 2009 program evaluation and of the agency's policies and practices regarding BEAS state registry regulations.⁶

Recommendations

Based on the ratings and reviewer observations and comments, there are two recommendations made for Pilot Health to address in its quality improvement plan.

Comprehensive Assessment (questions #1-9)

The protocol the reviewers followed was to rate all the questions in this section only if the cases were opened on or after the rule was adopted in late August 2008.

⁶ He-E 805.04(c): Case management agencies shall establish and maintain agency written policies and procedures regarding the following areas, and shall ensure that they are properly followed and enforced: (2) a process for confirming that each employee is not on the BEAS state registry established pursuant to RSA 161-F:49.

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This section assessed the timeliness of completing the initial comprehensive assessment (question #1) and whether each required section was adequately addressed. The comprehensive assessment is required to address a client’s biopsychosocial history (#2), functional ability (#3), living environment (#4), social environment (#5) self-awareness (#6), assessment of risk (#7), legal status (#8) and community participation (#9).

Pilot Health’s *Initial Intake* instrument’s content meets the requirement of He-E 805 though some sections could be enhanced as is explained further on in this section. The majority was complete and well done.

	Questions								
	1	2	3	4	5	6	7	8	9
count of (0) ratings	22	22	22	22	22	22	22	22	22
count of (1) ratings	3	1	5	0	9	0	0	0	10
count of (2) ratings	15	17	13	18	9	18	18	18	8
count of (3) ratings	0	0	0	0	0	0	0	0	0
Total	40	40	40	40	40	40	40	40	40

The questions of concern are questions #5 and #9.

The ratings for question #5⁷ were such that 9, or 23%, were rated as “1”, not meeting minimal standards. Though family members or friends were sometimes mentioned, the quality of the relationships was usually not discussed and neither were clients’ activities, avocational and spiritual interests as well.

The ratings for the community participation question (#9)⁸ were that ten records, or 25%, were rated as “1”, not meeting minimal standards. The components of community participation, as described in the rule, are included in several section of Pilot Health’s *Initial Intake* form but often little to nothing was documented.

Pilot Health is encouraged to review the reviewer comments that identify some challenges and some positive practices relative to the comprehensive assessment section.

⁷ Question #5: Social environment, including social/information relationships, supports, activities, avocational & spiritual interests.

⁸ Question #9: Community participation including the client’s need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her life.

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Pilot Health Recommendation #1

Pilot Health should provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its initial comprehensive assessments to ensure that clients' social environments and their community participation are comprehensively assessed.

Development of Care Plan (questions #11-19)

	Questions									
	#10 addressed in #9	11	#12 removed	13	14	#15 addressed in #14	16	#17 addressed in #16	18	19
count of (0) ratings		22		1	0		0		0	3
count of (1) ratings		3		16	7		3		15	3
count of (2) ratings		15		23	33		37		25	34
count of (3) ratings		0		0	0		0		0	0
Total		40		40	40		40		40	40

This section addressed:

- the timeliness of developing the initial (#11) and annual care plans (#19),
- whether care plans included client-specific measurable objectives and goals with timeframes (#13),
- whether care plans contained all the services and supports needed (#14),
- whether care plans addressed mitigating any risks for abuse, neglect, self-neglect and exploitation (#16), and
- whether care plans included contingency planning (#18).

Reviewers rated questions #13 through #18 based on the most current care plan which would be the initial care plan for cases opened less than a year or the most recent annually updated care plan for cases opened a year or more.

This section of questions proved to be the most challenging for Pilot Health particularly questions #13, and #18 with some concerns regarding question #14.

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- Forty percent (16) of the cases for question #13 were rated as one, does not meet minimal expectations, with fifty-eight percent (23) of the cases rated as two, meets minimal expectations.
- Eighteen percent (7) of the cases for question #14 were rated as one, with eighty-three percent (33) of the cases rated as two;
- Thirty eight percent (15) of the cases for question #18 were rated as not meeting minimal expectations, with sixty-three percent (25) of the cases rated as meeting minimal expectations.

