Monthly Monitoring Contacts:

Monthly monitoring contacts provide the Supports Coordinator with an opportunity to monitor the participant's overall health and wellbeing, as well as review the participant's satisfaction with their current service plan. Monitoring contacts also allow the Supports Coordinator to review and address new issues that may require additional follow up to ensure the participant's safety and minimize the potential for injury, hospitalization, or change in status. Follow up may require discussing recommendations with the participant, contact with their physician, making referrals to additional community resources, making changes to the participant's service plan, or providing educational materials to the participant.

These scripts are to be used by Supports Coordinators as a guide for asking appropriate follow-up questions to the mandatory questions found in COMPASS. These follow up questions are intended to elicit more information from the participant that may be useful in service and care planning. The questions listed do not need to be asked verbatim and can be asked differently based on the participant's specific cultural or linguistic needs, keeping in mind the information that needs to be gathered and documented in the case record. Document the participant's answers in the monitoring note in narrative form.

In order to be fully prepared for the monitoring contact, the Supports Coordinator should have the following information ready prior to contacting the participant:

- ☐ Participant's Service Summary or Person-Centered Service Plan
- ☐ Participant's Back-up Plan
- ☐ Estimated Date of MDHHS Re-Certification
- ☐ Due dates for any upcoming visits, Person-Centered Service Plan reviews, and/or Reassessments.

Monitoring Questions:

1. Have you had any new health problems recently?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What new health problems have you been experiencing?

- Have you seen or spoken to your physician about this new health problem?
    - Depending upon the health problems noted, the Supports Coordinator may find it appropriate to recommend that the participant follows up with their physician and/or seek emergency medical care. If so, this should be communicated to the participant and documented in the note.

- Are you having any increased difficulty with your daily routine because of these new health issues?

- Are you in need of any changes to your current MI Choice Waiver Services?
    - The Supports Coordinator should offer any appropriate MI Choice Services that might address any safety concerns caused by the new health issue.

2. Have your medications changed recently?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What changes have you had to your medications?
    - The Supports Coordinator will need to take note of all the required information to update the medication list. A summary of the medication changes should be documented in the note.
    - The Supports Coordinator will also need to immediately update the medication record in the participant's Next Assessment in COMPASS.

- Do you have any concerns or questions about your medication changes?
    - If yes, the Supports Coordinator may want to recommend that the participant follow up with the physician.
    - If appropriate, the Supports Coordinator may, with the participant's permission, contact the participant's physician to follow up with their questions or concerns.

- The Supports Coordinator should offer or recommend any Mi Choice Waiver services that may help mitigate any risks or safety concerns related to medications. Examples include:
    - Nursing Services – medication set up, participant education
    - Medication Dispenser

3. Have you gone to the Emergency Room or been admitted to the hospital recently?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

If the Supports Coordinator has already been notified of the ER visit or hospitalization and completed the follow up, prior to the monitoring contact, The Supports Coordinator should make note in the monitoring contact note and refer the reader to the previous progress note for details.

- Did you go the Emergency Room?

- Were you admitted to the hospital?

<u>If the participant reports an Emergency Room visit without admission:</u>

- What happened that caused you to seek emergency medical treatment?

- What hospital did you go to?

- What treatment did you receive?

- Did you receive any discharge instructions?
    - The Supports Coordinator should review the discharge instructions with the participant, if available. Ask if they have any questions or concerns about any of the information.

If the participant reports a hospital admission:

- Was this a planned or unplanned admission?
- What happened that caused you to be admitted to the hospital?
- What date were you admitted?
- What date were you discharged?
- Did you receive any new diagnosis, prognosis, treatments, etc?
- Did you receive any discharge instructions?
    - The Supports Coordinator should review the discharge instructions with the participant, if available. Ask if they have any questions or concerns about any of the information.
- Did you receive any orders for new Durable Medical Equipment (DME)?
    - If the participant received an order for DME at discharge, follow up with the participant ensuring receipt of the item must be documented.
- Are you in need of any changes to your current MI Choice Waiver Services?
    - The Supports Coordinator should offer any appropriate MI Choice Services that might mitigate the risk of a readmission to the hospital based on the participant's needs or situation.

Follow Up:

- If the ER visit or hospitalization results in a significant change of condition or need for additional services, the Supports Coordinator must schedule a full reassessment and PCSP review.
- All ER visits and hospitalizations should be tracked and noted within the RN portion of the "Next Assessment".
- If the hospitalization was not already reported, the Supports Coordinator must update the status and service summary to reflect the dates they were admitted. Supports Coordinators must also complete an Adverse Benefit Determination.
- The Supports Coordinator may want to contact the admitting hospital to get a copy of any important documentation, admission or discharge paperwork (if the CCD/ADT information is not available).
- Based on the details of the ER visit or Hospitalization, the Supports Coordinator may be able to provide resources to the participant to mitigate the risk of re-admission.
    - This may include referrals to UPCAP Health & Wellness programs like Matter of Balance, Personal Action Towards Health (PATH), Walk with Ease, etc.
    - This may include pamphlets or brochures on specific health conditions or diagnosis
    - Any resources or referrals provided to the participant should be documented.

