**Instructions for Completing I & OC Monitoring Tool-HCCBG**

I&OC has two codes for budgeting and reporting in ARMS:

-Code 040 is for the I&OC budget and the reporting of each Information and Assistance contact.

-Code 440 is for reporting Options Counseling clients and the reporting of one unit per client for every month in which each client receives Options Counseling.

**For HCCBG** **[040/440] Programmatic Monitoring:**

Complete pages 2 – 10, and provider completes page 11.

**For HCCBG [040/440] Fiscal Verification Only:**

Complete page 6.

**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.

NORTH CAROLINA DIVISION OF AGING AND

NC AREA AGENCIES ON AGING

**PERFORMANCE REVIEW: INFORMATION AND OPTIONS COUNSELING**

**Part I: Program Verification**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer:

Funding Source: **HCCBG [040/440]**

**PROGRAM DEFINITION –** (**Complete Questions 1- 3 last**)

1. Agency provides Information. (III A&B) Yes [ ]  No [ ]

2. Agency provides Assistance. (III A&B) Yes [ ]  No [ ]

3. Agency provides Options Counseling. (III C)Yes [ ]  No [ ]

**(1-3 must be “yes” to be in compliance with the Information and Options Counseling Service Standards)**

***\*\*Be sure to note below the specific documentation that was reviewed for each of the questions #4 through #16.***

CLIENT ELIGIBILITY

4. Persons served are 60 years of age or older or are Yes [ ]  No [ ]  N/A [ ]

 acting on behalf of a person 60 years of age or older.

 (IV.B.) (i.e. Client Record, Promotional materials, Service Policies, etc.)

 Documentation reviewed/Comments:

**MARKETING AND SERVICE PROMOTION**

5. Agency can show evidence that it promotes the Yes [ ]  No [ ]  N/A [ ]

 Information, Assistance and Options Counseling components

 of this service. (V.C.) (i.e.) Media, PSAs, fliers, newsletters, brochures, presentations, etc.)

 Documentation reviewed/Comments:

**SERVICE PROVISION**

6. Agency has capacity/capability to provide the following Yes [ ]  No [ ]  N/A [ ]

 functions: Determine problem/concern of individual, provide

 information related to problem/concern, research and refer

 to appropriate services, and (for Assistance) plan/coordination/follow-up

 (VI.B.1) (i.e. Client Record, Information Log)

 Documentation reviewed/Comments:

7. Agency records show how staff advocated on behalf Yes [ ]  No [ ]  N/A [ ]

 of an individual or group of individuals. (VI.B.8)

 (i.e. Letters of Support, Client Records, Presentations, etc.)

 Documentation reviewed/Comments:

 8. Agency has process for receiving initial inquiries for Yes [ ]  No [ ]  N/A [ ]

 Options Counseling and delivering Options Counseling

 in the setting and by the method desired by the individual.

 (VI.C.) (i.e., Verbal explanation or written procedure)

 Documentation reviewed/Comments:

 9. Agency delivers Options Counseling Yes [ ]  No [ ]  N/A [ ]

 in the setting and by the method desired by the individual.

 (VI.C) (i.e., Client Records, etc.)

 Documentation reviewed/Comments:

**COMMUNITY PARTNERSHIPS AND SERVICE COORDINATION**

10. Evidence exists that the Agency provides the following: (VII.C) Yes [ ]  No [ ]  N/A [ ]

 (If 1 or more of the following items are missing, mark “No” and include comments below)

* Cooperative working relationships with key service

provider agencies

* Coordinated services with other provider agencies on

behalf of clients

* Educational opportunities about the Options Counseling

Service to its community partners

 (i.e. letters of agreement, minutes of collaborative activities, joint committees, fliers,

 community events, joint publications, client records, copies of referrals, contact with providers)

 Documentation reviewed/Comments:

**RESOURCE FILE DEVELOPMENT AND MAINTENANCE**

11. Evidence exists that the Agency provides the following: (VIII.B & C) Yes [ ]  No [ ]  N/A [ ]

 (If 1 or more of the following items are missing, mark “No” and include comments below)

* Accurate resource file/database and updated within the last

12 months (electronic databases are included)

* Profile of each organization includes a minimum of:

 a) legal name, common name or acronym,

 b) address, c) telephone number, d) website address

 e) days/hours of operation, f) service(s)/program(s) provided,

 g) area served, h) branch offices.