These results demonstrate a need for Pilot Health to focus on case plan development.

The Reviewer Comments' section includes many comments relative to the cases reviewed and, though there were some care plans that provided evidence of positive practices relative to measurable, client-specific objectives and goals with timeframes (question #13), most care plans were deficient in either one or more of these components.

A practice that Pilot Health should consider improving is listing generic goals, such as "will have needs adequately met" and "health and welfare will not be jeopardized", with one-year time frames, i.e., "stop date" on "Case Management Plan". If, however, goals such as these also included specific objectives with distinct timeframes, the case plan would be adequate and would meet the intent of the rule.

Question #14 assesses whether care plans contain all the services and supports necessary to meet clients' needs, identify their funding sources and include all non-paid services. The case records reviewed indicated some services were not included on the case plans though there was evidence in progress notes of services being in place and/or full details were not included such as frequency of services and funding sources.

Question #16's results were good with only 8% (3 cases) of the care plans either did not address areas of risk identified in progress notes or evidence was lacking of the assessment of potential areas of risk. Pilot Health has an excellent format for its *Monthly Notes* in which outcomes are identified, updated and current risk status is assessed. One of the outcomes preprinted on the *Monthly Note* form is "will be free from abuse/neglect/exploitation" which provides the opportunity for consistent assessment.

Question #18's⁹ results were such that 38%, or 15 cases, had inadequate contingency planning as, in a number of cases, both alternative staffing and evacuation needs and plans were not addressed

⁹ Question 18: Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs.

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Pilot Health is encouraged to read the Reviewer’s Comments’ section for examples of both good practice and practice that is in need of improvement. The number of cases in which a comment was pertinent was provided.

Pilot Health Recommendation #2:

Pilot Health 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 all care plans:

1. contain client-specific, measurable objectives and goals with timeframes;
2. contain all services and supports and their funding sources; and
3. contain complete contingency plans.

Since Pilot Health has demonstrated only slight improvement from the 2009 Program Evaluation¹⁰ regarding question #13, it is expected to enhance its monitoring of clients’ care plans to ensure that they meet the criteria addressed in He-E 805.05(c) through its quality management record review process as described in He-E 805.10.

III. Monitoring and Evaluation of the Care Plan (questions #22-25)

	Questions						
	#20 addressed in #24	#21 addressed in #22	22T	22Q			
count of (0) ratings			0	0		0	0
count of (1) ratings			0	0		0	1
count of (2) ratings			40	40		40	39
count of (3) ratings			0	0		0	0
Total			40	40		40	40

Reviewers rated contact and progress notes during the period under review, January 2010 – February 2011, but focused primarily on the most current six months, i.e., September 2010 through early February 2011.

This section included three questions, one of which has two parts (#22):

- the timeliness (#22T) and adequacy of contacts with clients, providers and/or family members (#22Q);
- whether services were adequate, appropriate and provided (#24); and

¹⁰ Question #13 results were 21% rated as not meeting expectations in 2009 and 40% in 2011.

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- whether there was evidence that the client was actively engaged in his/her care plan and the case manager was making efforts to engage his/her client (#25).

This section is a definite strength for Pilot Health as its performance on the three questions was:

- #22T: 100% met expectations (rating of “2”)
- #22Q: 100% met expectations
- #24: 100% met expectations, and
- #25: 98% met expectations.

There are no recommendations for Pilot Health regarding the monitoring and evaluation of the care plan section of the program evaluation.

IV. Provider Agency Requirements/Individual Case Record (questions # 29-30)

	Questions				
	#26 removed	#27 addressed in #24	#28 error in numbering	29	30
count of (0) ratings				0	0
count of (1) ratings				0	0
count of (2) ratings				40	40
count of (3) ratings				0	0
Total				40	40

This section included the following two questions:

- #29: Face sheet is current and minimally includes client’s name, date of birth, address, Medicaid number, emergency contact information including phone number and address; and
- #30: A copy of the current Medical Eligibility Determination (MED) needs list/support plan is in the case record.

