MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

FY 2024 Required Corrective Action					
Standard	**Performance Measure**	**Recommendation (7)**	**Corrective Action Required (31)**	**Multi-Year Citation (13)**	**New Citation (18)**
1.1	3, 6		☒		☒
1.2	3, 5	☒			
2.1	3		☒		☒
3.4			☒		☒
3.5			☒		☒
4.4		☒			
5.1	14		☒	☒	
5.8	14		☒		☒
6.1	3		☒		☒
6.6	14	☒			
6.7			☒	☒	
6.8	3		☒		☒
7.1			☒	☒	
7.2			☒	☒	
7.3			☒		☒
7.5			☒		☒
7.6			☒		☒
7.7			☒	☒	
8.1	4, 14		☒		☒
8.3	11, 14		☒		☒

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8.4	11, 14		☒		☒
8.5	11, 14		☒	☒	
8.7	14	☒			
8.9			☒	☒	
8.10	14		☒		☒
8.13	14		☒		☒
8.1	14	☒			
9.2	14	☒			
9.4	14		☒		☒
9.5			☒		☒
9.6	14	☒			
10.2	14		☒	☒	
11.1	15		☒	☒	
11.2			☒	☒	
11.3	15		☒		☒
13.1	24		☒	☒	
13.2			☒	☒	
15.2			☒	☒	

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Citations Requiring Corrective Action:

Citation:

1.1. Was the Nursing Facility Level of Care Determination (NFLOCD) adopted from a long-term care provider or conducted within 7 days prior to or the day of initial enrollment and/or re-enrollment and entered into CHAMPS as required by MDHHS and the contract? - NEW CITATION

Issues Cited:

- Initial enrollment 01/31/24. The NFLOC was not completed within 7 days of enrollment. The Status Report identified the participant's enrollment 01/31/24. However, the FOC was completed 01/18/24 (13 days). (LO)

Root Cause Analysis:

- Misinterpretation of policy
- Need for Supports Coordinator training and education.
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations.

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.
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Who/What Will be Monitored:

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- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
- The results of monthly peer reviews, supervisory reviews, and chart audits will be tracked by the LTC Quality Improvement Specialist and analyzed by the LTC Quality Improvement Specialist, LTC Quality Improvement Manager, and Director of LTC Programs. The data will be utilized to determine any performance trends and identify areas in which improvement is needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Confirmation received from H.Hill 12/9/2024 that an enrollment must entered into CHAMPS within 7 days of any NFLOCD – initial and re-enrollments. NFLOCD still must be “entered” in CHAMPS within 14 days and can be adopted after 7 days if needed, but a new FOC will need to be completed. Will need to update policies ASAP to reflect this new guidance.

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Citation:

2.1. Is there a valid Freedom of Choice (FOC) form in the record for the Fiscal Year review period? – NEW CITATION

Issues Cited:

- FOC 09/07/23 contained a correction to the provider information. However, the correction was not completed according to policy. (JS)
- Documents provided for the review did not include a FOC for CHAMPS conducted 10/19/23 and entered 10/20/23 (Door 5). 2) Documents provided for the review did not include a FOC for CHAMPS conducted 12/14/23 and entered 12/14/23 (Door 7). (PM) – **WAS PROVIDED – CONFIRMED ITS IN PORTAL**
- FOC 01/24/24 and 03/07/24 were not signed by the activated Durable Power of Attorney (DPOA). (RB)

Root Cause Analysis:

- Supports Coordinator oversight
- Need for Supports Coordinator training and education
- Lack of policy or formal direction re: correcting documents

Staff Education Plan:

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Additional Notes:

- Will need to update policy to include process for correcting errors:
    - Draw a single line through the incorrect information
    - Write the corrected next to the crossed-out text (use different color ink if possible)
    - In cases where the correction isn't immediately obvious, an explanation should be provided
    - Sign and Date the correction.

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Citation:

3.4. Were agency specific forms accurate, complete, and did they conform to MDHHS policy and contract requirements? - NEW CITATION

Issues Cited:

- The Plan of Care Agreements 01/24/24, 03/07/24, and 08/14/24 were not signed by the activated Durable Power of Attorney (DPOA). (RB)
- Progress notes 04/09/24 and 04/10/24 identified the participant's receipt and signature of the waiver agency's "Email/Text Consent" form. However, the documents provided for review did not include the signed consent form. Progress notes 12/20/23, 02/15/24, 02/20/24, 03/22/24, 04/05/24, 04/09/24, 04/15/24, 04/24/24, 06/03/24, 06/17/24, and 06/28/24 identified email communication. The Review Notes: Progress note 06/26/23 (prior to the review period) identified the participant's receipt and signature of the waiver agency's email communication consent. However, did not include the signed consent for the timeframe 06/26/23 – 04/08/24 (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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Additional Notes:

- Reminder/Memo to staff reminding them to get signatures on text/email form annually.

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Citation:

3.5 Were alleged privacy breaches investigated, reported, and conform to MDHHS policy and contract requirements? - NEW CITATION

Issues Cited:

- Progress notes 01/31/24, 02/07/24, 02/28/24, 03/07/24, 04/03/24, 04/24/24, 05/22/24, 06/17/24, 08/14/24, and 09/11/24 identified the Supports Coordinator completed contacts and in-person visits with the participant and assisted living staff. However, the record lacked documentation validating the participant's Durable Power of Attorney approved contacts to others (RB)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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Additional Notes:

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Citation:

5.1 Did the Supports Coordinator (SC) contact the participant/guardian prior to assessments, home visits and/or planning meetings to ensure the date(s), time(s) and location(s) were convenient for the participant/guardian? (Performance Measure 18) – MULTI-YEAR CITATION (2)

Issues Cited:

- Progress note 04/09/24 identified the participant chose to conduct the Person-Centered Service Planning meeting (PCSP) on "04/15 at 10am." However, the PCSP was conducted on 04/16/24 (PM)
- 1) The Person-Centered Service Plan 12/14/23 identified, "(Participant) has dementia and may be an unreliable reporter. Please contact [daughter-in-law] (Power of Attorney) (S.B.) for information and scheduling." However, progress note 03/06/24 identified the participant's re-assessment was confirmed with the Assisted Living Facility staff and not with the participant. Additionally, the progress note identified, "contacted DPOA for (participant) also, to (Durable Power of Attorney) to let her know the appointment date and time." 2) The record did not validate advanced notice was provided to the participant for signature and delivery of agency documents 09/06/24 (RB)
- Progress note 08/09/24 identified the participant requested an in-person meeting on 08/16/24. However, the meeting was conducted on 08/12/24 (RV)