Related Monitoring Questions - These are existing monitoring contact questions that may relate to the hospitalization or ER visit. The participant may have provided information previously or the question may be answered during this line of follow-up questioning.

- Have your medications changed recently?
- Are you receiving any skilled care such as PT, OT, ST, or nursing?

4. Have you fallen recently?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- When did you fall?
- How did you fall?
- Did you get hurt? Did you sustain any injuries from the fall?
- Did you receive medical treatment after the fall? Did you go to the Emergency Room or see your doctor?
    - If the participant reports that they sustained an injury from the reported fall AND they received medical treatment for their injury, it is considered a critical incident.
    - Supports Coordinators will be responsible for entering the critical incident into the portal within 2 days of notification, and following up by investigating the incident surrounding the fall, determining whether or not it is a result of abuse or neglect, and implementing interventions and/or strategies to reduce the risk of future falls.
    - If the fall results in a significant change of condition or need for additional services, the Supports Coordinator must schedule a full reassessment and PCSP review.
- Would you be interested in additional resources to help with reducing your risk of falling in the future?
    - Offer information or provide the brochure for the Matter of Balance program through UPCAP
    - Provide them with printable brochures, fact sheets, or resources (available on website)
    - Utilize the Aging in Place toolkit from CAPABLE (available on website)
    - If they decline, make sure to note in the progress notes.

- Would you like to schedule an in-home visit and housing assessment so that I may assist in providing feedback on any safety concerns within the home or offer MI Choice Waiver services that may help to minimize future falls?

    - If the participant answers "yes", the Supports Coordinator should schedule a day and time to complete a home visit. Details of the visit and findings should be documented in the participant's next assessment and progress notes in COMPASS.
    - The Supports Coordinator can complete a more comprehensive evaluation by completing the Housing Assessment or Home Safety Evaluation in COMPASS, if appropriate
    - The Supports Coordinator should offer recommendations to improve safety within the home and document in COMPASS.
    - The Supports Coordinator should offer Mi Choice services that may mitigate risk of future injury. Examples include:
        - Specialized Medical Equipment & Supplies
        - Environmental Accessibility Adaptations
        - Community Living Supports
        - Nursing Services
        - Personal Emergency Response System

- Depending on the nature and reason for the fall, the Supports Coordinator may also find it appropriate to review current medication list with the participant.

    - If there are concerns about any medications, the Supports Coordinator may consult with the participant's primary physician, if the participant is agreeable, to discuss any concerns with falls and risk of injury

- The Supports Coordinator may find it appropriate to discuss the potential for skilled therapies (i.e. physical therapy, occupational therapy, etc) which may improve the participant's mobility, balance, and strength and therefore decrease the likelihood of future falls.
    - If the participant is agreeable, the Supports Coordinator may consult with the participant's primary physician to discuss the need for skilled therapies.

5. Are you receiving any skilled care such as PT, OT, ST, or Nursing?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What skilled services or therapies are you receiving?

- Are you getting them at home or outpatient?
    - If the participant is receiving skilled care in their home, ask for the name of the skilled agency providing the care.
        - The Supports Coordinator will need to contact the skilled agency to request the skilled care plan (please refer to the *Care Transitions Policy 2022-30* for more detailed process when a participant has been opened to skilled care.)
    - If the participant is receiving outpatient skilled services, ask for the name of the skilled provider.
        - The Supports Coordinator may want to contact the provider to request the skilled care plan.

6. Are your caregivers prompt and do they treat you with respect and dignity?

If the participant answers "**No**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What kind of concerns or issues are you having with your caregiver(s)?
    - Take note of any issues that might prompt a critical incident investigation. (Refer to the Critical Incident Policy 2022-28)

- Where is your caregiver from (contractive provider, self-determination, etc.)?
    - If the caregiver is from an agency, the Supports Coordinator will need to follow up with the contracted provider, if appropriate.
    - If the caregiver is a self-determination provider, the Supports Coordinator may want to provide more information regarding the self-determination program with the participant or their designated representative. Depending on the issue, the Supports Coordinator may also want to contact the Agency with Choice, if applicable.
    - If the caregiver is from a non-Waiver provider, The Supports Coordinator may want to ask the participant if they would like assistance contacting the agency or entity providing the care.

- Depending on the nature of the issues discussed or reported, the Supports Coordinator may want to offer the participant the option of having their services provided through a different provider, if available.

7. Are your services being delivered according to your PCSP?

If the participant answers "**No**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What services are not being provided according to your service plan?

- If the services are not being provided according to the service plan due to the direct care worker shortage or provider staffing issues, the Supports Coordinator may want to offer the participant the option of another provider (i.e. contracted provider agency, self-determination program) if available.
    - REMINDER: Progress notes must show that the Supports Coordinator is attempting to fulfill the full extent of services authorized on a MONTHLY basis, through contact with available or requested providers.