The reviewers recognized that obtaining a copy of the current MED from BEAS was not always a timely process so the question was not rated as deficient if the current MED was not in a case record.

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This section is also a strength for Pilot Health as expectations were met for both questions in this section for all cases.

There are no recommendations for Pilot Health regarding the case record requirement section of the program evaluation.

Quality Management and State Registry

Pilot Health had three recommendations as a result of its CY 2009 Program Evaluation, one of which was a suggested recommendation. The two recommendations were:

1. enhance its monitoring of each case manager's care plan development to ensure that:
 - a. care plans contain client-specific, measurable objectives with timeframes,
 - b. care plans contain all the services and supports necessary to address clients' needs and goals,
 - c. care plans contain adequate and appropriate contingency planning, and
 - d. care plans are comprehensively reviewed and updated on, at minimum, an annual basis to assure that the status of all a client's needs, goals and objectives are assessed, addressed and updated as needed.
2. work with the Division of Family Assistance to establish a process that provides clients' Medicaid financial eligibility information (question #31) including cost shares;

Suggested Recommendations

3. Pilot Health is encouraged to consider documenting their clients' Medicaid redetermination status such as redetermination dates and Medicare Part D statuses, Part D enrollment due dates and current Part D plans.

Regarding recommendation #1, Pilot Health's quality management process includes reviewing case records to determine if services were provided according to the case plans.

Pilot Health created and implemented a *Functional Assessment/Acuity Tool* that assesses an individual's capabilities related to Adult Daily Living (ADL) skills and Independent Adult Daily Living (IADL) skills. Pilot Health also clarified that the agency's policy is that care plans are reviewed at least annually.

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Suggested recommendation #3 is not a current issue as the department is in the process of enhancing the linkages between two databases, i.e., Options and New Heights to facilitate access to needed information.

BEAS asked Pilot Health about its policy and procedures regarding submitting the names of new staff to the BEAS State Registry; Pilot Health provided a copy of its *Pilot Health, LLC Orientation Checklist* which includes whether a registry report had been returned to the agency and provided a copy of a statement each new employee signs that affirms that he/she has never pled guilty to or been found guilty of abuse, neglect or exploitation.

Conclusions / Next Steps

DCBCS and BEAS appreciate the opportunity to visit the Pilot Health, LLC agency and to gather information through a review of a number of the agency's case records. DCBCS and BEAS acknowledge that by hosting this program evaluation, Pilot Health spent valuable work time gathering case records, being accessible for questions, and attending the initial and exit meetings with the program evaluation team. Pilot Health staff were very gracious and accommodating.

The 2010/2011 program evaluation is the second designed to review the Targeted Case Management rule, He-E 805, and proved to be another valuable exercise as DCBCS and BEAS continue to work internally and with their stakeholders to improve the quality of the Choices for Independence waiver program and to successfully meet the assurances and subassurances required by the Center for Medicare and Medicaid Services (CMS) of its home and community based care waiver programs for the elderly and chronically ill.¹¹

Pilot Health, LLC is expected to develop a quality improvement plan that includes the remedial action taken and/or planned including the date(s) action was taken or will be taken. The quality improvement plan should be submitted to DCBCS Quality Management at 129 Pleasant Street, Concord NH 03301 within sixty days of the receipt of this report.

¹¹ See the Appendix for the list of CMS Waiver Assurances and Subassurances

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Appendices

Case Management Program Evaluation – Review Instrument

Reviewers' Comments / Observations

CMS (1915c) Waiver Assurances and Subassurances

Abbreviations

Separate Attachment

List of sample cases reviewed and ratings

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**Case Management Program Evaluation – Review Instrument
Face Sheet**

Case Management Agency

Name:
Address:
City/town:

Participant Name

First: Middle initial Last:

