**Instructions for Completing Care Management Monitoring Tool – HCCBG**

**For programmatic monitoring of HCCBG code 610:**

\*Complete pages 2 – 4, page 5 - Fiscal Verification, and Client Record Review Excel Spreadsheet.

**Note:** If a provider is conducting a self-assessment on part or all of the monitoring tool, a signed and dated attestation statement should be included with the completed monitoring tool.

**NC DIVISION OF AGING**

**NC AREA AGENCIES ON AGING**

**CARE MANAGEMENT MONITORING TOOL**

**Part I: Program Verification**

Provider Agency:

Review Date:       State Fiscal Year:

Agency Staff Interviewed:

Signature of Reviewer(s):

Funding Source: **HCCBG [610]**

1. The Care Management unit has a Social Worker

and a Registered Nurse. Yes [ ]  No [ ]

* 1. The Registered Nurse holds a current license

issued by the North Carolina Board of Nursing. Yes [ ]  No [ ]

* 1. The Social Worker has a BSW or MSW or meets

State Personnel requirements for a Social Worker. Yes [ ]  No [ ]

 (VIII.A. 1. & 2). (p. 8 Care Management Service Standards)

 Documentation reviewed/Comments:

1. The agency completes a screening/intake instrument in

person or by phone that addresses the following:

* 1. Client’s identifying information Yes [ ]  No [ ]
	2. Client’s ability to perform activities

 of daily living Yes [ ]  No [ ]

* 1. Client’s ability to perform instrumental

 activities of daily living Yes [ ]  No [ ]

* 1. Client’s perception of health problems Yes [ ]  No [ ]
	2. Client’s perception of well-being

 (e.g. happy, sad, forgetful, confused) Yes [ ]  No [ ]

* 1. Client’s living arrangement

 (alone/with family) Yes [ ]  No [ ]

* 1. Availability of caregiver support Yes [ ]  No [ ]
	2. Services currently being received Yes [ ]  No [ ]

 (V.A.1.a.-h.) (pp. 3-4 Care Management Service Standards)

 Documentation reviewed/Comments:

1. The agency uses a comprehensive in-home\* assessment tool that addresses the following:
	1. Client’s identifying information Yes [ ]  No [ ]
	2. Client’s functional capacity (ADLs, IADLs) Yes [ ]  No [ ]
	3. Client’s medical status Yes [ ]  No [ ]
	4. Client’s social status Yes [ ]  No [ ]
	5. Client’s mental status Yes [ ]  No [ ]
	6. Client’s economic status Yes [ ]  No [ ]
	7. Client’s environmental status Yes [ ]  No [ ]

 (V.A.2.a.-h.) (pp. 4-5 Care Management Service Standards)

 Documentation reviewed/Comments:

1. Care plan forms contain the following elements:
2. Outcome oriented goal statements and conditions

 for case closure Yes [ ]  No [ ]

 b. Both informal and formal services to be provided Yes [ ]  No [ ]

 c. Agencies responsible for service provision Yes [ ]  No [ ]

 d. Frequency of service provision Yes [ ]  No [ ]

 e. Duration of service provision Yes [ ]  No [ ]

 f. Signature of the client/designated representative

 indicating agreement with the care plan Yes [ ]  No [ ]

1. Signature of the Registered Nurse and the

 Social Worker developing the care plan Yes [ ]  No [ ]

1. Date of the care plan development Yes [ ]  No [ ]

 (V.A.3.a.-h.) (pp. 5-6 Care Management Service Standards)

 Documentation reviewed/Comments:

**Part II: SUMMARY OF CLIENT RECORD REVIEW**

For the client record review section, pull a random sample of based on Section 308.2 B. and Administrative Letter No. 22-09. Attach ZGA-542 for Code 610. Use the accompanying Client Record Review Worksheet to record results of each client file review. After reviewing the client files, complete the questions listed below to summarize the client record information.

Funding Source: **HCCBG [610]**

Of the       (number) client files reviewed,

1. Out of       (number) clients needing registration information updated,        (number) had registration information updated. (IX A.) (p. 9)

1. (number) contained a completed screening/intake instrument. (V.A.1.) (pp. 3-4)

1. (number) contained a completed comprehensive multidimensional assessment signed and dated by the Registered Nurse and the Social Worker. (V.A.2.) (pp. 4-5)
2. Out of       (number) clients needing reassessments,      (number) were completed, signed and dated by the Registered Nurse and the Social Worker. (V.A.2.) (p. 5)

1. (number) care plans were developed within 12 working days of the initial screening/intake. (V.A.3.) (p. 5)
2. (number) care plans were signed and dated by the Registered Nurse and the Social Worker.

1. (number) care plans were reviewed quarterly by the Registered Nurse and the Social Worker. (V.A.3.) (p. 6)

1. (number) indicated that monthly contacts to the client were made. (V.A.4.a.) (p. 6)
2. (number) indicated that at least a quarterly in-home visit was made. (V.A.4.a) (p. 6)
3. Out of      (number) clients having health related needs,       (number) had the Registered Nurse conducting the quarterly home visits. (V.A.4.b.) (p. 6)

 11.       (number) clients were made aware of Client/Patient Rights. (VI.) (p. 8)

12. Out of       (number) clients referred for service,       (number) had

 signed a Release of Information form.

Additional Comments:

**Fiscal Verification- Part III**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer(s):

Funding Source: **HCCBG [610]**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

1. Agency budget (e.g., DAAS 732 A) shows monies

 (Including match if applicable) are used to support

 the Care Management service.Yes [ ]  No [ ]  N/A [ ]

 Documentation reviewed/Comments:

2. If positions are funded, Agency budget (e.g., DAAS 732 A1)

shows Care Management designated position(s) and

 % of position(s) funded for Care Management. Yes [ ]  No [ ]  N/A [ ]

 Documentation reviewed/Comments:

3. If the agency has collected consumer contributions,

 the ZGA 370 YTD matches the agency’s YTD

financial records.Yes [ ]  No [ ]  N/A [ ]

 Documentation reviewed/Comments:

4. At the time of the review, the % utilization rate is

 consistent with budget projections for the fiscal year.

 *(E.g., ZGA 370-YTD)*  Yes [ ]  No [ ]  N/A[ ]

 Documentation reviewed/Comments:

If not, describe any extenuating circumstances and/or

planned adjustments.

5. Any expenses for Care Management (e.g., payroll

 records, invoice for purchases) can be attached to a

 function of the Care Management service.

*(Select a month of reimbursement in ARMS and*

*document that reimbursement correlates with actual*

*expenses.)*  Yes [ ]  No [ ]  N/A [ ]

Documentation reviewed/Comments: