QUALITY ASSURANCE SOLUTIONS FOR DDS CASE MANAGERS

Lisa Brunson-Smith & Rachael Knight

PossABLE
Services. Lives. Futures.

OKLAHOMA
Human Services
Developmental Disabilities Services

LEARNING GOALS & OBJECTIVES

Learning Goal

Improve understanding of Quality Assurance standards by strengthening Individual Plan development skills through enhancement of Risk Assessment and Community Safety Planning and clarified Vision for the Future documentation.

Objectives

Define key Quality Assurance audit standards related to Individual Plan development.

Develop clear safety interventions that balance dignity of risk with safety considerations and compliance standards.

Facilitate meaningful conversations with people receiving services and their teams about future goals and what is important to and for the person, and clearly document them to meet compliance standards.

slido

Please download and install the Slido app on all computers you use.

Approximately what portion of DDS funding comes from the federal government?

ⓘ Start presenting to display the poll results on this slide.

WHY AUDITS MATTER

- The Community-Based Waiver is a funding option that allows states to "waive" regular state Medicaid plan services for alternative services.
- Roughly 2/3 of our money comes from federal funding.
- **Center for Medicaid and Medicare Services (CMS) mandates we score at or above 86% on our audits to continue receiving federal funding.**
- This is a mandatory training as part of our remediation to meet these thresholds.
- If we cannot get these scores increased, we are at risk of losing Waiver funding.

slido

Please download and install the Slido app on all computers you use.

DDS Waivers are renewed every __ years.

ⓘ Start presenting to display the poll results on this slide.

WHY AUDITS MATTER

Audits ask, "Does the IP contain methods that address safety and health risks and assessed needs?"

- DDS Waivers are renewed every 5 years.
- This past audit year, we received a compliance rate of 80%.

GET TO KNOW GWEN STACEY

Supporting Gwen's Safety

Gwen has no concept or awareness of health and safety risks. She requires staff assistance to complete all ADLS, ensure adequate hygiene, administer medications, prepare her Mealtime Assistance Plan and diet-approved meals, schedule medical appointments, provide transportation, assist in implementing therapeutic behaviors, and ensure safety. Gwen has a history of weight instability; this instability has led to a diagnosis of failure to thrive. She is also diagnosed with dysphasia and experiences constipation. Gwen requires hand-over-hand assistance and 1:1 supports at all times when bathing and toileting. This is due to of her lack of safety awareness or proper hygiene, which without supports, puts her at risk for illness and infection.

Without supports, Gwen is at risk of eating raw food or not eating at all, soiling her brief with no awareness of changing it, ingesting feces, and becoming ill from infection. She is unable to self-medicate or attend medical appointments without assistance, which could lead to a health crisis such as seizure, mental health decline, and other health concerns.

DEVELOPING SUPPORTS AT HOME & IN THE COMMUNITY

Give a detailed overview of the risks and supports needed to mitigate the health and safety concerns at home and in the community.

Think about all tasks that you complete in your daily life. Is this individual able to do them? If not, what assistance do they need, and what is the risk should they not have this assistance?

Remember that support needs will vary between home and community. Best practice is to break this question into a home section and a community section.

WHAT SUPPORTS DOES GWEN NEED TO BE SAFE AT HOME?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SAFETY AT HOME

Examples of Supports at Home

- Gwen is to have line-of-sight supervision during waking hours when in common areas of the home due to lack of health and safety awareness as well as a history of aggression with housemates. When in her room, she may be alone with a visual check every 5 minutes and an unobtrusive visual check every 30 minutes while asleep.
- Due to her history of aggression, Gwen should be visually supervised by staff when in the same room as housemates. If unsupervised, she may become agitated or aggressive, which could lead to harm for her housemate. This may result in Gwen being asked to leave the housemate arrangement.
- While in her yard, Gwen is at risks of falls. During ambulation, staff should remain within arm's reach and offer their arm to her while walking, especially on uneven terrain. If Gwen is sitting outside on the front porch, staff should remain within line of sight to assist with ambulation and possible stranger danger. Gwen does not possess the ability to understand friends versus strangers and could become aggressive with people approaching or passing by.

WHAT SUPPORTS DOES GWEN NEED TO BE SAFE IN THE COMMUNITY?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SAFETY IN THE COMMUNITY

Examples of Supports in the Community

In the community, per the PIP, staff should watch for signs of anxiety and respond by moving to a calm area or leaving the location. It also helps to bring items that Gwen can use while in the community to help reduce anxiety. Staff are to be trained on her PIP prior to working with Gwen to ensure therapeutic techniques are implemented and avoid community locations during “busy” times. Gwen is at risk of becoming anxious, aggressive, and/or fearful around crowds, with loud noises, or in unfamiliar locations. This may lead to a safety threat within her community and result in her not being welcomed back into stores or other visited community locations. Because of this, staff should always remain within arm’s reach for safety and to offer Gwen assistance. These risks may occur at any time in the community.

WHAT SUPPORTS DOES GWEN NEED TO LESSEN THE RISKS ASSOCIATED WITH THE CHOICES SHE MAKES?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SUPPORTS TO LESSEN RISKS

- The team must identify the choices the individual makes that puts them at risk.
- Think about the possible consequences of these decisions.
- What is the plan to mitigate each risk while allowing the individual the right to make their own choices and to have the dignity of risk?
- Choice-based risks are behaviors that the individual intentionally partakes in.

SUPPORTS TO LESSEN RISKS

- Supports for this may include:
  - Helping the individual create a supported decision-making team
  - Ensuring the individual has the information necessary to make an informed decision, even if it is not one the team completely agrees with
  - Providing professionals and supports that will work with the individual to teach them how to make informed decisions
  - Providing individuals with community resources as needed

SUPPORTS TO LESSEN RISKS

- Always remember, every adult has the right to make choices and to have the dignity of risk that accompanies those choices.
- Examples of intentional risk could include:
  - Use of tobacco or alcohol
  - Eating non–physician-prescribed or diet-approved foods
  - Sharing information freely online
  - Having unsafe relations
  - Choosing to leave home without notifying caretakers
  - Keeping a sleep schedule not conductive to their vocational program

SUPPORTS TO LESSEN THE RISKS ASSOCIATED WITH CHOICES MADE

Examples of Supports for Risks

Gwen chooses to smoke cigarettes. Her PCP has discussed with her the dangers of smoking including cancer and death. Gwen understands these dangers but still chooses to smoke.

Next, we identify the supports.

The team has addressed the dangers with her, and Gwen has stated that she will smoke and does not want staff to “bug” her about it. The team, including the PCP, has educated Gwen and will offer nicotine replacement therapy if Gwen requests it. At this time, staff will not talk with her about smoking.

WHAT SUPPORTS DOES GWEN NEED TO MANAGE A HEALTH CONDITION THAT PUTS HER OR OTHERS' HEALTH & SAFETY AT RISK?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SUPPORTS TO MANAGE HEALTH RISKS

- For this question, only list medical conditions that pose a risk and detail the risks associated with them.
- If assigned a DDS nurse, look at the Initial Health Review and the annual Health Summary.
- You may also verify conditions and check for new conditions with the individual &/or caretakers.
- Ask:
  - What risks are being posed to the individual and caretaker because of the condition(s)?
  - What supports are needed because of these condition(s)?
  - What limitations do(es) the condition(s) cause?