Participant (current) Living Arrangement

- own home
- adult family home
- assisted living facility (name of facility):
Check if client resides in one of these facilities: Meeting House Whitaker Place Summercrest
- congregate housing
- hospital (name of hospital):
- nursing facility (name of facility):
- residential care facility (name of facility):
- other:

Case Information

Participant's Medicaid #:
Participant's date-of-birth:
Participant's (current) Case Manager:
Date of referral to Case Management agency:
Date Case Management case closed:
Reason for case closure:

Program Evaluation Information:

Period under review (from previous annual program evaluation to date of current evaluation): to
Date of Review:
Reviewer First: Last: Agency / Position:

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Findings / Ratings (enter # in white (un-filled) boxes)	
1	does not meet minimal expectations, e.g., documentation is missing
2	meets minimal expectations as established in rules
3	exceeds minimal expectations, i.e., example of best practice
0	does not apply

Rule References He-E 805 [He-E 801 He-E 819]		Requirement / Topic	Timeliness	Quality / appropriateness	Comments (required for ratings of #1 and #3)
805.05(b)		I. Comprehensive Assessment (builds on MED, needs list, support plan)			
805.05(b)	1	Comprehensive assessment is conducted within 15 working days of assignment Include date comprehensive assessment completed.	<input type="checkbox"/>		
805.02(b) and 805.05(b)(2)(a)	2	Biopsychosocial history that addresses: <ul style="list-style-type: none"> • Physical health • Psychological health • Decision-making ability • Social environment (addressed in question #5) • Family relationships • Financial considerations • Employment • Avocational interests, activities, including spiritual • Any other area of significance in the participant's life (substance abuse, behavioral health, development disability, and legal systems) 		<input type="checkbox"/>	
805.05(b)(2)(b)	3	Functional ability including ADLs and IADLs		<input type="checkbox"/>	
805.05(b)(2)(c)	4	Living environment including participant's in-home mobility, accessibility, safety		<input type="checkbox"/>	

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Rule References He-E 805 [He-E 801 He-E 819]		Requirement / Topic	Timeliness	Quality / appropriateness	Comments (required for ratings of #1 and #3)
805.05(b)(2)(d)	5	Social environment including social/informal relationships, supports, activities, avocational & spiritual interests		<input type="checkbox"/>	
805.05(b)(2)(e)	6	Self-awareness including whether participant is aware of his/her medical condition(s), treatment(s), medication(s)		<input type="checkbox"/>	
805.05(b)(2)(f)	7	Risk including potential for abuse, neglect or exploitation by self or others; identify whether a separate Risk Assessment has been completed		<input type="checkbox"/>	
805.05(b)(2)(g)	8	Legal status including guardianship, legal system involvement, advance directives such as DPOA		<input type="checkbox"/>	
805.05(b)(2)(h)(i)	9 (and 10)	Community participation including the client's need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her life.		<input type="checkbox"/>	
805.05(c)		II. Development of Care Plan			
805.05(c)	11	Initial Care Plan is developed within 20 working days of assignment	<input type="checkbox"/>		
805.05(c)(1)	12	<ul style="list-style-type: none"> ▪ Removed. 			
805.05(c)(2)	13	<ul style="list-style-type: none"> ▪ contains client-specific measurable objectives and goals with timeframes [review most current care plan] 		<input type="checkbox"/>	

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Rule References He-E 805 [He-E 801 He-E 819]	Requirement / Topic	Timeliness	Quality / appropriateness	Comments (required for ratings of #1 and #3)	
805.05(c)(3)(a),(b) and (c) and 10-25 GM 5.14.10, and 10-30 GM 7.16.10, and 10-34 GM 7.30.10 ¹²	14 (and 15 and 33)	<ul style="list-style-type: none"> ▪ contains all the services and supports based on the clients' needs in order to remain in the community and as identified in the comprehensive assessment and MED ▪ paid¹³ services (identify) <ul style="list-style-type: none"> b) non-paid services (identify) c) enrolled in Medicare, Part D, if appropriate <p><i>(continued on next page)</i></p> <ul style="list-style-type: none"> d) maximize approved Medicaid state plan services before utilizing waiver services e) identify unfulfilled needs and gaps in services f) if pertinent, has there been consultation with an agency (community mental health center, area agency, etc) regarding diagnosis and treatment <p>[evaluate most current care plan]</p>		<input type="checkbox"/>	
805.05(c)(3)(d) and (e)	16 (and 17)	<p>Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s)</p> <p>Issues identified via sentinel event reporting:</p> <ul style="list-style-type: none"> • clients smoking while on oxygen • abuse (assaults) • medication abuse <p>[evaluate most current care plan]</p>		<input type="checkbox"/>	

¹² Ensure that homemaker services (HCSP) are not actually personal care (HHCP) and that spouses are not providers

¹³ Includes all paid services to be provided under Medicaid, including Medicaid state plan services, or other funding sources.

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Rule References He-E 805 [He-E 801 He-E 819]	Requirement / Topic	Timeliness	Quality / appropriateness	Comments (required for ratings of #1 and #3)
805.05(c)(3)(f), 805.02(l)	18 Contingency plan; the plan that addresses unexpected situations that could jeopardize the client’s health or welfare, and which: <ul style="list-style-type: none"> identifies alternative staffing addresses special evacuation needs) 		<input type="checkbox"/>	
805.05(c)(4)(a) and, 10-17 GM 4.14.10 ¹⁴	19 Care Plan is updated: <ul style="list-style-type: none"> annually, and in conjunction with annual MED redetermination [evaluate most current care plan]		<input type="checkbox"/>	Date of care plan reviewed:
805.05(d)	III. Monitoring and Evaluation of Care Plan ¹⁵			
805.05(d)(1)(a) and (b) 2009 CM Program Evaluation Summary Report	22 (and 21, 23, 32 and 38) No less than one monthly telephone contact and one face-to-face contact every 60 days. <i>(continue on next page)</i> Contacts notes with the client, other providers, and/or family members, should be frequent enough to adequately address the client’s needs including readiness for annual Medicaid redetermination; location and type of contact (phone, face-face) should be specified. Describe frequency of contacts and with whom.	<input type="checkbox"/>	<input type="checkbox"/>	
805.05(d)(2); and 805.04(f)(7) 10-25 GM 5.14.10 ¹⁶	24 (and 20, 27 and 35) Services are adequate, appropriate, provided as evidenced by: <ul style="list-style-type: none"> CM agency Care Plan (see ques. #14, 16, 18, 19) CM agency contact notes required for each client Progress notes that reflect areas contained in the care 		<input type="checkbox"/>	

¹⁴ Annual redetermination of medical eligibility for the CFI program includes review of the client’s needs and process to authorize services

¹⁵Current terminology: MED process includes development of “service plans” by BEAS Long Term Care Nurse; Case Management agencies develop “care plans”

¹⁶ Per 10-25 GM 5.14.10 (05/14/10): CM must “document types and amount of: home health services, personal care, physical care, physical therapy, occupational therapy, speech therapy, adult medical day, private duty nursing

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Rule References He-E 805 [He-E 801 He-E 819]		Requirement / Topic	Timeliness	Quality / appropriateness	Comments (required for ratings of #1 and #3)
		plan, including authorizations for new or changed services			
805.05(d)(3)	25	Participant is actively engaged in care plan – and case manager is making adequate and appropriate efforts to engage the participant (see contact and progress notes, e-mails and correspondence with clients and providers, notes re case specific meetings with providers)		<input type="checkbox"/>	
805.05(d)(4)	26	Removed			
	28	Instrument misnumbered with #28 overlooked			
805.04		Provider Agency Requirements			
805.04(f) 10-25 GM 5.14.10		IV. Case management agencies shall maintain an individual case record which includes:			
805.04(f)(1)	29	Face sheet including current (updated annually with the Care Plan and MED (see #19)) demographic and other information: name, DOB, address, Medicaid #, emergency contact person, phone number, address.		<input type="checkbox"/>	
805.04(f)(2)	n/a	Comprehensive assessment (see 805.05(b))			
805.04(f)(3)	n/a	Care plan (see 805.05(c))			
805.04(f)(4)	30	Current MED needs list/support plan		<input type="checkbox"/>	
805.04(f)(5)	31	Removed			
805.04(f)(6)	34	Removed			
805.04(f)(8)		Contact notes (see 805.05(d)(1))			
Info only	36	Removed.			
Info only	37	Removed			
805.04(f)(10)	39	Removed			