Root Cause Analysis:

- Supports Coordinator charting error
- Need for Supports Coordination training and education

Staff Education Plan:

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Citation:

5.8. Did the record reflect the Supports Coordinator (SC) gave the participant the opportunity to achieve and maintain independence and self-direction, which includes Self-Determination (SD) and the opportunity to direct and engage in the service planning process? - NEW CITATION

Issues Cited:

- Re-Assessment 11/13/23 indicated: "Client's father doesn't seem distressed, but he does want to get paid for helping, client agrees." Additionally, progress note 05/14/24 stated: "It was discussed that her father could be a paid caregiver through Arcadia and she reported that she would discuss this with him when he returns." The Service Authorization evidenced termination of Community Living Supports/Transportation (agency provided) 06/12/24. However, the record did not validate the Self-Determination service delivery option was offered or discussed by the SC with the participant (EJ)
- Progress note 10/17/23 indicated: "(Participant's daughter/DPOA) reported that her son is still interested in becoming a paid caregiver but has not filled out the paperwork yet." Additionally, progress note 12/11/23 stated: "they are planning to hire a grandson who is now living in the home to be a self-determination worker." The Service Authorization evidenced termination of Community Living Supports (agency provided) 06/07/24. However, the record did not validate the Self-Determination service delivery option was offered or discussed by the SC with the participant. (JS)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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Additional Notes:

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Citation:

6.1. Did the Waiver Agent (WA) complete the Initial Assessment (IA) and/or Re-Assessment(s) (RA) as required by CMS and the MDHHS contract? - NEW CITATION

Issues Cited:

- Progress note 09/20/24 identified the participant "has been considering going to a NF. She is becoming more unsure of herself and worried about falls." The SC discussed and offered additional Community Living Support (CLS) services Monday-Friday for 2 hours in morning. However, the record lacked documentation supporting the SC conducted a Re-Assessment due to the significant change in status (AK)
- Progress note 04/12/24 identified the Waiver Agent was notified of the implementation of Hospice services 04/08/24. However, the record lacked documentation supporting the SC conducted a Re-Assessment due to the significant change in status. (JF)
- Initial Assessment conducted 09/07/23. Progress note 12/13/23 evidenced the Supports Coordinator Registered Nurse (SCRN) contacted the participant in an attempt to schedule the subsequent RA (98 days). 2) The Service Authorization and Adverse Benefit Determination Notice supports termination of Community Living Support services 06/07/24 per participant choice. However, the record lacked documentation to evidence the reason for termination of this service and/or the need for a significant change assessment. (JS)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
- The results of monthly peer reviews, supervisory reviews, and chart audits will be tracked by the LTC Quality Improvement Specialist and analyzed by the LTC Quality Improvement Specialist, LTC Quality Improvement Manager, and Director of LTC Programs. The data will be utilized to determine any performance trends and identify areas in which improvement is needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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Additional Notes:

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Citation:

6.7 If the Supports Coordinator (SC) identified the use of restraints or seclusion, did the SC evaluate, address, and offer alternatives to the use of restraints or seclusion? MULTI-YEAR CITATION (3)

Issues Cited:

- The record identified the use of bed rails. However, documentation did not identify the purpose or the length of the bed rails. (FN)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.
- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

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Who Is Responsible for Monitoring & Reporting Results:

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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Policy was updated in the manual following last CQAR

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Citation:

6.8. Was the information in the assessment consistent, providing a clear picture of the participant's strengths, needs, and abilities, and contained relevant information and explanations? - NEW CITATION

Issues Cited:

- Missing Data Report 04/16/24 included 4 incomplete data fields in Sections I, J, N and Q (AK)
- Re-Assessment (RA) 11/13/23 contained discrepancies: 1) Section J identified the participant exhibited sleep problems daily in the past 3 days. However, the comment section did not address this issue. 2) Section Q indicated: Meals: # Days: 0. However, the Service Authorization supported implementation of Home Delivered Meals 08/18/23 (daily). 3) Section P indicated the participant primary mode of locomotion is her wheelchair. However, data item: "Distance wheeled self - Farthest distance wheeled self at one time in the last 3 days indicated "Did not use wheelchair." 4) Section Q indicated Home Nurse: # Days: 3. However, the comment section did not address this identified issue. 5) Section Q indicated: Medical alert bracelet or electronic security alert: Not ordered AND did not occur. However, the Service Authorization supported a Personal Emergency Response System authorized 10/16/23. (EJ)
- Re-Assessment 01/23/24 Section Q identified no formal care in place. However, the record identified the participant received Community Living Support services through Self- Determination. (FN)
- 1) Re-Assessment (RA) 12/11/23 indicated: Personal assistants/aides: # Days: 0, Homemaking services: # Days: 0, and Meals: # Days: 0. However, the Service Authorization supported implementation of Home Delivered Meals 10/17/23 (daily) and Community Living Supports 11/15/23 (24 units per week). 2) RA documentation evidenced the participant's daughter referred to as her "Guardian." However, documents provided identified the participant's daughter as her Durable Power of Attorney (DPOA). (JS)

Root Cause Analysis:

- Supports Coordinator Error
- Need for Supports Coordinator training and education

Staff Education Plan:

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- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts

monitored and one-on-one education/training provided, if warranted.

- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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Additional Notes:

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Citation:

7.1 Did the Medication Record include all prescribed medications? MULTI-YEAR CITATION (3)

Issues Cited:

- Documents provided included the Hospice Plan of Care (certification period 10/25/23 – 12/23/23). The Hospice Plan of Care Medication List was not congruent with the Medication and Allergy Report 11/13/23 and "Next." 1) The Hospice Plan of Care identified the participant was prescribed Bacitracin and Oxycodone-Acetaminophen 5/325 mg. However, the Medication and Allergy Report 11/13/23 and "Next" did not identify these medications. 2) The Medication and Allergy Report 11/13/23 and "Next" identified Calcitriol and Ondansetron. However, the Hospice Plan of Care did not identify these medications (EJ)
- Progress note 09/18/24 identified the participant was started on a new medication and, "he will update SC (Supports Coordinator) once he has this information." However, the corresponding Medication and Allergy Report was not updated to list the medication change as of the date of review (09/30/24). The Review Notes: Incorrect spelling of medication [Fluticasone]. (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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MI Choice Clinical Quality Assurance Review

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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September but did not receive a response yet.