SUPPORTS TO MANAGE HEALTH RISKS

Examples of Supports for Risks

Gwen has a history of weight instability; this instability has led to a diagnosis of failure to thrive. Due to this, she is high risk for malnutrition and death. Gwen is monitored for weight loss and takes medication to increase her appetite, which staff administer. Staff monitor food intake and report to her nutritionist and primary care physician by health care coordinator.

Gwen has dysphasia, which puts her at risk for aspiration pneumonia. Staff should be trained on Gwen's Mealtime Assistance Plan prior to feeding her.

Gwen has constipation and takes medication. Constipation puts her at risk of impaction and death. She has a bowel protocol that is to be renewed annually. Gwen has a history of seizure disorder and takes medication. Staff are to call 911 if Gwen has a seizure.

IS THE CASE MANAGER REVIEWING PROGRESS AS REQUIRED BY POLICY & ENSURING THE IMPLEMENTATION OF THE IP & ADDENDUMS?

WHAT DOES THIS MEAN?

- This question addresses our review of the IP and our monitoring of progress made for the person through quarterly reports.
- Last waiver year we reported a compliance rate of 85%.

HOW CAN WE GROW?

Quarterly and Provider Reports

slido

Please download and install the Slido app on all computers you use.

What months are quarterly reports due?

ⓘ Start presenting to display the poll results on this slide.

QUARTERLY PROGRESS REPORTING

Documenting Progress

- We document progress on outcomes through reviewing quarterly provider reports.
- The quarterly months are **April, July, October, and January.**
- Completed CM quarterly reports are due by the final day of the quarterly months.

ORGANIZATION: THE KEY TO QUARTERLY REPORTS

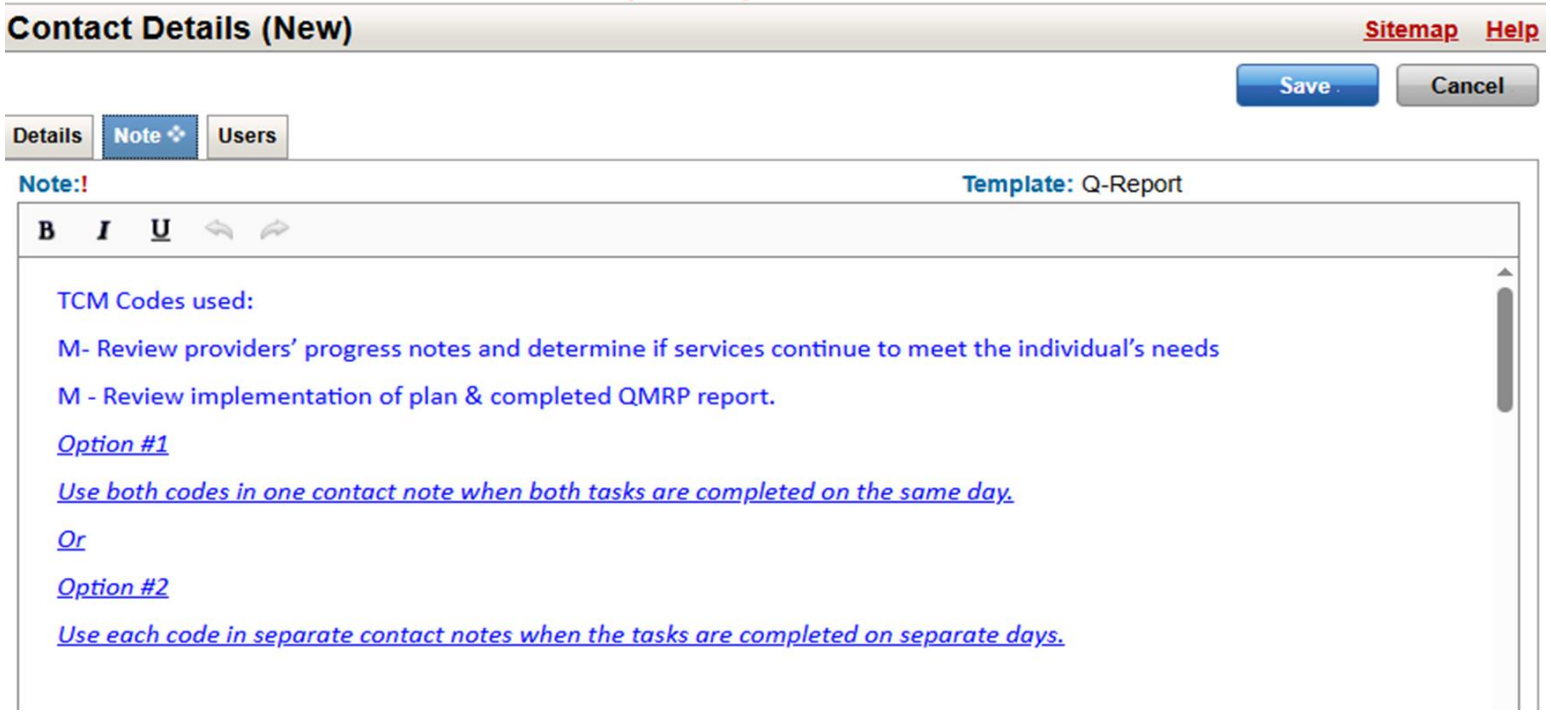
Create an organization spreadsheet or chart to keep track of which reports you have received and which you are lacking.

Do not wait until the end of the month to begin problem resolution for reports that you did not receive. Start that process as soon as possible after the due date of the 10th.

Save time by reviewing all of a person's provider reports, comparing those to outcomes in the IP in one sitting, and then doing a single contact note (rather than a separate note per provider report).