Total questions: 21

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General Observations

Include observations pertinent to the case reviewed that have not otherwise been captured by the questionnaire and that would be useful to record as evidence of best practice and/or evidence of challenges to providing effective, appropriate and quality care.

Program Evaluation Completed: Date:
Name:

Quality Management

Program Evaluation Reviewed: Date:
Name:

Original Filed: DCBCS Quality Management
Copy Filed: BEAS Quality Management

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BEAS Case Management Program Evaluation: Reviewers Comments / Observations
Pilot Health, LLC April 11 – April 14, 2011

Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
I. Comprehensive Assessment			
1	Comprehensive assessment is conducted within 15 working days	<ul style="list-style-type: none"> ▪ Initial assessment was not dated nor was their a progress note to indicate when the assessment was completed ▪ Initial intake completed 2 months from date of referral (2008) and very brief ▪ All areas are addressed but not comprehensively 	
2	Biopsychosocial history	<ul style="list-style-type: none"> ▪ Very limited information; comprehensive biopsychosocial history not provided ▪ Each section addressed with one sentence only ▪ Avocational interests, activities, spiritual not addressed (2) ▪ Most areas minimally addressed 	<ul style="list-style-type: none"> ▪ Very informative
3	Functional ability, including ADLs and IADLs	<ul style="list-style-type: none"> ▪ Not addressed (2) ▪ Incomplete; not all ADLs assessed 	
4	Living environment		
5	Social environment	<ul style="list-style-type: none"> ▪ Client’s socialization needs and identification of relationships not addressed ▪ Not addressed (6) ▪ Mentions client has friends and/or relatives but social environment not assessed (2) 	

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
6	Self-awareness		
7	Risk, including potential for abuse, neglect or exploitation by self or others		<ul style="list-style-type: none"> Well documented
8	Legal status		
9	Community participation	<ul style="list-style-type: none"> Not addressed in initial, comprehensive assessment (8) Only addressed how client accesses transportation (1) 	<ul style="list-style-type: none"> well documented <ul style="list-style-type: none"> client enjoys playing cribbage and bowling; goes on group excursions several times/year
10	Address in #9		
II. Development of Care Plan			
11	Initial Care plan is developed within 20 working days of assignment	<ul style="list-style-type: none"> initial care plan developed within 40 days initial care plan (2010) not in chart and could not be located by agency 	
12	Removed		
13	Care plan contains measurable objectives and goals with timeframes	<ul style="list-style-type: none"> goals are generic and not client-specific (10) <ul style="list-style-type: none"> goal that client “wants to get healthier” does not include client-specific objectives goal: health & welfare will not be jeopardized goal: will have service needs met no goal regarding managing diabetes and other medical conditions client had goal to lose weight; not included on care plan 	<ul style="list-style-type: none"> “one of the best, includes client-specific goals & interventions” has both short-term and long-term goals (1) case manager worked with client regarding some needs client not willing to address well documented; included language barrier (Spanish) and education regarding services available goals are client-specific, e.g., “needs safe, secure entrance to home”