* Access by I&OC Staff to the resource file/database
* Resource file/database which includes both public and private resources

Documentation reviewed/Comments (i.e. database, etc.):

**SERVICE DOCUMENTATION**

12. Evidence exists that the Agency provides the following: (IX.B) Yes [ ]  No [ ]  N/A [ ]

 (If 1 or more of the following items are missing, mark “No” and include comments below)

* Daily log/tracking system of contacts
* Written procedures to ensure confidentiality of client

Information

* Required documentation for Information, Assistance, and

Options Counseling contacts (see Attachment A)

Documentation reviewed/Comments:

**REPORTING & REIMBURSEMENT**

13. Agency reports monthly summary of client I&A contacts to the Yes [ ]  No [ ]  N/A [ ]

 Aging Resources Management System (ARMS).

 (X.C.1.) (i.e. Compare ZGA 546 report to Agency records)

 Documentation reviewed/Comments:

14. Agency registers clients receiving Options Counseling Yes [ ]  No [ ]  N/A [ ]

 using the Client Registration Form – DAAS 101 (Long

 Form). (X.C.)

 Documentation reviewed/Comments:

15. Agency enters into ARMS, 1 unit per client for every month Yes [ ]  No [ ]  N/A [ ]

 a client receives Options Counseling. (X.C.) (ZGA 542)

 Documentation reviewed/Comments:

**STAFF COMPETENCE AND SUPERVISION**

16. Evidence exists that the Agency provides the following: (XII.B & C) Yes [ ]  No [ ]  N/A [ ]

 (If 1 or more of the following items are missing, mark “No” and include comments below)

* Orientation program for Information and

 Assistance Staff *(includes at a minimum: purpose and function*

 *of I & A; role of the agency; administrative structure and policies*

 *for providing the service)*

* Designated staff, space, and tools to provide the service
* At least one certified Options Counselor on staff
* Options Counselor Supervisor: *a) completed the Options*

*Counseling Concepts and Standards Training,*

*b) maintains copies of Options Counselor’s current*

*certificates, and c) annually reviews all client records*

*using the Documentation Checklist*

 (i.e. orientation schedule, manual, training notes, job descriptions, OC certificate, evaluations, checklist, etc.)

 Documentation reviewed/Comments:

**Please explain any questions with extenuating circumstances or N/A answers:**

**Notes:**

**Part II: Fiscal Verification**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer:

**HCCBG funds [040/440]**

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

1. Agency budget *(e.g., DAAS 732 A)* shows monies Yes [ ]  No [ ]  N/A [ ]

 (Including match if applicable) are used to support

 the I & OC service.

 Documentation reviewed/Comments:

2. If positions are funded, Agency budget *(e.g., DAAS 732 A1)* Yes [ ]  No [ ]  N/A [ ]

shows I & OC designated position(s) and % of position(s)

funded for I & OC.

 Documentation reviewed/Comments:

1. If the agency has collected consumer contributions, Yes [ ]  No [ ]  N/A [ ]

the ZGA 370 YTD matches the agency’s YTD

financial records.

 Documentation reviewed/Comments:

1. At the time of the review, the % utilization rate is consistent Yes [ ]  No [ ]  N/A [ ]

with budget projections for the fiscal year.

*(E.g., ZGA 370 YTD)*

Documentation reviewed/Comments:

 If not, describe any extenuating circumstances and/or

 planned adjustments.

5. Any expenses for I & OC (e*.g., payroll records, agency’s*   Yes [ ]  No [ ]  N/A [ ]

 *general ledger, agency’s expense account)* for I & OC

 can be attached to a function of the I & OC service.

 *(Select a month of reimbursement in ARMS and document*

 *that reimbursement correlates with actual expenses.*

Documentation reviewed/Comments

#### Attachment A:

####  Service Documentation

**CLIENT DATA OR RECORD REVIEW:** Used to support monitoring decisions for client eligibility, service provision, and service documentation in Part 1: Program Verification.