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Citation:

7.2 Did the Medication Record include the name, prescribing physician name (as indicated on the prescription bottle), purpose, strength/dose, frequency, and route for all medications? MULTI-YEAR CITATION (4)

Issues Cited:

- Medication and Allergy Report 10/20/23 and "Next" did not identify the strength/dose for Albuterol and Symbicort (DR)
- 1)The Medication and Allergy Report 12/11/23 and "Next" listed Advair. However, the Medication and Allergy Report did not contain the number of puffs. 2) The Medication and Allergy Report 12/11/23 and "Next" identified the participant's prescribing physician as "Dr. Kates." However, the contingency plan documented Dr. French as the participant's physician (JS)
- The Medication and Allergy Report 01/05/24 and "Next" listed Diclofenac strength/dose as "1.5." (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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Who/What Will be Monitored:

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reviews.

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Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September, but did not receive a response yet.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

7.3. Did the record validate the Clinical Supports Coordinator reviewed the medications and sought resolution for an identified issue(s)? - NEW CITATION

Issues Cited:

- 1) Re-Assessment 10/20/23 did not validate the Clinical Supports Coordinator conducted a review of the participant's medications. 2) Progress note 03/15/24 identified the participant had medication changes. However, did not validate the Clinical Supports Coordinator conducted a review of the participant's medications. 3) Progress note 07/12/24 identified the participant had medication changes. However, did not validate the Clinical Supports Coordinator conducted a review of the participant's medications (DR)
- Progress note 08/09/24 identified the participant's one time prescription for "Farxiga has run out, so they will talk to PCP to see if he wants that to continue or not." However, documentation did not validate the (SC) addressed the compliance issue(s) and took action to reduce the risk of medication mismanagement (FN)
- Progress note 10/03/23 identified the participant had medication changes. Progress note 10/04/23 validated that the Support Coordinator (SC) received the participant's updated medication list and medical information. However, the documentation provided for the review did not include the medication list and medical information provided by the participant. Agency Follow-Up Not Required. Progress note 01/05/24 validated the Clinical Supports Coordinator conducted a review of the participant's medications. (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations.

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September but did not receive a response yet.

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Citation:

7.5. Did the Medication Record identify the participant's known pharmaceutical, environmental, and food allergies, including allergic reactions or identify the participant had no known allergies? - NEW CITATION

Issues Cited:

- Documents provided included Liquid Nutritional Supplements (LNS) prescriptions 12/18/23 and 06/19/24. The LNS prescriptions identified the participant was allergic to "HCTZ." However, this allergy was not identified on the Medication and Allergy Report 01/23/24 and "Next." (FN)
- Medication and Allergy Report 11/17/23 and "Next" identified the participant's allergies. However, the reactions to those allergies were not identified (JJ)

Root Cause Analysis:

- Need for Supports Coordinator training and education
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations.

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September, but did not receive a response yet.

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Citation:

7.6. Did the Supports Coordinator (SC) assess/document how the participant's medications were managed? **- NEW CITATION**

Issues Cited:

- The record contained incongruent information regarding the participant's medication management. Re-Assessment 10/20/23 Section P identified the participant was independent with medication management. However, Section R evidenced the participant was adherent with medications 80% or more of the time and would be speaking to "Bay Mills Health Clinic to see if she would be eligible for medication management services again, now that she is on more medications (DR)
- Re-Assessment 12/14/23 and 03/07/24 Section R identified, "Needs reminders to take medications: No." However, the comment section identified, "Medication setup and cueing is needed." (RB)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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Who/What Will be Monitored:

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- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
- The results of monthly peer reviews, supervisory reviews, and chart audits will be tracked by the LTC Quality Improvement Specialist and analyzed by the LTC Quality Improvement Specialist, LTC Quality Improvement Manager, and Director of LTC Programs. The data will be utilized to determine any performance trends and identify areas in which improvement is needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
- Supports Coordinators will be responsible for conducting no less than one peer review monthly. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The LTC Quality Improvement Specialist and LTC Quality Improvement Manager will be responsible for analyzing all data from the peer reviews, supervisory reviews, chart audits, and report findings to the Director of LTC Programs.
- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September, but did not receive a response yet.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

7.7 Did the Supports Coordinator (SC) address issues the participant had with medication regimen compliance and take action to reduce the risk of medication mismanagement? MULTI-YEAR CITATION (3)

Issues Cited:

- Re-Assessment 10/20/23 identified the participant was compliant with medications 80% or more of the time. Additionally, the record identified, "The Bay Mills Tribe RN feels that (participant name) can manage her medications on her own, so has been doing so. However, (participant) is planning on discussing this again with her physicians at the Bay Mills Health Clinic to see if she would be eligible for medication management services again, now that she is on more medications." However, documentation did not validate the SC addressed the compliance issue(s) and took action to reduce the risk of medication mismanagement. The Review Notes: Re-Assessment 10/20/23 identified the participant did not have a medication list. However, the record did not validate the SC offered to provide a medication list or that the participant declined a medication list when offered (DR)
- Progress note 08/09/24 identified the participant's one time prescription for "Farxiga has run out, so they will talk to PCP to see if he wants that to continue or not." However, documentation did not validate the (SC) addressed the compliance issue(s) and took action to reduce the risk of medication mismanagement. (FN)

Root Cause Analysis:

- Need for Supports Coordinator training and education
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations.

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

- Medication policy was updated during FY2024 to reflect additional guidance provided by MDHHS and clarification of contract language – sent to MDHHS and MPHI in August 2024 and again in September, but did not receive a response yet.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.1. Did the Supports Coordinator (SC) develop, evaluate, and update the Person-Centered Service Plans (PCSP) as required by Federal Regulations and the MDHHS contract? - NEW CITATION

Issues Cited:

- Progress note 09/20/24 identified the participant "has been considering going to a NF. She is becoming more unsure of herself and worried about falls." The SC discussed and offered additional Community Living Support (CLS) services Monday-Friday for 2 hours in morning. However, the record lacked documentation supporting the SC evaluated and updated the PCSP due to the significant change in condition. (AK)
- 1) The initial Person-Centered Service Plan 10/26/23 did not contain the participant's dated signature. 2) Progress note 04/12/24 identified the Supports Coordinator was informed of the implementation of Hospice services 04/08/24. However, a re-evaluation of the participant's PCSP was not conducted (JF)
- 1) Initial Assessment conducted 09/07/23. Progress note 12/13/23 evidenced the Supports Coordinator Registered Nurse (SCRN) contacted the participant in an attempt to schedule the subsequent PCSP update (98 days). Progress note 12/21/23 identified the SCRN completed "the RN portion of the Re-Assessment" (106 days). 2) Person-Centered Service Plan 09/07/23 evidenced the participant preferred RA to be conducted every 360 days. However, a RA must be conducted 90 days following an initial enrollment. 3) The Service Authorization and Adverse Benefit Determination Notice supports termination of Community Living Support services 06/07/24 per participant choice. However, PCSP "Next" was not updated to reflect this change. (JS)
- Progress note 07/22/24 identified the Supports Coordinator (SC) was informed that the participant reported, "he has to have a catheter insertion today at doctor's office during appointment." However, the record lacked evidence to support a re-evaluation of the participants PCSP. (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.

- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.
- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.3. Did the Supports Coordinator ensure the participant was provided education and information to make informed decisions regarding personal choice(s)?
- NEW CITATION

Issues Cited:

- Re-Assessment 10/20/23 Section M identified the participant "Has some difficulty hearing in louder situations and certain pitches. Hearing exam over 2 years ago. Has not been recommended for hearing [aids]." However, the record lacked documentation evidencing the Supports Coordinator provided health education on the importance of preventative health exams, providing the participant the opportunity to make an informed decision. (DR)
- Re-Assessment 11/13/23 Section J identified the participant's lack of preventative health exams (colonoscopy and mammogram). However, the record lacked documentation evidencing the Supports Coordinator provided health education on the importance of preventative health exams providing the participant the opportunity to make an informed decision. (EJ)
- Re-Assessment 01/23/24 Section J identified the participant's lack of preventative health exams (pneumovax and influenza). However, the record lacked documentation evidencing the Supports Coordinator provided health education on the importance of preventative health exams providing the participant the opportunity to make an informed decision. (FN)
- Initial Assessment 12/14/23 Section L identified the participant had upper dentures and own bottom teeth. The record did not validate the Supports Coordinator provided education to the participant's representative as the participant had moderately impaired decision- making skills per Section E (JA)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
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- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout

the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
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Who Is Responsible for Monitoring & Reporting Results:

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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.4. Did the Person-Centered Service Plan (PCSP) identify the participant's issues that are triggered and require continued monitoring by the Supports Coordinator (SC)? - NEW CITATION

Issues Cited:

- 1) Progress note 05/22/24, 07/16/24, and 09/11/24 identified issues with the participant's mood (mean demeanor, calling staff names and saying degrading comments to them). However, the record lacked documentation evidencing the Supports Coordinator educated the participant/family to report the participant's health status changes to the participant's physician and/or seek alternative medical services. 2) Progress note 06/15/24 identified the participant was seen in the emergency department and was treated for low blood sugar. Additionally, the record identified the participant required glucose monitoring and was encouraged to follow-up with her primary care physician. However, the record lacked documentation evidencing the Supports Coordinator educated the participant/family to report the participant's health status changes to the participant's physician and/or seek alternative medical services (RB)
- Progress note 07/22/24 identified the participant "has to have a catheter insertion today at doctor's office during appointment." Additionally, progress note 08/12/24 and 09/03/24 identified the participant reported he was self-catheterizing himself 3-4 times per day. However, this health and welfare risk was not identified on the PCSP for monitoring and/or education by the SC, including the interventions (catheter supplier and urologist). (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Who Is Responsible for Monitoring & Reporting Results:

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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.5 Did the Person-Centered Service Plan (PCSP) include the process for minimizing risk factors, planning, and supporting the participant? (Performance Measure 17, 18) MULTI-YEAR CITATION (4)

Issues Cited:

- PCSP 01/31/24 did not evidence interventions for Social. PCSP documentation stated: "The following people and services will assist me in achieving my goals: To Be Determined." Agency Follow-Up Not Required. PCSP 04/16/24 identified an intervention for Social. 2) The record identified the participant saw a Dermatologist due to Lichen Sclerosis. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. (AK)
- The record identified the participant received psychiatric care, counseling, pain management, diabetic foot care from primary care physician and Supplemental Nutrition Assistance Program (SNAP). However, these non-waiver services were not contained within the PCSP, Back-Up Plan or Service Summary. (DR)
- Re-Assessment 11/13/23 Section G indicated: "Client has a phone number for a counselor but hasn't called to make an appointment yet." However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Authorization. (EJ)
- The record identified the participant saw a cardiologist to manage his International Normalized Ratio (INR) levels. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary (FN)
- Documentation supported the participant diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), as well as depression and anxiety. The record identified the participant received neurological treatment. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. (JJ)
- 1) PCSP identified assistance provided by the participant's grandsons and a great- granddaughter. However, the names of the grandsons and great-granddaughter were not contained within PCSP "Next," Back-Up Plan, or Service Authorization. 2) Re-Assessment 12/11/23 use of J&B Medical for incontinence supplies. However, this non-waiver service was not contained within PCSP "Next," Back-Up Plan, or Service Authorization. 3) PCSP "Next" continued to identify Community Living Supports (CLS) as an intervention. However, the Service Authorization evidenced termination of CLS 06/07/24 per participant request. (JS)
- 1) Progress notes 01/31/24, 02/07/24, 02/28/24, 03/07/24, 04/03/24, 04/24/24, 05/22/24, 06/17/24, 08/14/24, and 09/11/24 identified the Supports Coordinator completed contacts and in-person visits with the participant and assisted living staff. However, the record lacked documentation validating the participant's Durable Power of Attorney approved contacts to others. 2) Progress note 07/16/24 identified the participant, "does go to foot care off site." However, this non-waiver service was not contained within the PCSP, Back- Up Plan or Service Summary. 3) The contingency plan 12/14/23, 03/07/24, and "Next" identified: "The following supports will receive a copy of the back-up plan and the person- centered service plan report: (S.B.) and (D.B.)." However, progress note 08/14/24 identified, "Participant signature received on PCSP. Participant does not want copy sent to anyone else." The PCSP was not updated to reflect the participant's preference. (RB)
- 1) The Desired Outcomes identified in the Person-Centered Service Plans did not contain the necessary actions that would help meet the goal. Skin Condition: Assistance with Nail Care My Desired Outcome identified, "(Participant) has diagnosis of Parkinson's and is in need of assist with homemaker tasks to remain living in the community." The PCSP did not support an outcome evaluation for the identified issue (nail care). 2) Progress notes

12/20/24, 02/15/24, 02/20/24, 03/22/24, 04/05/24, 04/09/24, 04/15/24, 04/24/24, 06/03/24, 06/17/24, and 06/28/24 identified email communication. The PCSP did not support this method of communication was the participant's preferred form of communication. The Review Notes: Progress notes 04/09/24 and 04/10/24 identified the participant's receipt and signature of the waiver agency's "Email/Text Consent" form. Additionally, progress note 06/26/23 (prior to the review period) identified the participant's receipt and signature of the waiver agency's email communication consent. However, the documentation provided for the review did not include the signed consents. 3) Re-Assessment 01/05/24 Section E identified the participant's receipt of neurology services. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 4) Progress note 02/23/24 identified the participant's receipt of allergy services. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 5) Progress note 05/06/24 identified the participant's receipt of cardiology services. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 6) Progress note 06/25/24 identified the participant's receipt of orthopedic services. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 7) Progress note 08/12/24 identified the participant's receipt of urology services. However, this non-waiver service was not contained within the PCSP, Back-Up Plan or Service Summary. 8) Progress note 08/12/24 identified the participant had to self-catheterize three to four times daily. However, the PCSP "Tasks I can perform" section did not include this task. Additionally, the provider of the catheter supplies was not identified in the PCSP, Back-Up Plan or Service Summary (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education
- Lack of updated Medicaid Provider Manual and consistent notification methods from MDHHS on policy changes, guidance, and/or interpretations

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Who/What Will be Monitored:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.9 Did the Supports Coordinator (SC) contact and collaborate in accordance with MDHHS policy and contract requirements? MULTI-YEAR CITATION (4)

Issues Cited:

- Progress note 02/02/24 identified the participant's nurse from skilled care had been discharged and Physical Therapy to discharge in one week. Monitoring contact 02/21/24 identified, "Physical Therapist made his last visit today." However, the record lacked documentation to validate the SC contacted the skilled agency for collaboration and service coordination (AK)
- Progress note 11/16/23 identified the SC requested a copy of the Skilled Plan of Care. However, the record lacked documentation to validate the SC contacted the skilled agency for collaboration and service coordination. Agency Follow-Up Not Required. Skilled certification end date 12/23/23 (EJ)

Root Cause Analysis:

- Supports Coordinator error
- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
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Who/What Will be Monitored:

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reviews.

- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
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Who Is Responsible for Monitoring & Reporting Results:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.10. Did the Person-Centered Service Plan (PCSP) include outcome evaluations for each goal as required by Federal Regulation and the MDHHS contract?
- NEW CITATION

Issues Cited:

- PCSP 04/16/24 did not contain goal evaluations for the goal "I want to recover and not burden family." (AK)
- 1) Initial Assessment conducted 09/07/23. Progress note 12/13/23 evidenced the Supports Coordinator Registered Nurse contacted the participant in an attempt to schedule the subsequent PCSP update (98 days). Progress note 12/21/23 identified the SCRN completed "the RN portion of the Re-Assessment" (106 days). 2) Person-Centered Service Plan 09/07/23 evidenced the participant preferred RA to be conducted every 360 days. However, a RA must be conducted 90 days following an initial enrollment. (JS)
- Re-Assessment 01/05/24 identified the participant's receipt of monthly nursing services for nail care due to tremors associated with Parkinson's disease. However, the PCSP did not contain an outcome evaluation for this issue. (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

8.13. Did the participant approve the Person-Centered Service Plan (PCSP)? - NEW CITATION

Issues Cited:

- The record lacked documentation to support the participant's written authorization of the PCSP. (JA)
- The record lacked documentation to support the participant's/representative's written authorization of PCSP 10/26/23 and 01/24/24. (JF)
- The record lacked documentation to support the participant's written authorization of PCSP 01/25/24 and 04/23/24 (MS)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

9.4. Did the record validate the participant was offered all appropriate services? - NEW CITATION

Issues Cited:

- Re-Assessment (RA) 10/20/23 identified the participant "eats less than 2 meals per day." Additionally, the record identified the participant "has only been eating her one HDM per day. She has been struggling with securing an SD aide to assist with cooking." The participant "can only cook if she is sitting on her walker." However, the record lacked documentation supporting the Supports Coordinator evaluated the participant's need for an increase in Home Delivered Meals. 2) RA 10/20/23 identified, "The Bay Mills Tribe RN feels [participant] can manage her medications on her own, so has been doing so. However, is planning on discussing this again with her physicians at the Bay Mills Health Clinic to see if she would be eligible for medication management services again, now that she is on more medications." However, the record lacked documentation to support the participant was offered MI Choice Nursing services or a Medication Dispenser (DR)
- Re-Assessment 12/11/23 Section D indicated: "Client and her daughter want chore service for snow removal." However, the record lacked documentation to support Chore services was offered. (JS)

Root Cause Analysis:

- Need for Supports Coordination training and education

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

9.5. Did the Supports Coordinator (SC) authorize a change in service(s) or provide the participant with appropriate alternatives as required by MDHHS and the contract? - NEW CITATION

Issues Cited:

- The Service Authorization and Adverse Benefit Determination identified termination of Community Living Supports/Transportation services per participant request 06/12/24. However, the record lacked documentation identifying the reason for termination of services or that the SC provided appropriate alternatives (EJ)
- The Service Authorization and Adverse Benefit Determination identified termination of Community Living Supports per participant request. The record lacked documentation identifying the reason for termination of services or that the SC provided appropriate alternatives. (JS)
- Progress note 06/11/24 identified the SC was notified that the participants Adult Day program (Take Five) would need to suspend the participant services as the participant requires two-person assist off toilet and they are down to one staff person. However, the record did not identify the participant was provided with an appropriate alternative. Agency Follow-Up Not Required. Progress note 09/06/24 identified the participant has returned to "Take Five" Adult Day program (LO)

Root Cause Analysis:

- Need for Supports Coordinator training and education.

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

10.2 Did the Supports Coordinator (SC) assess the presence of, or the need for, non-waiver services, and then, as preferred by the participant, provide the participant/guardian with information and/or assistance linking to non-waiver services or resources, and/or provide ongoing coordination and monitoring?
MULTI-YEAR CITATION (5)

Issues Cited:

- Re-Assessment (RA) 10/20/23 Section K identified the participant "eats soft food and cuts food very small to make chewing easier." The participant "is hoping that once she gets her bottom dentures, chewing will be easier." Additionally, Section L identified the participant had "one more fitting next month, before she can get her lower dentures at the Bay Mills Dental Clinic." However, the record lacked documentation evidencing the SC offered/provided assistance in ensuring the participant's dental needs were met. 2) RA 10/20/23 Section M identified the participant had "some difficulty hearing in louder situations and certain pitches. Hearing exam over 2 years ago. Has not been recommended for hearing [aids]. Has rx (prescription) bi-focals, but has had trouble adjusting to them. Currently, (participant name) has both reading and driving glasses from Bay Mills Vision Clinic." However, the record lacked documentation evidencing the SC offered/provided assistance in ensuring the participant's hearing and vision needs were met. 3) Progress note 12/11/23 identified the SC made a referral to J&B per the participant's request. Progress note 12/22/23 identified the participant "received [two] boxes of sample products from J&B Medical. She thinks she has determined the best product for herself, so she will be calling J&B Medical to submit her first order." However, the record lacked documentation evidencing the participant received incontinence supplies (DR)
- Re-Assessment 01/23/24 Section K identified the participant reported "groceries are expensive so they have to limit what they can purchase. Discussed Food as Medicine [Program] and he would like CM to mail him the info." However, the record lacked documentation evidencing the SC provided the participant with information and resources for the Food as Medicine Program (FN)
- Progress note 12/14/23 identified the participant was "interested in incontinence products when Medicaid is approved." However, the record did not validate a J&B referral was completed until 01/16/24 (33 days). Agency Follow-Up Not Required. Progress note 03/22/24 identified incontinence supplies through J&B received (JA) – **MEDICAID WASN"T APPROVED UNTIL 1/3/2024**
- Progress note 07/12/24 indicated: "No meds but is trying to find a Dermatologist who will do telemedicine." However, the record lacked documentation evidencing any further follow-up regarding the participant's need for a dermatologist (telehealth). (JJ)
- Progress note 05/31/24 identified the participant's grandfather "plans on calling J&B Medical to see if they can change the type of undergarments that (participant) receives, to ones that are easier for the staff to change." However, the record lacked documentation evidencing any further follow-up regarding the participant's J&B supplies, as warranted. 2) Progress note 07/17/24 identified the participant had completed an application for Palliative care and they "are just waiting to hear if McLaren is going to accept the referral/application." However, the record lacked documentation evidencing any further follow-up regarding the participant's need for palliative care and assistance provided, as warranted (LO)
- Progress note 04/15/24 identified the participant/caregiver requested an increase in the amount of wipes and undergarments. Additionally, the progress note supported the Supports Coordinator (SC) contacted J&B Medical Supply and was advised the nurse would contact the participant to do another assessment. However, the record lacked documentation validating follow-up by the SC for resolution and the participant's receipt of increased incontinence supplies. 2) Progress note 05/22/24, 07/16/24, and 09/11/24 identified issues with the participant's mood (mean demeanor, calling staff names and saying degrading comments to them). Additionally, progress note 05/22/24 stated, "her family is going to see about taking her to a provider to get medication to assist with mood." However, the record lacked documentation evidencing the SC provided the participant with information and

resources for mental health services. 3) Progress note 06/15/24 was encouraged to follow-up with her primary care physician for hypoglycemic episode. However, documentation did not validate the SC prov'ded follow-up to ensure the participant's follow-up with a new primary care physician for disease management. (RB)

- Progress note 07/22/24, 08/12/24, and 09/05/24 identified the participant reported that he was self-catheterizing three to four times daily. However, the record lacked documentation evidencing any further follow-up regarding the participant's disease management (catheter supplies). (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

11.1 Did the Supports Coordinator (SC) contact the newly-enrolled participant/guardian to ensure service delivery in accordance with MDHHS policy and contract requirements? (Performance Measure 20) MULTI-YEAR CITATION (2)

Issues Cited:

- The Service Summary identified Home Delivered Meals implemented 12/15/23. However, the record did not validate the SC ensured service delivery until progress note 01/02/24 (18 days). 2) The Service Summary identified Liquid Nutritional Supplements (LNS) implemented 12/15/23. However, the record did not validate the SC ensured service delivery until progress note 01/11/24 (27 days). 3) The Service Summary identified the implementation of a Community Living Supports (CLS) 12/21/23. However, follow-up to ensure the participant's receipt of CLS services were conducted 01/11/24 (21 days). 4) The Service Summary identified Nursing implemented 01/01/24. However, the record did not validate the SC ensured service delivery until 01/23/24 (22 days). (JA)
- The Service Summary identified Home Delivered Meals implemented 01/31/24. However, the record did not validate the SC ensured service delivery until progress note 02/15/24 (15 days) (LO)
- The Service Summary identified the implementation of Home Delivered Meals 03/19/24. However, follow-up to ensure the participant's receipt and satisfaction was conducted 04/16/24 (28 days) (MS)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

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Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
- Supports Coordinators will be responsible for conducting no less than one peer review monthly. Supports Coordinators are required to send all completed peer reviews to the Director of LTC Programs.
- The LTC Quality Improvement Specialist and LTC Quality Improvement Manager will be responsible for analyzing all data from the peer reviews, supervisory reviews, chart audits, and report findings to the Director of LTC Programs.
- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

11.2 Did the Supports Coordinator (SC) contact the participant/guardian/designated person for follow-up and monitoring as specified in the Person-Centered Service Plan (PCSP) in accordance with MDHHS policy and contract requirements? MULTI-YEAR CITATION (13)

Issues Cited:

- Progress note 03/15/24 was not completed according to policy when making a late entry or an amendment to the record. 2) Progress note 05/02/24 was not completed according to policy when making a late entry or an amendment to the record (AK)
- The PCSP identified the participant preferred monitoring contacts every 36 days. Monitoring contact 01/20/24 – 02/15/24 (37 days). 04/22/24 – 05/28/24 (37 days). 07/11/24 – 08/19/24 (40 days). 2) Progress notes referred to the participant's daughter as her "guardian." However, Durable Power of Attorney (DPOA) documents provided identified the participant's daughter as her DPOA. (JS)
- The PCSP identified the participant preferred monitoring contacts every 30 days. 02/23/24 – 03/26/24 (32 days). (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.
- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
- The results of monthly peer reviews, supervisory reviews, and chart audits will be tracked by the LTC Quality Improvement Specialist and analyzed by the LTC Quality Improvement Specialist, LTC Quality Improvement Manager, and Director of LTC Programs. The data will be utilized to determine any performance trends and identify areas in which improvement is needed.

Who Is Responsible for Monitoring & Reporting Results:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

11.3. Did the Supports Coordinator (SC) ensure service delivery in accordance with the PCSP, including the use of the participant's back-up plan or an out-of-network provider, as required by Federal Regulations and the MDHHS contract? - NEW CITATION

Issues Cited:

- Progress note 06/07/24 (PCSP meeting) indicated: Participant is happy with services. No changes requested at this time." However, the Service Authorization and Adverse Benefit Determination dated 06/07/24 evidenced termination of Community Living Support (CLS) services per participant request. The Back-Up Plan evidenced the participant Service Need Level 1A and the record lacked documentation to support implementation of the participant's back-up plan and/or utilization of alternate service providers, when Community Living Support services were terminated 06/07/24 (JS)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts monitored and one-on-one education/training provided, if warranted.
- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

- The LTC Quality Improvement Specialist will complete an internal chart audit on at least 1 participant chart from each UPCAP satellite office monthly. The audit tool for the internal chart audit will be based on the record review tool utilized for CQAR.
- The results of monthly peer reviews, supervisory reviews, and chart audits will be tracked by the LTC Quality Improvement Specialist and analyzed by the LTC Quality Improvement Specialist, LTC Quality Improvement Manager, and Director of LTC Programs. The data will be utilized to determine any performance trends and identify areas in which improvement is needed.

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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- The LTC Quality Improvement Specialist and LTC Quality Improvement Manager will be responsible for analyzing all data from the peer reviews, supervisory reviews, chart audits, and report findings to the Director of LTC Programs.
- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

13.1 Did the record contain a complete and up-to-date contingency plan in accordance with MDHHS policy and contract requirements? (Performance Measure 30) **MULTI-YEAR CITATION (4)**

Issues Cited:

- The contingency plans 01/30/24, 04/16/24 and "Next" contained the acronym (PCP). Therefore, not understandable or written in plain language (13.1)
- The contingency plan provided to the participant was incomplete. The contingency plan did not identify the participant's psychiatrist, counselor/therapist, pain specialist, or Supplemental Nutrition Assistance Program (SNAP), service providers and contact information for these service providers (DR)
- The contingency plan provided to the participant was incomplete. 1) The contingency plan 11/13/23 did not contain the provider's name and contact information for Skilled services. Agency Follow-Up Not Required. Skilled certification end date 12/23/23. 2) Re-Assessment 11/13/23 Section G indicated: "Client has a phone number for a counselor but hasn't called to make an appointment yet." However, the contingency plan did not identify this service provider and contact information for the service provider. (EJ)
- The contingency plan 01/23/24 contained the acronym (PCP). Therefore, not understandable or written in plain language. 2) The contingency plan 01/23/24 provided to the participant was incomplete. The contingency plan identified "My Back-Up Plan For Care Is: No formal services. Daughter V. is back up." However, the record validated the participant received Community Living Support services through Self-Determination. 3) The contingency plan 01/23/24 did not identify the participant's cardiologist and contact information for the service provider (FN)
- The contingency plan provided to the participant was incomplete. The contingency plan identified "My DPOA: none." However, the record validated the participant had an activated Durable Power of Attorney (DPOA). Agency Follow-Up Not Required. Participant dis- enrolled. (JA)
- The contingency plan provided to the participant was incomplete. 1) Documentation supported the participant received neurological treatment. However, the contingency plan did not identify the participant's neurological provider(s) and contact information for the service provider. 2) The participant's contingency plan listed "Family Care Doctors" as her physician (JJ)
- The contingency plan provided to the participant was incomplete. 1) Re-Assessment (RA) 12/11/23 identified the participant's utilization of tribal benefits. However, the contingency plan did not identify the participant's tribal provider and contact information for the service provider. 2) PCSP identified assistance provided the participant's "grandsons" and a great- granddaughter. However, the contingency plan did not identify these critical supports, including names and contact information. 3) Re-Assessment documentation evidenced the participant's use of J&B Medical for incontinence supplies. However, the contingency plan did not identify this service provider and contact information for the service provider. (JS)
- The contingency plan provided to the participant was incomplete. The contingency plan did not identify the participant's Supplemental Nutrition Assistance Program (SNAP) l service provider and contact information for the service provider. (MS)
- The contingency plan provided to the participant was incomplete. 1) The contingency plan 12/14/23, 03/07/24, and "Next" identified: "The following supports will receive a copy of the back-up plan and the person-centered service plan report: (S.B.) and (D.B.)." However, progress notes 03/07/24 and 08/14/24 identified, "the participant does not want a copy sent to anyone else." The contingency plan was not updated to reflect the participant's preference. 2) Progress note 07/16/24 identified the participant, "does go to foot care off site." However, the contingency plan did not identify the provider and contact information for the service provider (RB)

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

- The contingency plan provided to the participant was incomplete. 1) The contingency plan 01/05/24 identified: My DPOA: None. However, Informal Support Task (A.V.) identified, "Durable Power of Attorney advocate." 2) The contingency plan "Next" did not identify the participant's Cardiologist, Neurologist, Urologist, Allergist, and Orthopedic providers and contact information for these service providers. 3) The contingency plan "Next" did not identify who provided the participant's catheter supplies and contact information for the service provider (RV)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
- UPCAP's Policy and Procedure Manual will be reviewed by the Internal Quality Committee to ensure the contents are accurate and meeting required program standards. The Internal Quality Committee meets on a weekly basis to review any necessary changes needed to policies and procedures, program documents, or other program-related processes. UPCAP has developed a review and approval process for all policy and procedure updates. UPCAP also tracks policy updates, educational notifications sent to staff, and trainings conducted. If needed, policies and procedures specific to this citation will be updated and submitted to MDHHS/CQAR for review.
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- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

- To ensure ongoing compliance, this citation will be added to the monthly inter-office peer review form and the supervisory review form. Peer reviews and supervisory reviews will be completed monthly. No less than 20 charts will be included in the monthly inter-office peer reviews and supervisory reviews.
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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Who Is Responsible for Monitoring & Reporting Results:

- The Director of LTC Programs (Terry LaFave) will provide oversight to all staff responsible for monitoring, as well as review of all completed peer/chart reviews. The Regional RN Supervisor (Tammy Nettell) will be responsible for completing Supervisory Reviews on all new enrollments and reporting results to the Director of LTC Programs. The LTC Quality Improvement Manager (Ellen Bernier) will be responsible for developing the quarterly exercise and reporting results to the Director of LTC Programs. LTC Quality Improvement Specialist (Missy LaPlaunt) will be responsible for completing monthly chart audits and reporting results to the Director of LTC Programs.
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- The Director of LTC Programs or the LTC Quality Improvement Manager will be responsible for collecting and reporting results to CQAR.

Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

13.2 Did the participant/guardian receive a copy of the contingency plan in accordance with MDHHS policy and contract requirements? If no, were they offered a copy and declined? MULTI-YEAR CITATION (2)

Issues Cited:

- The record lacked documentation to support the initial contingency plan 01/30/24 was sent to the participant's representative in a timely manner. Agency Follow-Up Not Required. Contingency plan was sent to the participant 03/08/24 (38 days). (AK)
- The record lacked documentation to support contingency plan 11/13/23 was provided to the participant. 2) The Service Authorization identified termination of Home Delivered Meals 12/14/23; and Community Living Supports/Transportation services 06/12/24. However, the record lacked documentation to support an updated copy of the contingency plan was provided to the participant. (EJ)
- The record lacked documentation to support the initial contingency plan 12/14/23 was sent to the participant. Agency Follow-Up Not Required. The contingency plan was mailed 01/18/24 (35 days). (JA)
- The record lacked documentation to support the initial contingency plan 10/26/23 and the updated contingency plan (updated to include Hospice services) was provided to the participant/representative. (JF)
- The record lacked documentation to support contingency plan 12/11/23 was provided to the participant/representative. 2) The Service Authorization supported termination of Community Living Supports and the record lacked documentation to support an updated copy of the contingency plan was provided to the participant/representative (JS)
- The record lacked documentation to support the updated PCSP 03/07/24 was sent to the participant in a timely manner. Agency Follow-Up Not Required. PCSP was sent to the participant on 05/08/24 (62 days). (RB)

Root Cause Analysis:

- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
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- Supports Coordinators that do not meet requirements on monthly peer reviews, chart audits, or supervisory reviews may also have additional charts

monitored and one-on-one education/training provided, if warranted.

- The Director of LTC Programs and LTC Quality Improvement Manager will send out informal email communication to Supports Coordinators throughout the year that contain policy reminders, educational materials, and recognition for improved performance.

Who/What Will be Monitored:

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Who Is Responsible for Monitoring & Reporting Results:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Citation:

15.2 Was the Adverse (Advance) Action Notice (AAN) and/or Adverse Benefit Determination (ABD) complete, and accurate? MULTI-YEAR CITATION (3)

Issues Cited:

- ABD 07/16/24 identified Home Delivered Meals (HDM) cancellation effective 07/16/24. However, the Service Authorization identified HDMs authorized 02/05/24 – 07/06/24. (AK)
- ABD with mailing date 05/16/24 identified Community Living Support (CLS) was reduced effective 05/20/24 per the participant's request. However, the Service Summary identified CLS reduced effective 05/19/24. (DR)
- The Status Report identified out of service area of 09/15/24 – 09/16/24. Additionally, ABD 09/03/24 identified a stop date of 09/15/24. However, progress note 09/17/24 identified the participant was out of the service area 09/16/24 – 09/17/24. (RV)

Root Cause Analysis:

- Supports Coordinator error
- Need for Supports Coordinator training and education

Staff Education Plan:

- Further education and follow up on this standard will be provided at the all-staff meeting scheduled for January 17, 2025. Leadership (Director, Regional Supervisor and Quality Manager) will specifically address every citation and review requirements for each one.
- On a quarterly basis the LTC Quality Improvement Manager will create and distribute an educational exercise on Mi Choice program standards and requirements, including specific citations received in the FY2024 review, for all Supports Coordinators to complete.
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MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Who/What Will be Monitored:

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Additional Notes:

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Recommendations (Not Resulting in Citation):

Recommendation:

1.2. Did the Waiver Agent (WA) validate the accuracy of the Nursing Facility Level of Care Determination (NFLOCD) assessed Door and ensure the validity of the NFLOCD(s) in CHAMPS?

Issues Cited:

- Re-Assessment 04/16/24 Section T identified the participant qualified through NFLOCD Door 1. However, the assessment documentation did not validate eligibility. Immediate Agency Follow-Up Not Required. NFLOCD 06/06/24 validated the participant's eligibility through Door 1. (AK)

Recommendation:

4.4: Did the Waiver Agent use the correct care setting statuses?

Issue Cited:

- Progress note 01/05/24 identified, "(Participant) was just out of town with his family for several days." However, the Status Report did not identify this care setting statuschange. Progress note 05/06/24 identified the participant "will be spending the night" for medical appointments and would be out of the service area from 06/06/24 - 06/07/24. Additionally, the service authorization validated the participant's receipt of private transportation (592 units) on 06/07/24. However, the Status Report did not identify this care setting status change. 3) Progress note 09/17/24 identified the participant was out of the service area 09/16/24 – 09/17/24. However, the Status Report identified the participant was out of the service area from 09/15/24 - 09/16/24. Additionally, the Notice of Adverse Beneficiary Determination Notice mailed on 09/03/24 identified a stop date of 09/15/24 (RV)

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Recommendation:

6.6: Did the Supports Coordinator (SC) provide the participant the opportunity to manage environmental and home-based risks throughout the care planning and service delivery as required by MDHHS and the contract?

Issue Cited:

- Re-Assessment 01/23/24 Section D identified "Grab bars may be needed around the tub at some point." However, to ensure the participant's safety, the record did not support the SC assisted the participant with obtaining grab bars (FN)

Recommendation:

8.7: Did the services and supports on the Person-Centered Service Plan (PCSP) include the details of the intervention (provider name, type of provider, type of service, service amount/frequency/duration)?

Issue Cited:

- PCSP 04/23/24 and "Next "identified the participant's receipt of J&B Medical supplies. However, the frequency of the service was not identified on the plan (MS)

Recommendation:

8.14: Did the participant receive a copy of their Person-Centered Service Plan (PCSP) as required by Federal Regulations and the MDHHS contract? If no, were they offered a copy and declined?

Issue Cited:

- The record lacked documentation to support the initial PCSP 12/14/23 was sent to the participant. Agency Follow-Up Not Required. PCSP was mailed 01/18/24 (35 days). (JA)
- The record lacked documentation to support the initial PCSP 10/26/23 and the updated PCSP (updated to include Hospice services) was provided to the participant or a copy was declined, when offered (JF)
- The record lacked documentation to support the updated PCSP 03/07/24 was sent to the participant in a timely manner. Agency Follow-Up Not Required. PCSP was sent to the participant on 05/08/24 (62 days) (RB)

MI Choice Clinical Quality Assurance Review

Corrective Action Plan/ UPCAP Services, Inc. Fiscal Year: 2024

Recommendation:

9.2: Is the Service Summary accurate and complete?

Issue Cited:

- The Service Authorization evidenced the start date for Supports Coordination services as 10/26/23 (Fund Code 100). However, the Status Report identified WA-Y 11/01/23. (JF)

Recommendation:

9.6: Did the authorized MI Choice Program services meet requirements as defined in the MI Choice chapter of the Medicaid Provider Manual?

Issue Cited:

- The Service Summary identified the Waiver Agent authorized Nursing services 03/16/23. While documentation supported ongoing interdisciplinary contacts, the record lacked documentation supporting the communication was with the nurse providing the nail care, a diagnosis to support the need for nail care, and that the nursing needs of the participant were being addressed. The Review Notes: The physician order 08/23/23 provided for the review was not signed by the participant's physician, and therefore, not valid (RV)