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
		<ul style="list-style-type: none"> ▪ difficult to determine what current problems/goals are; no short-term goals/objectives identified ▪ issues in progress notes not included in care plan, i.e.: <ul style="list-style-type: none"> ○ client depressed, abusing alcohol; suffered recent loss of brother ○ client needs transportation to AA meetings ○ client managing macular degeneration ○ client requested hoyer life ▪ no measurable objectives ▪ goal of obtaining dental care but no timeframe ▪ goal to obtain power chair could have been included as short-term goal ▪ goals did not change despite requesting increased services (1) ▪ all goals have 1-year timeframes; no short-term goals identified (4) ▪ MED mentions client's medical condition but nothing included on care plan (has tumor, scheduled for surgery) ▪ Changes in residence and health status not addressed (1) 	
14 (and	Care plan contains all the services and supports based on the participants' needs in order to remain in the	<ul style="list-style-type: none"> • Did not include case management on the care plan (6) or mental 	<ul style="list-style-type: none"> • Includes paid and unpaid services (2)

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
15 and 33)	community and as identified in the comprehensive assessment and MED a) Paid services (identify) b) Non-paid services (identify) c) Enrolled in Medicare, Part D, if appropriate d) Maximize approved Medicaid state plan services e) Identify unfulfilled needs and gaps in services f) Consultation re diagnosis and treatment, if pertinent	<p>health services (2); both services are evident per progress notes</p> <ul style="list-style-type: none"> • Does not include that client's friends and family assist him as unpaid providers of transportation and housework • Frequency of services and funding not documented • Does not include non-paid services (6); does not include non-Medicaid services (2) • Family and services they provide not included as non-paid services (4) • Client sees psychiatric nurse; not included on care plan • Client mentioned needing Meals-on-Wheels 5x/week; not included in care plan • Services listed (RN, HHA, HMKR) but not what they are addressing 	
15	Addressed in #14		
16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s)	<ul style="list-style-type: none"> ▪ Progress notes always rate risk; indicated case manager was considering making report to Adult Protective Services regarding husband's behavior but no further documentation ▪ Client lives with daughter who is 	<ul style="list-style-type: none"> • well documented (3) • referral to Adult Protective Services re self-neglect; is reflected on Case Management Plan <i>Abuse Risk</i> section

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
		<p>disabled and is able to care for her mother; assessment regarding the daughter's ability to take care of her mother is desirable as mother very vulnerable due to age, Alzheimer's and failing health</p> <ul style="list-style-type: none"> ▪ Risk of client's smoking while using oxygen not addressed 	
17	Addressed in #16		
18	Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs	<ul style="list-style-type: none"> • plan states that client "would have great difficulty evacuating the facility by herself" but does not specify what is needed to safely evacuate client • client wheelchair bound, no indication of who would assist/ how client could evacuate • evacuation plan but alternative staff not addressed (4) • client needs assistance in emergency but no plan (4) • alternative staffing not addressed (8) • client's wheelchair does not fit through door; no plan to address 	<ul style="list-style-type: none"> ▪ well documented (6) ▪ contingency plan included that client would stay with her sister
19	Care plan is updated: annually, and in conjunction w/annual MED	<ul style="list-style-type: none"> ▪ care plan due to be updated; month overdue ▪ Care plan update 7 months overdue 	<ul style="list-style-type: none"> ▪ Unable to determine current Care Plan as it is not dated

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
20	Addressed in #24		
21	Addressed in #22		
III. Monitoring and Evaluation of Care Plan			
22 (and 21, 23, 32 and 38)	No less than 1 monthly telephone contact and 1 face-to-face contact every 60 days		<ul style="list-style-type: none"> • notes are very informative (9) • notes are very comprehensive (1) • case manager in contact with client in hospital and later in rehab facility
23	Addressed in #22		
24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: <ul style="list-style-type: none"> • CM agency Care Plan • CM agency contact notes • Progress notes 	<ul style="list-style-type: none"> • Client at risk of not being able to attend day program as comes without insulin and incontinent supplies; no evidence of being addressed • No evidence of case manager contacting provider with whom client was complaining about and was causing client to be stressed 	<ul style="list-style-type: none"> • Services have changed to reflect client's changing health needs (2) • Monthly notes address client's services and whether she needs anything or if anything needs to change • Community provider's care plan in case record
25	Participant is actively engaged in Care Plan	<ul style="list-style-type: none"> • Lacking evidence of engaging client 	<ul style="list-style-type: none"> • Evidence that client is actively involved (8) • Client, brother & niece all actively engaged
26	Removed		
27	Addressed in #24		
28	Error in numbering		

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Question		Reviewer Comments	
		Challenges/Concerns	Positive practices
IV. Provider Agency Requirements / Individual Case Records			
29	Face sheet		Safety Plan is well done
30	Current MED needs list / support plan		
31	Removed		
32	Addressed in question #22		
33	Addressed in question #14		
34	Removed		
35	Addressed in question #24		
36	Removed		
37	Removed		
38	Removed		
39	Removed		

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General Observations	
Challenges / Concerns	Positive practices
<p>Progress notes had many spelling errors, (e.g., Adavan instead of Ativan, Zanic instead of Xanax)</p>	<p>Monthly Note format is good; includes:</p> <ul style="list-style-type: none"> • Client report • Care coordinator assessment • Plan • Outcomes; each outcome has identified risk status: <ol style="list-style-type: none"> 1. crisis 2. high risk 3. moderate risk 4. stable
<p>Care Plan does not reflect increased number of hours of services.</p>	
<p>Monthly notes do not indicate any action by the case manager other than listening and recording client's comments; there are e-mails that demonstrate case manager's follow-up on some issues</p>	
<p>Client told case manager that her sister, who lives in Mass., is being abused financially by her children and the client had not reported the situation to Mass. APS. Case Manager could have/should have contacted NH APS Central Intake for information re making a report to Mass. APS.</p>	
<p>Recommend including goal/objective of monitoring stress of family as daughter provides all the care for her mother and is DPOA for health and finances.</p>	

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CMS (1915c) Waiver Assurances and Subassurances		
Assurances	Subassurances	
Level of Care	Persons enrolled in the waiver have needs consistent with an institutional level of care	
	Subassurances	a. An evaluation for Level of Care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future
		b. The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver
		c. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care
Service Plan	Participants have a service plan that is appropriate to their needs and that they receive the services/supports specified in the plan	
	Subassurances	a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
		b. The state monitors service plan development in accordance with its policies and procedures
		c. Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.
		d. Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan
		e. Participants are afforded choice: e.1. between waiver services and institutional care e.2. between / among waiver services, and e.3. providers

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CMS (1915c) Waiver Assurances and Subassurances		
Assurances	Subassurances	
Qualified Providers	Waiver providers are qualified to deliver services / supports	
	Subassurances	a. The state verifies that providers, initially and continually, meet required licensure and / or certification standards and adhere to other standards prior to their furnishing waiver services
		b. The state monitors non-licensed / non-certified providers to assure adherence to waiver requirements
		c. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
Health and Welfare	Participants' health and welfare are safeguarded and monitored	
	Subassurance	The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
Financial Accountability	Claims for waiver services are paid according to state payment methodologies	
	Subassurance	State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Administrative Authority	The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.	
	Subassurance	The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local / regional non-state agencies (if appropriate) and contracted entities.

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Abbreviations

Abbreviation	Terminology
ADL	Activities of Daily Living
BEAS	Bureau of Elderly and Adult Services
CFI	Choices for independence program, formerly known as the Home and Community Based Care Services – Elderly and chronically Ill Waiver Program (HCBC-ECI)
CM	Case Management or Case Manager
CMS	Center for Medicare and Medicaid Services
CY	Calendar Year
DCBCS	Division of Community Based Care Services
DPOA	Durable Power of Attorney
HCBC – ECI	Home and Community Based Care Services – Elderly and Chronically Ill Waiver Program renamed the Choices for Independence program (CFI)
IADL	Instrumental Activities of Daily Living
LOC	Level of Care
NF	Nursing Facility
PCP	Primary Care Physician
PCA	Personal Care Attendant
PCSP	Personal Care Service Provider
PES	Participant Experience Survey
PH	Pilot Health, LLC
POC	Plan of Care
SFY	State Fiscal Year