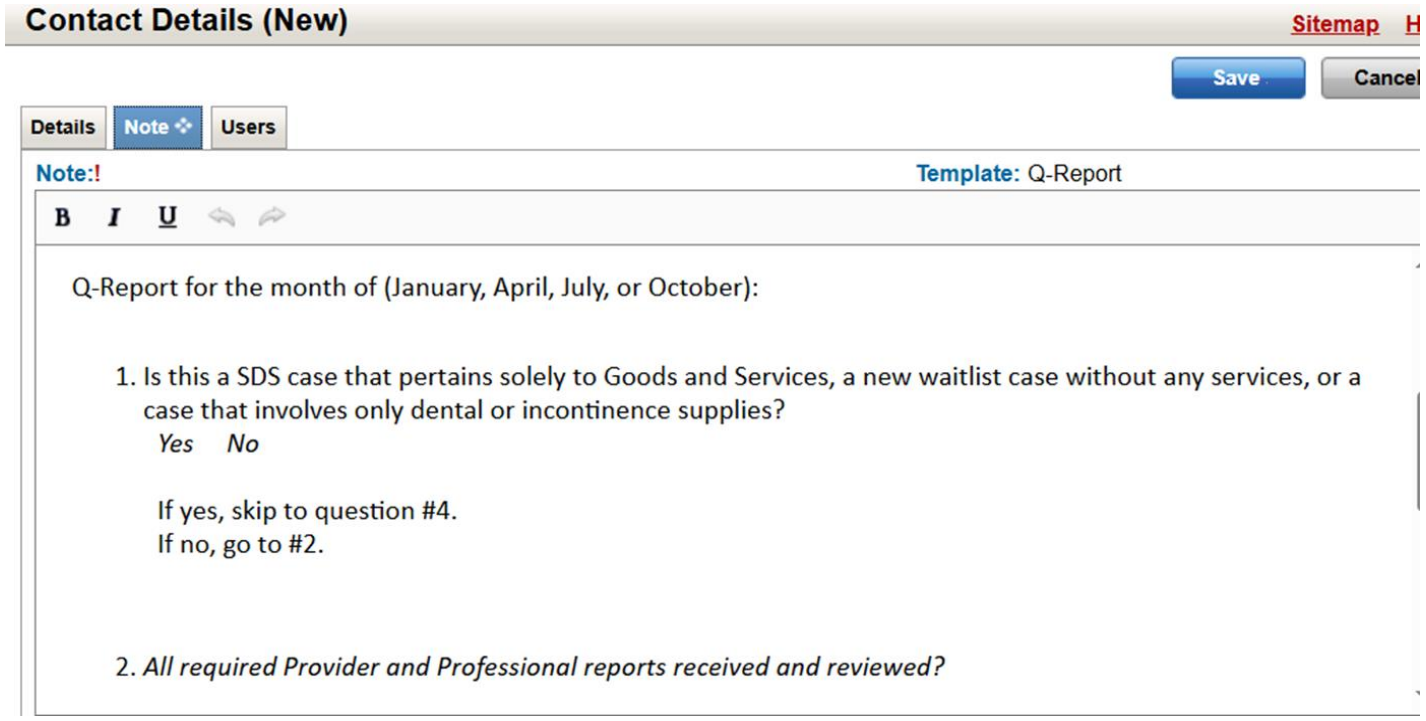
COMPLETING A QUARTERLY REPORT

Step One: Review Instructions



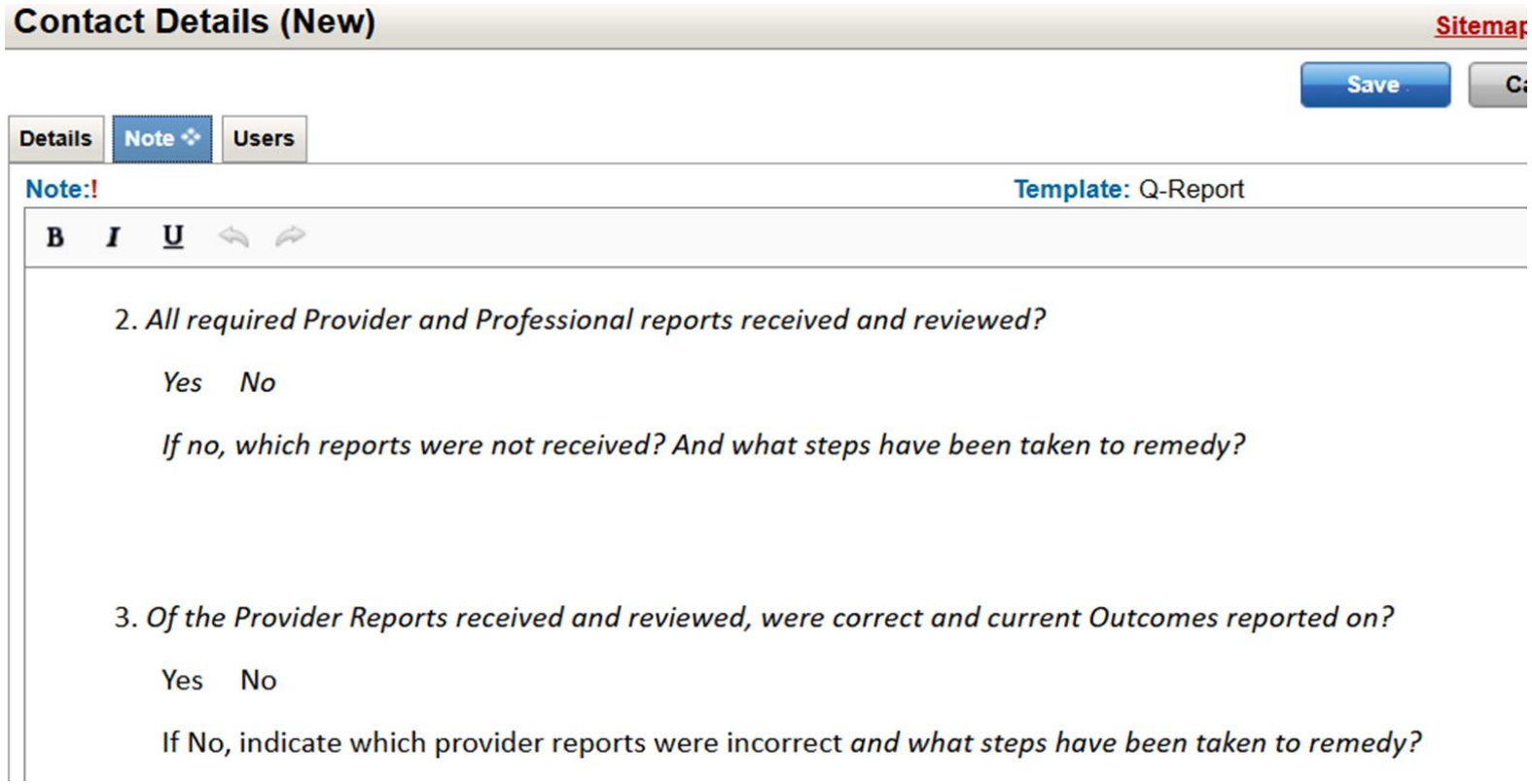
COMPLETING A QUARTERLY REPORT

Step Two: Scroll to Body of Q-Report Template



COMPLETING A QUARTERLY REPORT

Step Three: Scroll to Questions Regarding the Reports



COMPLETING A QUARTERLY REPORT

Step Four: Answer the Following

Question 2 asks, “All required Provider and Professional reports received and reviewed?”

- Here you will answer “Yes” or “No” as to whether you received and reviewed all the reports.
- If “No,” answer the sub question, “Which reports were not received? And what steps have been taken to remedy?”
  - Here you will detail all actions you have taken up to this point to obtain the report, such as problem resolution emails or making calls to the professional/provider.
  - You will document all efforts here. You will add a contact note addressing and reporting your conversations and agreements.
  - Remember to document when the missing report has been received.

COMPLETING A QUARTERLY REPORT

Step Four: Answer the Following

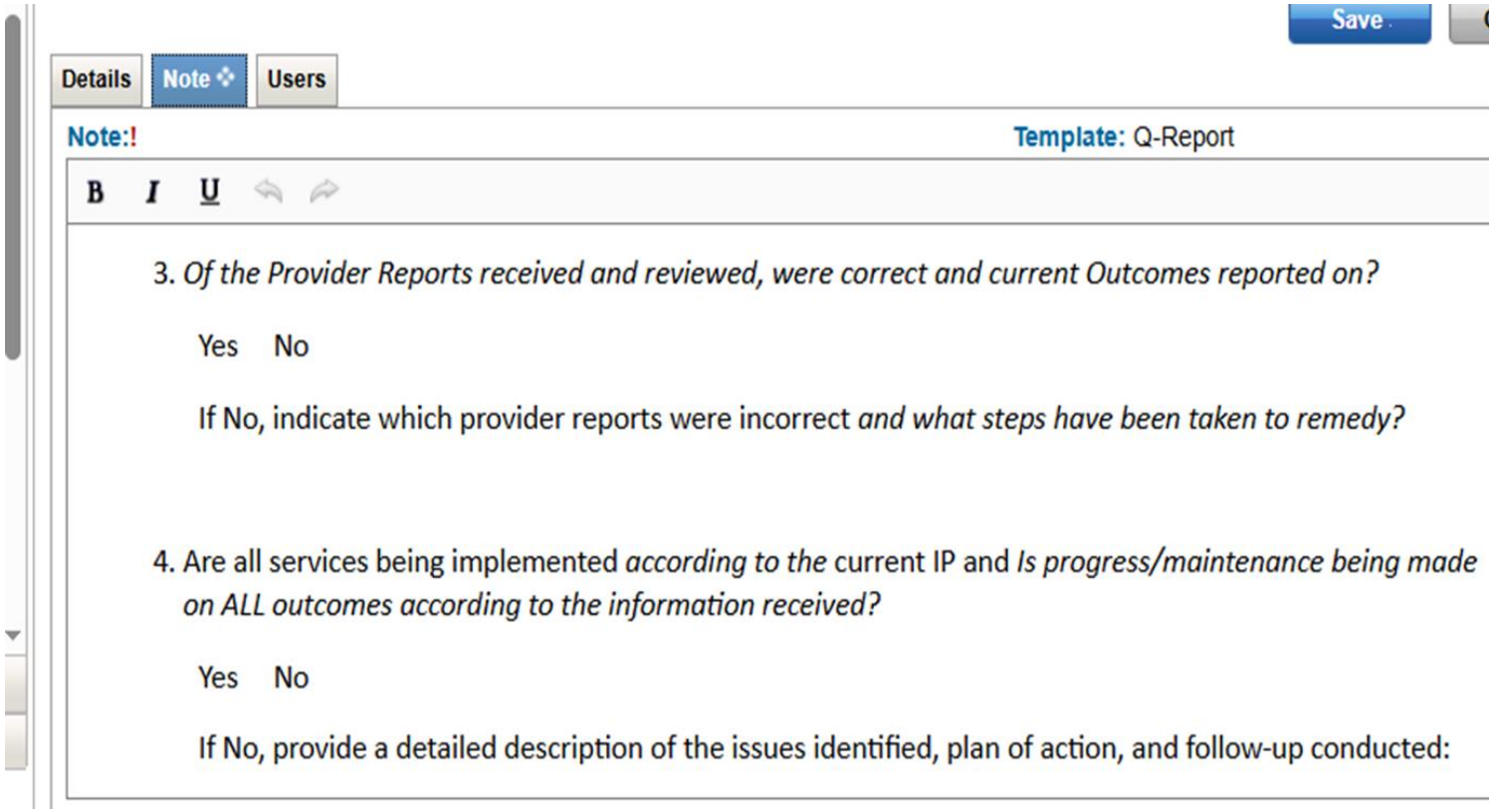
Question 3 asks, “Of the Provider Reports received and reviewed, were correct and current Outcomes reported on?”

Here you will address answer “Yes” or “No.”

- Make sure to review the outcomes within the IP.
- Determine whether the correct outcomes are being reported on.
- If “No,” respond to the following prompt: “Indicate which provider reports were incorrect and what steps have been taken to remedy.”
  - Describe what steps of the problem resolution process you have completed, including giving deadlines, sending emails, calling providers, etc.

COMPLETING A QUARTERLY REPORT

Step Five: Complete the Final Portion of the Quarterly Report



COMPLETING A QUARTERLY REPORT

Question 4 asks, “Are all services being implemented according to the current IP and is progress/maintenance being made on ALL outcomes according to the information received?”

- It is important to read the provider report data to determine if a person is making or maintained progress, has regressed on progress, or has refused to work on an outcome or action step.
- This question is extremely vital to answer as it documents the monitoring of the outcomes.

First, answer “Yes” or “No.”

- Then, if “No,” you will provide a detailed description of the issues identified, plan of action, and follow-up conducted.

We must always document the reason when the person has made no progress on their outcome.

EXAMPLES OF COMPLETING QUARTERLY REPORTS

Example One

The outcome states that: **Brent will participate in community activities 2 times per week.**

- We document in question 4 that the provider's report states that "Brent was sick for most of the month and in the hospital. He didn't feel up to going into the community."
- Next, we document what is being done to remedy this: "As Brent is recovering health and stamina, he will begin going back to community activities this month. He will begin with attending 1 per week and increasing to 2 per week as health improves."

Example Two

The outcome states that: **Ava will complete her range-of-motion program at least 5 out of 7 days per week.**

- We document on question 4 that the provider's report states that "Ava did not complete her range-of-motion program due to staff turnover; current (new) staff have not yet been trained on her program."
- "Case Manager reached out to physical therapy, who has already scheduled a training for new staff next week."

PROVIDER REPORTS

Documenting Receiving

- The Provider Report template is used to document the receipt and review of the quarterly progress report from the provider.
- Use TCM Code: M - Review providers' progress notes & determine if services continue to meet the individual's needs.
- Provider reports are due to the CM by the 10th of the quarterly month.

DOES THE IP ADDRESS ALL THE SERVICE RECIPIENT'S NEEDS AS IDENTIFIED IN THE ASSESSMENT?

HOW WE CAN GROW

- Best practice is to answer every question with a “Yes,” “No,” or “Not at this time” before moving on to the next question or going into further detail to answer the current question.
- Check to make sure the numbers remain accurate to the questions answered, as sometimes pasting into the IP will alter the number style.
- Make sure to review and reference the professional assessments while writing the IP draft.
- The IP should be written in 3rd person unless you are quoting the individual.

VISIONS FOR THE FUTURE

What Does This Mean?

- Don’t we all have a vision of the future for ourselves?
- What does your perfect day look like?
- Ask these questions to get good answers:
  - What does your best day look like? Who is it with? Where is it at?
  - What would be your dream job?
  - If you could do a community activity of your choice each week, what would it be?
- During the wrap of the PCA (which is completed prior to the IP draft), you may wish to begin this conversation based upon the PCA responses.

VISIONS FOR THE FUTURE

<u>The vision statement will typically address such life areas as:</u>

- Where the individual wants to live and with whom
- What type of job they would like
- What personal relationships they desire to develop or strengthen and how they will be supported
- How the individual wants to spend their leisure time

VISIONS FOR THE FUTURE

Use “I” statements in the vision only when you are quoting the actual statements made by the individual. Otherwise, use the person’s name. Be as specific and detailed as possible, so the vision “comes alive.”

When struggling with the Vision for the Future, the Important To, or the Important For, take this opportunity to request a Person-Centered Facilitator. The form is in CCM Documents – Read Only.

You will create and complete the form and send to Cindy Leishman. She will assign a Person-Centered Facilitator, and a meeting will be arranged to complete a full PCA. *This is super fun and should not be called a meeting; it should be called a party!*

VISIONS FOR THE FUTURE BREAKOUT ACTIVITY

ACTIVITY PROMPTS

For the Interviewer

- “What’s something you’d really like to do or learn in the next year?”
- “Tell me about a great day you’ve had recently.”
- “Who are the people you enjoy spending time with?”
- “What helps you feel safe and comfortable in your community?”

For the Observer

- What went well in the interview?
- Were the questions person-centered?
- Did the interviewer draw out meaningful insights?
- Suggestions for improvement?

GROUP ACTIVITY DEBRIEF

- What surprised you?
- What did you find challenging?
- How did it feel to be in the “individual” role?
- What will you do differently in your real interviews?

SESSION CLOSE OUT

WHAT QUESTIONS DO YOU HAVE?

QUALITY ASSURANCE SOLUTIONS FOR DDS CASE MANAGERS

Lisa Brunson-Smith & Rachael Knight

PossABLE
Services. Lives. Futures.

OKLAHOMA Human Services
Developmental Disabilities Services

Headshot Station

RESERVE YOUR SPOT

No spots left? Stop by!

We'll fit you in for a walk-up.