8. Are you satisfied with your services being provided at this time?

If the participant answers "**No**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- Why are you not satisfied with your services?
- Are there services that you feel you need that you are not receiving?
- Would you like to schedule a Person-Centered Planning meeting to discuss your concerns and make any changes to your current service plan?
    - If the participant answers "yes", the Supports Coordinator should schedule a day and time to complete the in-person PCSP review.

9. Has there been a change in your eating or sleeping patters recently?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- Has the change been with your eating or your sleeping habits?
    - If they report a change in eating habits, follow script for nutrition below.
    - If they report a change in sleeping patterns, follow script for sleep below.

Nutrition:

- What changes or issues have you been experiencing?
- Are you having any difficulty preparing your food? If so, why?
- Are you having any difficulty chewing or swallowing your food? If so, why?
- Are you having any difficulty affording groceries or securing meal options?
- Would you be interested in additional resources?
    - Provide information regarding local congregate meal sites available in their community (available on website & 2-1-1)
    - Provide them with information regarding local food banks or pantries (available on website & 2-1-1)
    - Provide them with information regarding the U.P. Food as Medicine Program (available on website)
    - Provide them with printable brochures, fact sheets, or resources (available on website)
- If appropriate, the Supports Coordinator may recommend the addition of applicable Mi Choice Waiver Services that might help mitigate any risks associated with eating and nutrition. (Do not forget to update the PCSP to include any interventions)

- Home Delivered Meals
- Nutritional Supplements

- Depending on the nature and reason for the issues or changes in eating habits, the Supports Coordinator may also find it appropriate to recommend physician involvement or review current medication list with the participant.

    - If there are concerns about any medications, the Supports Coordinator may consult with the participant's primary physician, if the participant is agreeable, to discuss any concerns with the participant's eating habits.
    - If the Supports Coordinator believes that the participant should follow up with their primary care physician to rule out any health-related issues related to the change in eating habits, the Supports Coordinator may consult with the participant's primary physician, if the participant is agreeable. The Supports Coordinator may also recommend and assist with scheduling an appointment with the participant's primary care physician.

Sleep:

- What changes or issues have you been experiencing?

- Are you having any new or increased pain that is contributing to changes with your sleep?

- Would you be interested in additional resources?

    - Provide them with printable brochures, fact sheets, or resources (available on website)
    - Provide them with a printable sleep diary (available on website)

- If appropriate, the Supports Coordinator may recommend the addition of applicable Mi Choice Waiver Services that might help mitigate any risks associated with sleep. (Do not forget to update the PCSP to include any interventions)

    - Specialized Medical Equipment

- Depending on the nature and reason for the issues or changes in sleeping patterns, the Supports Coordinator may also find it appropriate to recommend physician involvement or review current medication list with the participant.

    - If there are concerns about any medications, the Supports Coordinator may consult with the participant's primary physician, if the participant is agreeable, to discuss any concerns with the participant's sleeping habits.
    - If the Supports Coordinator believes that the participant should follow up with their primary care physician to rule out any health-related issues related to the change in sleep habits, the Supports Coordinator may consult with the participant's primary physician, if the participant is agreeable. The Supports Coordinator may also recommend and assist with scheduling an appointment with the participant's primary care physician.

10. Do you have any concerns or needs that we can help you with at this time?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What kind of needs or concerns do you have?
    - Because high variance of potential answers to this question, Supports Coordinators can follow up with information regarding community resources, MI Choice Services, or educational materials based on the individual concerns of the participant.

11. Have you had any changes in your Medicaid?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What changes have you experienced?

- Depending on the participant's issue, the Supports Coordinator may need to contact their local MDHHS office for more information or assistance.

12. Have you received any letters from MDHHS recently or need assistance completing the application?

If the participant answers "**Yes**" to this question during the monthly monitoring contact, please follow the below script for suggested follow-up questions and interventions.

- What did you receive from MDHHS?
    - The Supports Coordinator should ask the participant to relay the contents of the letter or correspondence received.
- Do you need any assistance in understanding the letter?
    - If necessary, the Supports Coordinator may need to schedule a quick home visit to review the letter and assist the participant in understanding the contents of the letter or correspondence.
    - The Supports Coordinator may also need to follow up with the local MDHHS office, if necessary

- Did you receive any paperwork that needs to be filled out and returned to MDHHS?
    - If yes, the Supports Coordinator may need to schedule a home visit to assist the participant with completing any applications or redeterminations and gather any required verifications.
    - If the participant has not received any correspondence, the Supports Coordinators should review the date of Medicaid Recertification in the Participant's case file. Remind the participant of their redetermination date and that they should contact their Supports Coordinator when they receive it so that the SC may assist.

Effective Date:

- 03/09/2023

Document History:

- Reviewed 09/26/2023 – Internal Quality Team
    - No changes needed.