1. **Information**

Request all data on log (paper or electronic) for a given month. Sample 1/10 of contacts for each staff persons handling Information contacts with multiple days of the month included. The maximum sample per staff member should be 10. If there are fewer than 10 log entries, review all.

If any data is missing from more than 20% of sampled contacts, then corrective action may be needed.

For each of the contacts sampled, check ([x] ) if the data exists.

**STAFF PERSON #1 – NAME:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Record Includes: Date, Nature of Concern, and Action Taken |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**STAFF PERSON #2 – NAME:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Record Includes: Date, Nature of Concern, and Action Taken |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**STAFF PERSON #3 – NAME:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Record Includes: Date, Nature of Concern, and Action Taken |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**2. Assistance**

Request all client records (paper or electronic) for a given month. Use a random sample of 1/10 of Assistance records (or a minimum of 10 client records); if there are fewer than 10 records, review all. Make sure that a least one record maintained by each staff member providing “Assistance” is included in the sample. Look for trends by staff person.

Items 1-4 should be found in each record. If absent in more than 20% of records, corrective action may be needed. Items 5 and 6 should be found in record, based on the assistance requested/indicated. If not included in more than 20% where requested/indicated, corrective action may be needed.

For each of the records sampled, check ([x] ) if the data exists.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| CLIENT INITIALSor LAST NAME |       |       |       |       |       |       |       |       |       |       |
| 1. Record Includes: Date of contact, Client ID (name, address/phone and/or email address, depending on contact), and Client/Caregiver age eligible (60+) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 2. Client needs (problems) identified, information and/or referral given to address needs  |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 3. Client plan exists |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 4. Follow-up contact and date  |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 5. Coordination of services |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 6. Individual/family advocacy |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**3. Options Counseling**

Request all client records (paper or electronic). Use a random sample of 1/10 of the agency’s Options Counseling records (or a minimum of 10 client records); if there are fewer than 10 records, review all. It is likely that multiple months will need to be reviewed to have a full sample. Make sure that a least one record maintained by each staff member providing “Options Counseling” is included in the sample. Look for trends by staff person.

Items 1-11 should be found in each record. If absent in more than 20% of records, corrective action may be needed.

For each of the records sampled, check ([x] ) if the data exists.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| CLIENT INITIALSor LAST NAME |       |       |       |       |       |       |       |       |       |       |
| 1. Record Includes: Date of contact, Client ID (name, address/phone and/or email address, depending on contact), and age eligible (60+) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 2. Setting/Method of Contact, Time Spent, and Counselor’s Signature/Initials are noted |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 3. Summary of contacts provides a clear picture of client’s situation & addresses: preferences & needs, options discussed, & options selected.  |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 4. Summary, or electronic attachment, or a written copy of action plan (unless declined & documented) Includes components outlined in Standard IX |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 5. Follow-up outlines client’s current situation, outcomes since last contact, whether Action Plan steps occurred, if not, why, & any next steps needed.  |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| 6. Notation & date when Options Counseling ends. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**Attachment B**

**Review of Progress: Information and Options Counseling Staff**

#

Staff #1 Staff #2 Staff #3 Staff #4

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Staff First and Last Name: |       |       |       |       |
| 1. Date staff’s I&A  responsibilities started  |       |       |       |       |
| 1. 2. Date Options

 Counseling duties started (if applicable) |       |       |       |       |
| 1. 3. Date orientation completed

 (*Mark for first year only*) |       |       |       |       |
| 1. Annual 10 hours of training completed for each I/OC staff. \**Specify year reviewed and total number of training hours* (Ex: 2025,12 hours)
 |       |       |       |       |
| 5. Assessment of competence is  addressed by supervisor:  specify date(s) (i.e. annual review) |       |       |       |       |

#### Attachment C

#### Site Review

This document must be completed by the Provider for each site. It must be filed at the site for review by the AAA during the performance review process.

Name of Site:      Date:

Provider Review Completed By:      Title:

1. The site is accessible to the target population. Yes [ ]  No [ ]

2. The site is available for walk-in clients. Yes [ ]  No [ ]

3. A room for confidential interviews with clients is available. Yes [ ]  No [ ]

Write any comments.