QUALITY ASSURANCE SOLUTIONS FOR DDS CASE MANAGERS

Lisa Brunson-Smith & Rachael Knight

PossABLE
Services. Lives. Futures.

OKLAHOMA
Human Services
Developmental Disabilities Services

LEARNING GOALS & OBJECTIVES

Learning Goal

Improve understanding of Quality Assurance standards by strengthening Individual Plan development skills through enhancement of Risk Assessment and Community Safety Planning and clarified Vision for the Future documentation.

Objectives

Define key Quality Assurance audit standards related to Individual Plan development.

Develop clear safety interventions that balance dignity of risk with safety considerations and compliance standards.

Facilitate meaningful conversations with people receiving services and their teams about future goals and what is important to and for the person, and clearly document them to meet compliance standards.

slido

Please download and install the Slido app on all computers you use.

Approximately what portion of DDS funding comes from the federal government?

ⓘ Start presenting to display the poll results on this slide.

WHY AUDITS MATTER

- The Community-Based Waiver is a funding option that allows states to "waive" regular state Medicaid plan services for alternative services.
- Roughly 2/3 of our money comes from federal funding.
- **Center for Medicaid and Medicare Services (CMS) mandates we score at or above 86% on our audits to continue receiving federal funding.**
- This is a mandatory training as part of our remediation to meet these thresholds.
- If we cannot get these scores increased, we are at risk of losing Waiver funding.

slido

Please download and install the Slido app on all computers you use.

DDS Waivers are renewed every __ years.

ⓘ Start presenting to display the poll results on this slide.

WHY AUDITS MATTER

Audits ask, "Does the IP contain methods that address safety and health risks and assessed needs?"

- DDS Waivers are renewed every 5 years.
- This past audit year, we received a compliance rate of 80%.

GET TO KNOW GWEN STACEY

Supporting Gwen's Safety

Gwen has no concept or awareness of health and safety risks. She requires staff assistance to complete all ADLS, ensure adequate hygiene, administer medications, prepare her Mealtime Assistance Plan and diet-approved meals, schedule medical appointments, provide transportation, assist in implementing therapeutic behaviors, and ensure safety. Gwen has a history of weight instability; this instability has led to a diagnosis of failure to thrive. She is also diagnosed with dysphasia and experiences constipation. Gwen requires hand-over-hand assistance and 1:1 supports at all times when bathing and toileting. This is due to of her lack of safety awareness or proper hygiene, which without supports, puts her at risk for illness and infection.

Without supports, Gwen is at risk of eating raw food or not eating at all, soiling her brief with no awareness of changing it, ingesting feces, and becoming ill from infection. She is unable to self-medicate or attend medical appointments without assistance, which could lead to a health crisis such as seizure, mental health decline, and other health concerns.

DEVELOPING SUPPORTS AT HOME & IN THE COMMUNITY

Give a detailed overview of the risks and supports needed to mitigate the health and safety concerns at home and in the community.

Think about all tasks that you complete in your daily life. Is this individual able to do them? If not, what assistance do they need, and what is the risk should they not have this assistance?

Remember that support needs will vary between home and community. Best practice is to break this question into a home section and a community section.

WHAT SUPPORTS DOES GWEN NEED TO BE SAFE AT HOME?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SAFETY AT HOME

Examples of Supports at Home

- Gwen is to have line-of-sight supervision during waking hours when in common areas of the home due to lack of health and safety awareness as well as a history of aggression with housemates. When in her room, she may be alone with a visual check every 5 minutes and an unobtrusive visual check every 30 minutes while asleep.
- Due to her history of aggression, Gwen should be visually supervised by staff when in the same room as housemates. If unsupervised, she may become agitated or aggressive, which could lead to harm for her housemate. This may result in Gwen being asked to leave the housemate arrangement.
- While in her yard, Gwen is at risks of falls. During ambulation, staff should remain within arm's reach and offer their arm to her while walking, especially on uneven terrain. If Gwen is sitting outside on the front porch, staff should remain within line of sight to assist with ambulation and possible stranger danger. Gwen does not possess the ability to understand friends versus strangers and could become aggressive with people approaching or passing by.

WHAT SUPPORTS DOES GWEN NEED TO BE SAFE IN THE COMMUNITY?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SAFETY IN THE COMMUNITY

Examples of Supports in the Community

In the community, per the PIP, staff should watch for signs of anxiety and respond by moving to a calm area or leaving the location. It also helps to bring items that Gwen can use while in the community to help reduce anxiety. Staff are to be trained on her PIP prior to working with Gwen to ensure therapeutic techniques are implemented and avoid community locations during “busy” times. Gwen is at risk of becoming anxious, aggressive, and/or fearful around crowds, with loud noises, or in unfamiliar locations. This may lead to a safety threat within her community and result in her not being welcomed back into stores or other visited community locations. Because of this, staff should always remain within arm’s reach for safety and to offer Gwen assistance. These risks may occur at any time in the community.

WHAT SUPPORTS DOES GWEN NEED TO LESSEN THE RISKS ASSOCIATED WITH THE CHOICES SHE MAKES?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SUPPORTS TO LESSEN RISKS

- The team must identify the choices the individual makes that puts them at risk.
- Think about the possible consequences of these decisions.
- What is the plan to mitigate each risk while allowing the individual the right to make their own choices and to have the dignity of risk?
- Choice-based risks are behaviors that the individual intentionally partakes in.

SUPPORTS TO LESSEN RISKS

- Supports for this may include:
  - Helping the individual create a supported decision-making team
  - Ensuring the individual has the information necessary to make an informed decision, even if it is not one the team completely agrees with
  - Providing professionals and supports that will work with the individual to teach them how to make informed decisions
  - Providing individuals with community resources as needed

SUPPORTS TO LESSEN RISKS

- Always remember, every adult has the right to make choices and to have the dignity of risk that accompanies those choices.
- Examples of intentional risk could include:
  - Use of tobacco or alcohol
  - Eating non–physician-prescribed or diet-approved foods
  - Sharing information freely online
  - Having unsafe relations
  - Choosing to leave home without notifying caretakers
  - Keeping a sleep schedule not conductive to their vocational program

SUPPORTS TO LESSEN THE RISKS ASSOCIATED WITH CHOICES MADE

Examples of Supports for Risks

Gwen chooses to smoke cigarettes. Her PCP has discussed with her the dangers of smoking including cancer and death. Gwen understands these dangers but still chooses to smoke.

Next, we identify the supports.

The team has addressed the dangers with her, and Gwen has stated that she will smoke and does not want staff to “bug” her about it. The team, including the PCP, has educated Gwen and will offer nicotine replacement therapy if Gwen requests it. At this time, staff will not talk with her about smoking.

WHAT SUPPORTS DOES GWEN NEED TO MANAGE A HEALTH CONDITION THAT PUTS HER OR OTHERS' HEALTH & SAFETY AT RISK?

Let's review some examples of how we can document supporting Gwen in a clear and detailed manner.

SUPPORTS TO MANAGE HEALTH RISKS

- For this question, only list medical conditions that pose a risk and detail the risks associated with them.
- If assigned a DDS nurse, look at the Initial Health Review and the annual Health Summary.
- You may also verify conditions and check for new conditions with the individual &/or caretakers.
- Ask:
  - What risks are being posed to the individual and caretaker because of the condition(s)?
  - What supports are needed because of these condition(s)?
  - What limitations do(es) the condition(s) cause?

SUPPORTS TO MANAGE HEALTH RISKS

Examples of Supports for Risks

Gwen has a history of weight instability; this instability has led to a diagnosis of failure to thrive. Due to this, she is high risk for malnutrition and death. Gwen is monitored for weight loss and takes medication to increase her appetite, which staff administer. Staff monitor food intake and report to her nutritionist and primary care physician by health care coordinator.

Gwen has dysphasia, which puts her at risk for aspiration pneumonia. Staff should be trained on Gwen's Mealtime Assistance Plan prior to feeding her.

Gwen has constipation and takes medication. Constipation puts her at risk of impaction and death. She has a bowel protocol that is to be renewed annually. Gwen has a history of seizure disorder and takes medication. Staff are to call 911 if Gwen has a seizure.

IS THE CASE MANAGER REVIEWING PROGRESS AS REQUIRED BY POLICY & ENSURING THE IMPLEMENTATION OF THE IP & ADDENDUMS?

WHAT DOES THIS MEAN?

- This question addresses our review of the IP and our monitoring of progress made for the person through quarterly reports.
- Last waiver year we reported a compliance rate of 85%.

HOW CAN WE GROW?

Quarterly and Provider Reports

slido

Please download and install the Slido app on all computers you use.

What months are quarterly reports due?

ⓘ Start presenting to display the poll results on this slide.

QUARTERLY PROGRESS REPORTING

Documenting Progress

- We document progress on outcomes through reviewing quarterly provider reports.
- The quarterly months are **April, July, October, and January.**
- Completed CM quarterly reports are due by the final day of the quarterly months.

ORGANIZATION: THE KEY TO QUARTERLY REPORTS

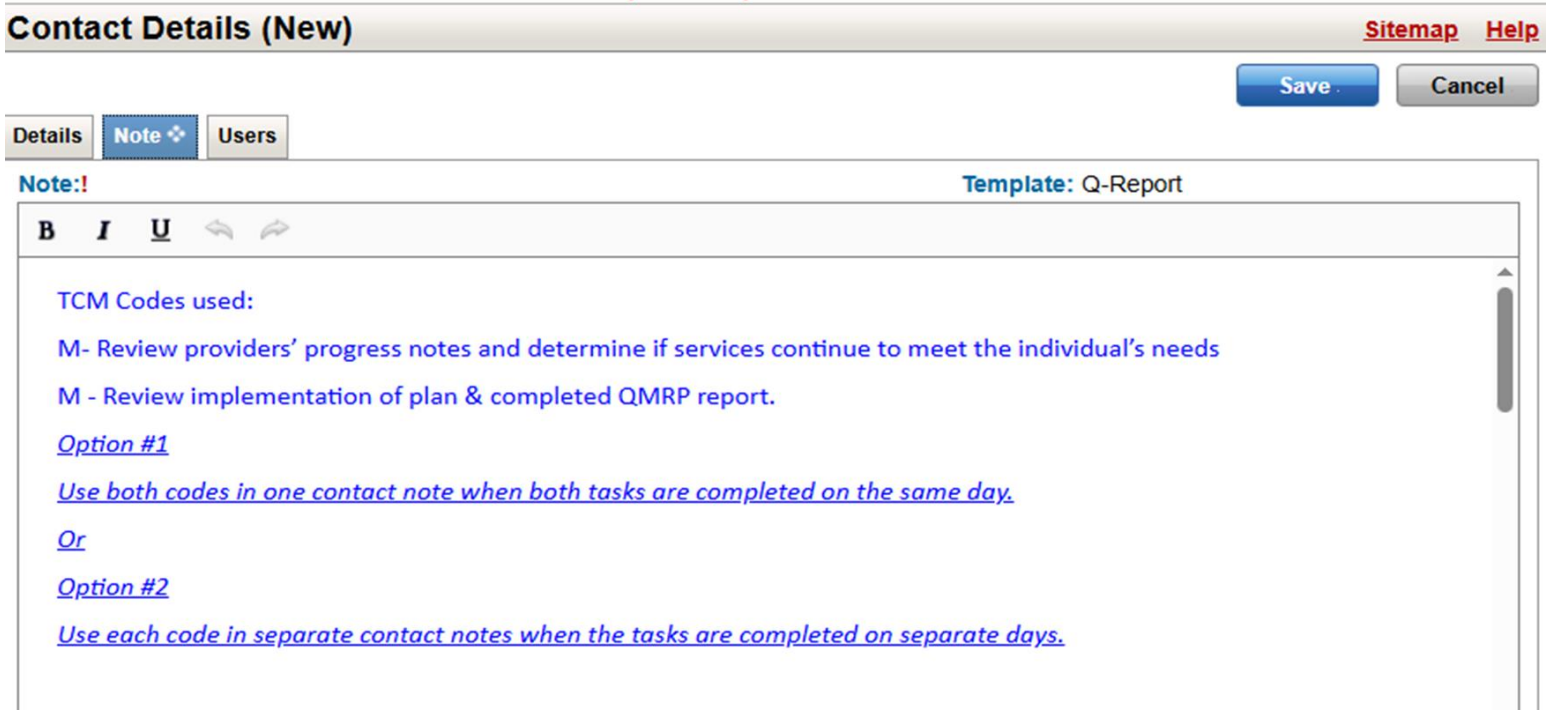
Create an organization spreadsheet or chart to keep track of which reports you have received and which you are lacking.

Do not wait until the end of the month to begin problem resolution for reports that you did not receive. Start that process as soon as possible after the due date of the 10th.

Save time by reviewing all of a person's provider reports, comparing those to outcomes in the IP in one sitting, and then doing a single contact note (rather than a separate note per provider report).

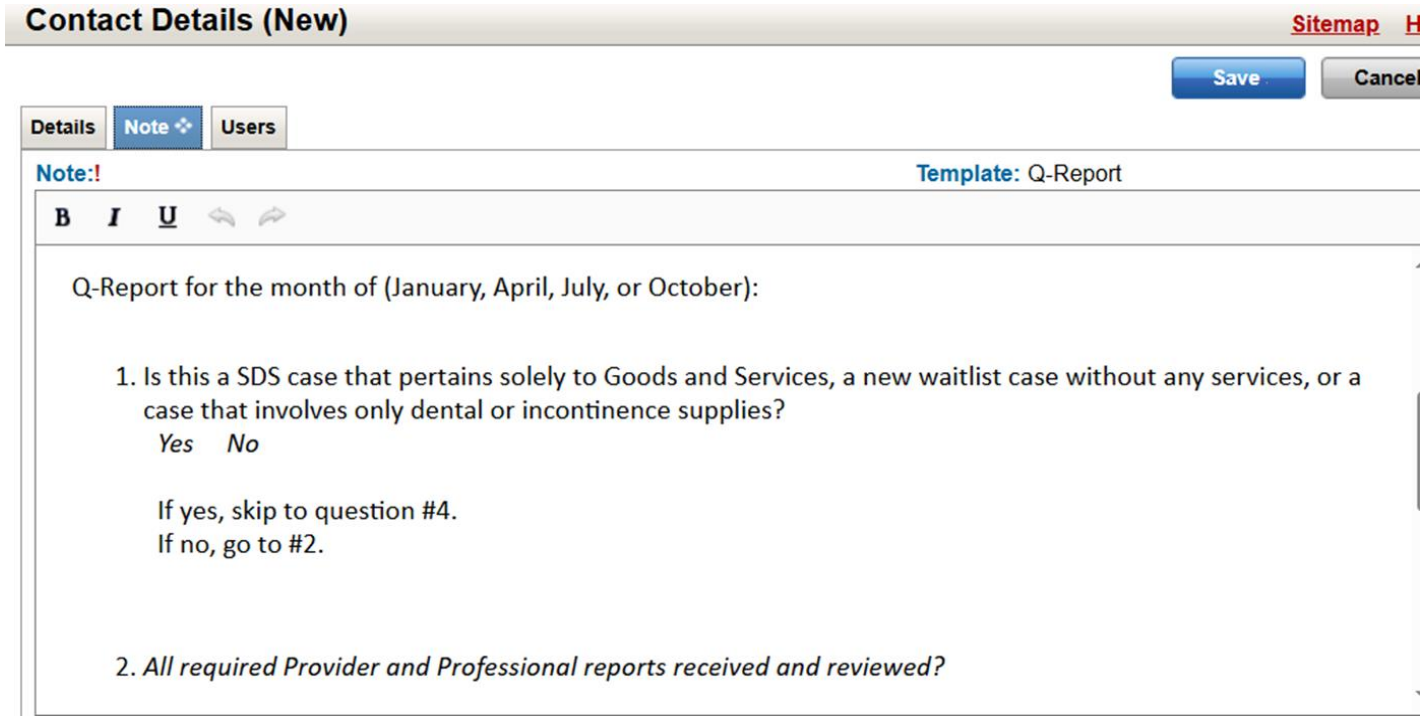
COMPLETING A QUARTERLY REPORT

Step One: Review Instructions



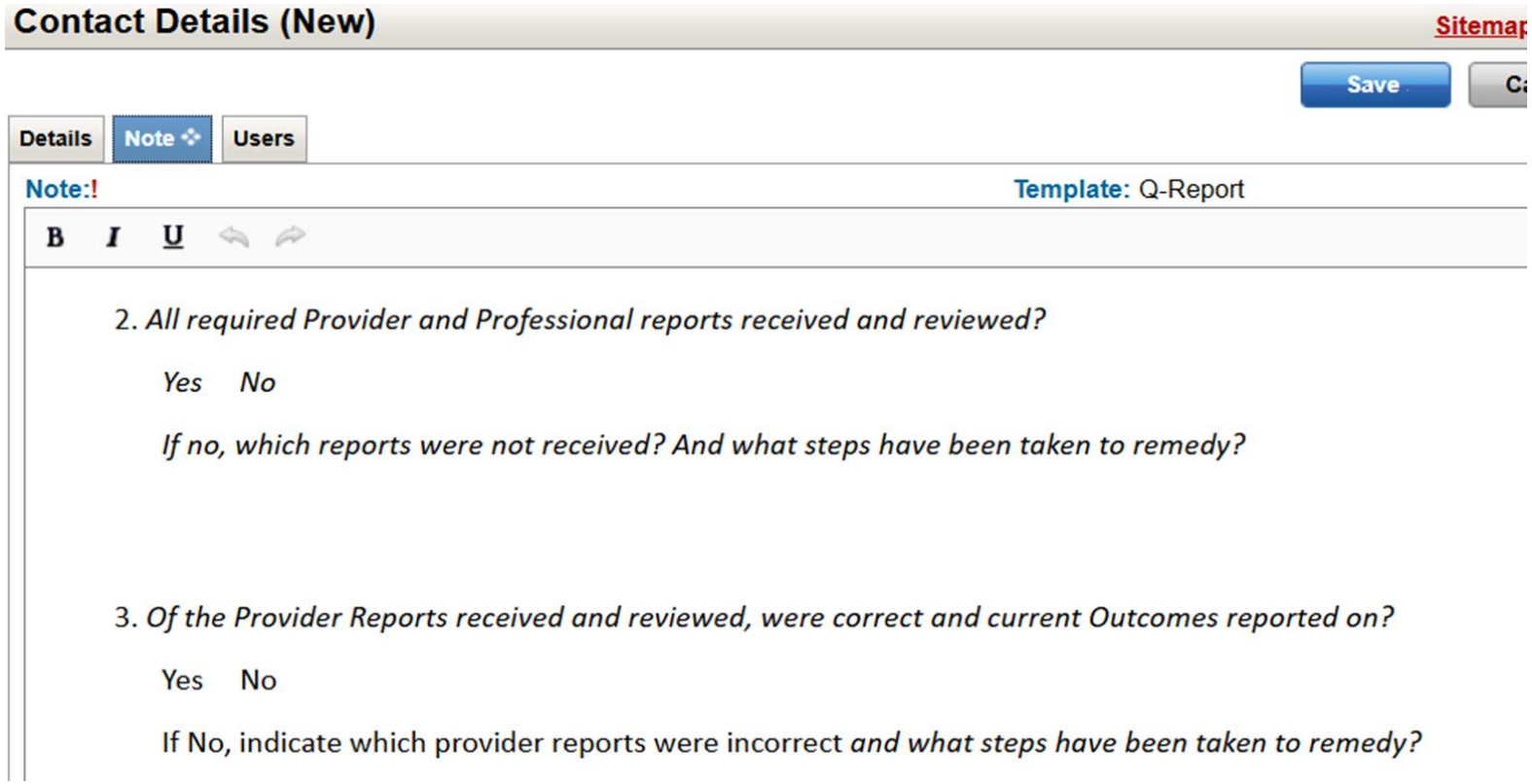
COMPLETING A QUARTERLY REPORT

Step Two: Scroll to Body of Q-Report Template



COMPLETING A QUARTERLY REPORT

Step Three: Scroll to Questions Regarding the Reports



COMPLETING A QUARTERLY REPORT

Step Four: Answer the Following

Question 2 asks, “All required Provider and Professional reports received and reviewed?”

- Here you will answer “Yes” or “No” as to whether you received and reviewed all the reports.
- If “No,” answer the sub question, “Which reports were not received? And what steps have been taken to remedy?”
  - Here you will detail all actions you have taken up to this point to obtain the report, such as problem resolution emails or making calls to the professional/provider.
  - You will document all efforts here. You will add a contact note addressing and reporting your conversations and agreements.
  - Remember to document when the missing report has been received.

COMPLETING A QUARTERLY REPORT

Step Four: Answer the Following

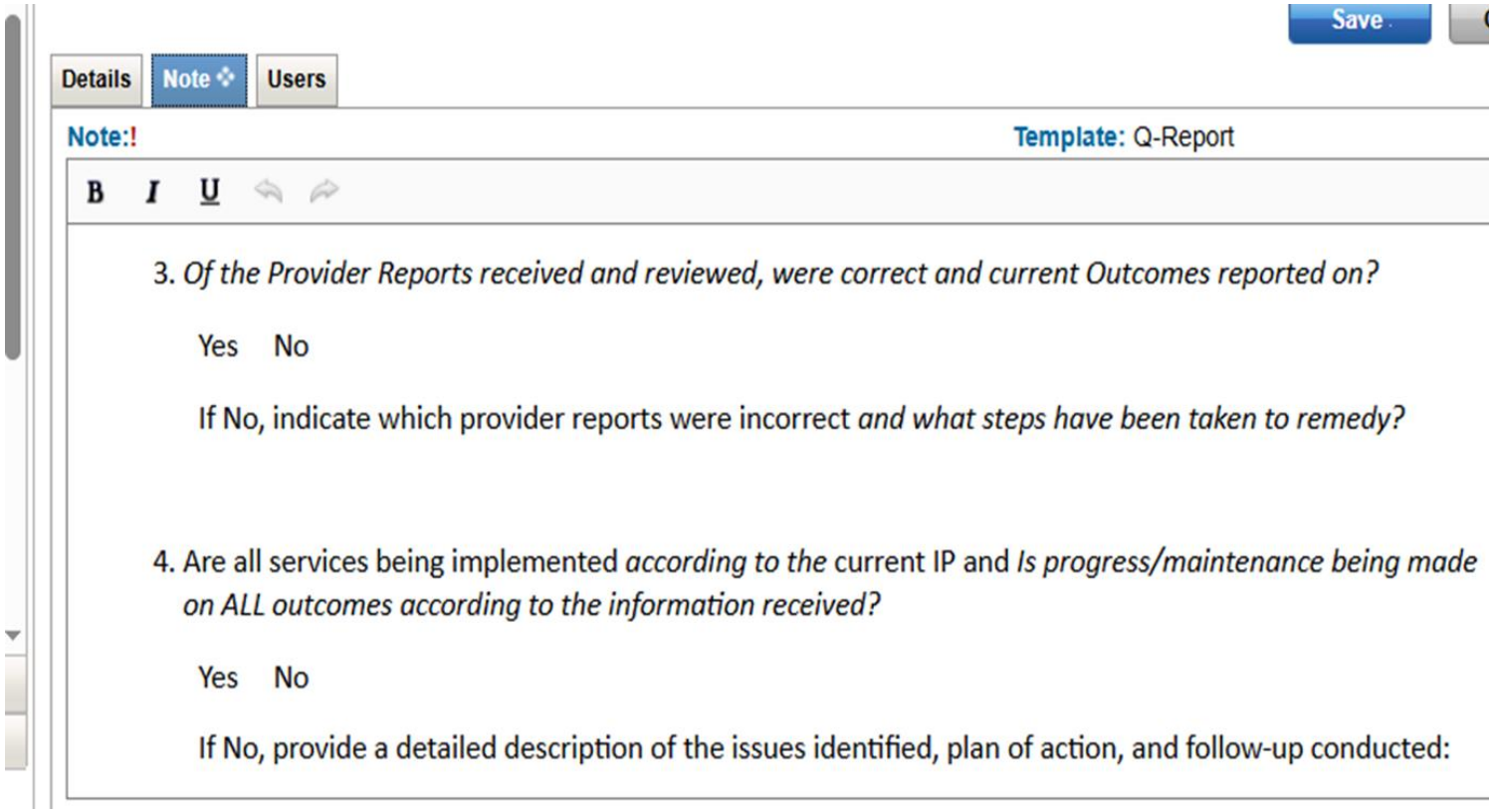
Question 3 asks, “Of the Provider Reports received and reviewed, were correct and current Outcomes reported on?”

Here you will address answer “Yes” or “No.”

- Make sure to review the outcomes within the IP.
- Determine whether the correct outcomes are being reported on.
- If “No,” respond to the following prompt: “Indicate which provider reports were incorrect and what steps have been taken to remedy.”
  - Describe what steps of the problem resolution process you have completed, including giving deadlines, sending emails, calling providers, etc.

COMPLETING A QUARTERLY REPORT

Step Five: Complete the Final Portion of the Quarterly Report



COMPLETING A QUARTERLY REPORT

Question 4 asks, “Are all services being implemented according to the current IP and is progress/maintenance being made on ALL outcomes according to the information received?”

- It is important to read the provider report data to determine if a person is making or maintained progress, has regressed on progress, or has refused to work on an outcome or action step.
- This question is extremely vital to answer as it documents the monitoring of the outcomes.

First, answer “Yes” or “No.”

- Then, if “No,” you will provide a detailed description of the issues identified, plan of action, and follow-up conducted.

We must always document the reason when the person has made no progress on their outcome.

EXAMPLES OF COMPLETING QUARTERLY REPORTS

Example One

The outcome states that: **Brent will participate in community activities 2 times per week.**

- We document in question 4 that the provider's report states that "Brent was sick for most of the month and in the hospital. He didn't feel up to going into the community."
- Next, we document what is being done to remedy this: "As Brent is recovering health and stamina, he will begin going back to community activities this month. He will begin with attending 1 per week and increasing to 2 per week as health improves."

Example Two

The outcome states that: **Ava will complete her range-of-motion program at least 5 out of 7 days per week.**

- We document on question 4 that the provider's report states that "Ava did not complete her range-of-motion program due to staff turnover; current (new) staff have not yet been trained on her program."
- "Case Manager reached out to physical therapy, who has already scheduled a training for new staff next week."

PROVIDER REPORTS

Documenting Receiving

- The Provider Report template is used to document the receipt and review of the quarterly progress report from the provider.
- Use TCM Code: M - Review providers' progress notes & determine if services continue to meet the individual's needs.
- Provider reports are due to the CM by the 10th of the quarterly month.

DOES THE IP ADDRESS ALL THE SERVICE RECIPIENT'S NEEDS AS IDENTIFIED IN THE ASSESSMENT?

HOW WE CAN GROW

- Best practice is to answer every question with a “Yes,” “No,” or “Not at this time” before moving on to the next question or going into further detail to answer the current question.
- Check to make sure the numbers remain accurate to the questions answered, as sometimes pasting into the IP will alter the number style.
- Make sure to review and reference the professional assessments while writing the IP draft.
- The IP should be written in 3rd person unless you are quoting the individual.

VISIONS FOR THE FUTURE

What Does This Mean?

- Don’t we all have a vision of the future for ourselves?
- What does your perfect day look like?
- Ask these questions to get good answers:
  - What does your best day look like? Who is it with? Where is it at?
  - What would be your dream job?
  - If you could do a community activity of your choice each week, what would it be?
- During the wrap of the PCA (which is completed prior to the IP draft), you may wish to begin this conversation based upon the PCA responses.

VISIONS FOR THE FUTURE

<u>The vision statement will typically address such life areas as:</u>

- Where the individual wants to live and with whom
- What type of job they would like
- What personal relationships they desire to develop or strengthen and how they will be supported
- How the individual wants to spend their leisure time

VISIONS FOR THE FUTURE

Use “I” statements in the vision only when you are quoting the actual statements made by the individual. Otherwise, use the person’s name. Be as specific and detailed as possible, so the vision “comes alive.”

When struggling with the Vision for the Future, the Important To, or the Important For, take this opportunity to request a Person-Centered Facilitator. The form is in CCM Documents – Read Only.

You will create and complete the form and send to Cindy Leishman. She will assign a Person-Centered Facilitator, and a meeting will be arranged to complete a full PCA. *This is super fun and should not be called a meeting; it should be called a party!*

VISIONS FOR THE FUTURE BREAKOUT ACTIVITY

ACTIVITY PROMPTS

For the Interviewer

- “What’s something you’d really like to do or learn in the next year?”
- “Tell me about a great day you’ve had recently.”
- “Who are the people you enjoy spending time with?”
- “What helps you feel safe and comfortable in your community?”

For the Observer

- What went well in the interview?
- Were the questions person-centered?
- Did the interviewer draw out meaningful insights?
- Suggestions for improvement?

GROUP ACTIVITY DEBRIEF

- What surprised you?
- What did you find challenging?
- How did it feel to be in the “individual” role?
- What will you do differently in your real interviews?

SESSION CLOSE OUT

WHAT QUESTIONS DO YOU HAVE?

QUALITY ASSURANCE SOLUTIONS FOR DDS CASE MANAGERS

Lisa Brunson-Smith & Rachael Knight

PossABLE
Services. Lives. Futures.

OKLAHOMA Human Services
Developmental Disabilities Services

Headshot Station

RESERVE YOUR SPOT

No spots left? Stop by!

We'll fit you in for a walk-up.