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Issue: AAA Complaint Policy & Procedures

Policy: The Alliance for Aging and the service providers shall develop complaint procedures to process and resolve client dissatisfaction with services.

Purpose: Complaint procedures shall address the quality and timeliness of services, provider complaints or any other advice related to complaints other than termination, suspension or reduction in services that require the grievance process.

Procedures:

I. Each service provider must develop policies and procedures to track client complaints with services. The policy will be reviewed annually by Alliance for Aging staff to determine compliance.

A. Service providers must have a policy detailing how they will identify and resolve client complaints and satisfaction issues.
B. The complaint policy shall include the procedures on how they notify clients of their complaint policy.
C. Complaint procedures shall address the quality and timeliness of services, provider and direct service worker complaints, or any other advice related to complaints other than termination, suspension or reduction in services that require the grievance process as described in Appendix 1, Department of Elder Affairs Programs and Services Handbook.
D. The Provider must have a complaint log which includes the date of the complaint, nature of complaint and the outcome of each complaint.
E. The complaint policy and the complaint logs will be reviewed annually by AAA staff during the Provider’s annual monitoring visit to identify trends. A summary of the issues, if trends are identified, will be included in the provider’s annual monitoring report for follow up.
F. The Provider’s Quality Assurance and Quality Improvement Policies and Procedures may be reviewed by the AAA to determine if changes are necessary to address any trends identified.

II. Clients receiving DOEA funded services who contact the AAA/ADRC regarding any service receipt complaints will be transferred to the Program Integrity Unit. The appropriate staff assigned to the provider serving the client will be responsible for following up on the complaint to ensure resolution.

A. AAA staff will track complaints reported by clients in the client complaint log.
B. The complaint log shall include the date of the complaint, nature of the complaint and the outcome of each complaint.
C. The complaint log will be reviewed periodically to ensure proper resolution of all logged complaints and to address any trends.

III. Repeated reporting may trigger an immediate investigation and appropriate corrective action steps to be taken by the service provider.
IV. Clients will be afforded the opportunity to grieve any adverse action deemed as a termination, suspension or reduction in services.
Issue: Client Grievance Procedures

Policy: The Alliance shall develop, implement, and ensure that its Providers have established grievance procedures to process and resolve client dissatisfaction with or denial of service(s), and address complaints regarding the termination, suspension or reduction of services.

Purpose: Consumers will be afforded the opportunity to grieve any adverse action deemed as a termination, suspension or reduction in service.

Procedures:

I. When suspending, reducing or terminating any active client services, service providers must do the following:

A. The client must be informed by the Provider, in writing, no less than 10 calendar days prior to the date of any adverse action to be taken. Prior notice is not applicable when the health or safety of the recipient is endangered, if action is not taken immediately; however, notice must be made as soon thereafter as practicable.

B. The notice shall contain the following elements:
   1. A statement of what action is being taken;
   2. The reason(s) for the intended action;
   3. An explanation of:
      a. The recipient’s right to a grievance review. The request shall be made in writing and delivered within ten (10) calendar days of the date the notice is postmarked. The service provider shall offer the recipient assistance in writing, submitting and delivering the request.
      b. The recipient’s right, after a grievance review, for further appeal.
      c. The recipient’s right to seek redress through the courts, if applicable.
      d. A statement indicating that if a grievance review is requested, current services will continue until a final decision is made regarding the adverse action.
      e. A statement advising that the client may represent himself/herself or use legal counsel, a relative, a friend or other qualified representative in the review proceedings.

C. Services cannot be reduced or terminated, nor any adverse action taken during the 10 day period.
D. Within seven (7) calendar days after receiving a request for review from the client, the Provider shall acknowledge receipt of the request in writing. The written acknowledgment shall include:

1. The date, time and place scheduled for the review;
2. The designation of one or more impartial reviewers who have not been involved in the decision at issue;
3. The opportunity to examine the client’s case record within a reasonable time before the review. Copies of the case record shall be provided at no cost to the client, if requested;
4. The opportunity for the client or the client’s representative to informally present argument, evidence or witnesses at a reasonable time before or during the review; and
5. A contact person for any accommodations required under the Americans with Disabilities Act, including assistance, if needed, to attend the review, and assurance that the intended adverse action will not be taken until all appeal rights have been exhausted.

B. All grievance reviews shall be conducted at a reasonable time, date and place by one or more impartial reviewers who have not been directly involved in the initial determination of the adverse action.

F. The reviewer(s) shall provide written notification to the client, within seven (7) calendar days after the grievance review. The written notice shall include the following information:

1. The decision and the detailed reason(s) for the decision;
2. The effect the decision has on the client’s current benefits, if favorable, or the circumstances regarding continuation of current benefits until all appeal rights are exhausted, if not favorable;
3. The client’s right to appeal an adverse decision to the Alliance for Aging by written request within seven (7) calendar days, except in decisions involving the professional judgment of a legal assistance provider;
4. The availability of assistance in writing, submitting and delivering the appeal to the appropriate agency;
5. The client’s right to represent himself/herself or be represented by legal counsel, a relative, a friend or other qualified representative; and
6. The client’s right to file a grievance with the Florida Bar relative to complaints involving the provision of legal representation in cases where the recipient is represented by a legal assistance service provider.

G. All records of the activities undertaken by the Provider must be filed in the client’s file.
II. When appealing an adverse action to the Alliance the following steps shall be followed:

A. Within seven (7) calendar days after receiving a notice of appeal from of a grievance review decision from a client, the AAA shall send the client written acknowledgement of receipt of the appeal notice. The written acknowledgement shall also provide notice of:

1. The date, time and place of the scheduled appeal hearing;
2. The designation of one or more impartial AAA officials who have not been involved in the decision at issue;
3. The opportunity to examine the client’s case record within a reasonable time before the appeal hearing. Copies of the case record shall be provided at no cost to the client and/or the representative, if requested;
4. The opportunity for the client or the client’s representative to informally present argument, evidence or witnesses during the appeal;
5. A contact person for any accommodations required under the Americans with Disabilities Act, including assistance, if needed, to attend the appeal hearing; and
6. A statement that current benefits will continue until all appeal rights are exhausted.

B. All appeal hearings involving grievance reviews shall be conducted at a reasonable time, date and place by one or more impartial Alliance for Aging officials who have not been directly involved in the determination of the adverse action.

C. The designated Alliance for Aging official(s) shall provide written notification to the client within 7 calendar days after the grievance review appeal is heard. The notification shall include the following information:

1. The decision and the detailed reason(s) for the decision;
2. The effect the decision has on the client current benefits, if favorable, or the circumstances regarding continuation of current benefits until all appeal rights are exhausted, if not favorable;
3. A contact person for any accommodations required under the Americans with Disabilities Act.
4. Notification that the Alliance for Aging’s decision shall be the final decision.

D. All records of the activities undertaken by the Alliance must be preserved and remain confidential. A copy of the final decision must be placed in the client’s file.

Alliance for Aging, Policies and Procedures
Revised April 2014
Reviewed, May 2017
E. In computing any period of time prescribed by these guidelines, the last day of the established time frame shall be included, unless it falls on a Saturday, Sunday or legal holiday. If the last day falls on a Saturday, Sunday or legal holiday, the established time frame shall be extended until the end of the next business day.
Issue: Alliance’s Technical Assistance and Training for service providers.

Policy: Each AAA must provide an on-going program of technical assistance and training, both programmatic and financial, to service providers under the area plan. The AAA may provide technical assistance by verbal and written communications, during on-site visits, at training or workshop sessions, or during other conferences and meetings.

Purpose: To provide technical assistance to service providers to ensure compliance and understanding of programmatic and financial program requirements.

Procedures:

A. The AAA will provide an on-going program of technical assistance and training, both programmatic and financial, to service providers. The AAA will provide technical assistance by verbal and written communications, during on-site visits, at training or workshop sessions, or during other conferences and meetings.

B. Technical assistance may result from specific requests or may result from an apparent need for such assistance based on reports, assessments, inquiries, or other information received by the AAA.

C. Quarterly training will be conducted for providers, case managers, and/or assessors by Alliance for Aging’s Contract Management Staff. Training sessions may be scheduled more frequently, if needed. If there are fewer than ten persons registered for a scheduled training, the training may be postponed until the following quarter.

D. The trainings will include, at a minimum, the following topics:
   1. DOEA Care Plan and Certification;
   2. Adult Protective Services (APS) Reporting Requirements;
   3. DOEA APS Referral Tracking Tool; and
   4. DOEA APS Referrals Operation Manual
   5. DOEA Policy Notices and Transmittals

E. Other training topics may include:
   1. Aging Network Overview;
   2. Overview of the DOEA assessment instruments (701A, 701B and 701S)
   3. CCE and ADI Copay Training
   4. DOEA Programs and Services Handbook Overview;
   5. CIRTS Data Entry and Reporting Requirements;
   6. Record-Keeping/Documentation Requirements; and/or
   7. Confidentiality Requirements.

F. Certification: Care plan certification requires attendance at the training session(s) and scoring a minimum of 80% on the post-test. Notification will be forwarded to each participant indicating their score. Individuals that do not successfully pass the care plan certification will be required to retake the course during the next scheduled training.

G. The AAA will maintain a record of all persons who attended the trainings as well as the scores achieved on the care plan test.

H. All aging network staff responsible for conducting screening and assessments using the Department Screening (701S) must be trained and certified as required by DOEA policy.

Revised April, 2014
Revised May, 2017
ISSUE: Providers will ensure the collection and maintenance of client and service information in CIRTS.

POLICY: The Alliance must ensure that Providers enter all required data per the DOEA Programs & Services Handbook for clients and services in the CIRTS database. The data must be entered into the CIRTS before the Provider submits their request for payment and expenditure reports to the Alliance.

PURPOSE: The Providers are required to maintain current and accurate client and service information in CIRTS by using the CIRTS reports in the web-based CIRTS database.

PROCEDURE:

I. Client Enrollment
   a. Program enrollment information must be entered in CIRTS for all clients receiving case management or OAA and LSP Registered Services, and all individuals receiving services through OAA Title IIIIE programs, and individuals receiving transportation through LSP and OABegin must be entered in CIRTS. For a list of registered services, refer to Appendix A of the DOEA Programs and Services Handbook.
   b. All clients receiving case management services must have an annual care plan entered in CIRTS.

II. Client Assessments
   a. Client must be assessed by the Provider using the required DOEA assessment instrument and enrolled in CIRTS prior to receiving services. The assessment must be completed by staff that have been certified in the DOEA assessment instrument and approved by the Alliance.
   b. Assessment information must be entered in accordance with the Assessment Instructions (DOEA 701D).
   c. Assessments entered in CIRTS must have all of the required fields completed, in full with sufficient details, including all “Notes and Summary” sections.

III. Service Reporting
   a. Each service performed shall be recorded as specified in the Client Information and Registration Tracking System (CIRTS) guidelines, Appendix C of the DOEA Programs and Services Handbook. Supporting documentation of services provided must be adequate to permit fiscal and programmatic evaluation, and ensure internal management.
   b. Services must be reported in CIRTS as per each service’s Appendix A-Service Descriptions and Standards.
   c. For center-based services (Congregate Meal, Adult Day Care), Monthly Aggregate Reporting of units must be reported in CIRTS by the location of where the service is provided.
   d. For monthly aggregate services reported in CIRTS, the number of clients served each month must be reported in the Services Reported Screen in CIRTS with each monthly billing.
   e. For programs and services requiring an unduplicated client count, the client must be enrolled in CIRTS, and once per fiscal year, the Provider must enter a “0” in the Units field to confirm that the client is still receiving services. The entry must be completed during the month of the each contract year.
IV. CIRTS Inactive Enrollment Status
   a. Clients may only remain inactive in CIRTS for a period not to exceed three months.
   b. If a provider determines that a client will be inactive for any reason for a period not to exceed three months, the “Owner” of the client may change the client’s status from “ACTV” to “INAC” on the enrollment screen in CIRTS.
   c. The provider will run the CIRTS “All Enrollments During a Time Range” report on a monthly basis.
   d. Ten days prior to the end of the three months period, provider staff will contact client to determine status and to inform client of pending case action. Provider’s grievance procedure will be implemented, as appropriate, if program enrollment will be terminated. Documentation must be kept in the client’s file.
   e. The owner provider will terminate the “INAC” status of any clients who have been “INAC” for a period exceeding three months after the (10) days grievance period if no further action is taken by the client and/or representative. Exceptions will be granted on a case-by-case basis with written permission from the owner provider’s Contract Manager.
   f. During annual monitoring and more often if appropriate, Contract Manager’s will run “All Enrollments during a Time Range” report and review for compliance with the above procedures.

V. CIRTS Data Integrity
   A. In order to ensure CIRTS data accuracy, Providers must run all CIRTS reports listed below monthly, or more often depending on the size of the agency, to verify that client and service data in CIRTS is accurate. All exceptions must be cleared within 2 weeks of running the report.

   1. Assessment Overdue Report (ACTV or ACTV & APCL)
      a) This report lists all ACTV and APCL clients who have an overdue assessment.
      NOTE: Providers must ensure that all active clients have the required annual unduplicated count “0” before running this report. Active clients without an unduplicated count will not be captured in this report. The Provider must run the “Active Client Not Served in a Time Range” reports in CIRTS to ensure all required unduplicated client counts are entered in CIRTS prior to running this report.
      b) Clients in the overdue assessment report who have been released and are APPL in CIRTS for the LTCC program must not be reassessed by the Provider. The Provider should enter a note in the file indicating “that the annual assessment will be delayed, the individual is being processed for EMS, and that CARES will be doing the initial assessment for SMMC LTC”.
      c) Providers must submit a CIRTS Change/Delete form to the CIRTS Specialist requesting an ownership change for clients still owned but no longer served by the Provider.

   2. Assessment Overdue Report (APCL only)
      a) This report lists all APCL clients who have an overdue assessment. All clients wait listed for services must be rescreened annually.

Revised May, 2017
b) Providers must submit a CIRTS Change/Delete form to the CIRTS Specialist requesting an ownership change for clients still owned but no longer served by the Provider.

3. Clients Enrolled who have moved to Another PSA.
   a) The provider must close the enrollment for any client that has moved to another PSA.

4. Active Clients not Served in a Time Range
   a) This report shows clients that are active in CIRTS but have no services reported in the specified time range. If a client is no longer receiving services, the Provider must terminate the client enrollment in CIRTS. The Alliance recommends a 3 month grace period, if the client is hospitalized and/or in a rehab. Documentation must be in the file indicating why the client remains open, if services are not being provided.

5. Incomplete Assessment Report
   a) This report lists all assessments that have been partially saved in CIRTS. The Provider is required to complete and/or delete the assessment identified in this report.

6. Clients Served not Enrolled
   a) The Provider must not bill services for clients that are not enrolled in CIRTS. If the client is receiving services, an enrollment code, and the required "unduplicated 0 count" must be entered in CIRTS. The unduplicated count must be entered annually within the first month of the new contract year, if the client is still active in the program.

7. Consumer Age Verification Report
   a) The provider must justify all exceptions identified in this report. Clients under 60 must not be served unless they meet the exception criteria as specified in the DOEA Programs and Services Handbook. Justification and documentation must be kept in the client’s file for monitoring purposes. The appropriate code must be entered in CIRTS in order to clear the exception from this report.

8. ACTV CCE, HCE, and ADL Clients with no Care Plan
   a) All clients active in CCE, HCE and ADL are required to have annual care plans entered in CIRTS. Clients listed in this report have no initial or annual care plan entered in CIRTS.

9. Duplicate Client Social Security Numbers in CIRTS
   a) Provider must run this report and correct the records for clients that show active in CIRTS with multiple social security numbers.
   b) The Providers must request confirmation of the correct social security from the client.
   c) If a social security number (SSN) error in CIRTS caused a client to be listed, then the Provider must verify accuracy of the SSN, correct CIRTS by moving all client records from the incorrect SSN to the correct SSN and notify the CIRTS Specialist of the error.

Revised May, 2017
d) A CIRTS change/delete form must be forwarded to the CIRTS Specialist requesting to delete the incorrect record only after the Provider has transferred the information in CIRTS from the incorrect record to the correct record. The Provider and/or the CIRTS Specialist may need to coordinate the transfer of data with other service providers that may be servicing or served the client.

10. Medicaid Waiver Eligible (CCE Providers Only)
   a) The Provider must refer all clients identified on this report to the ADRC to wait list for the SMMCLTC program, as per contract and program requirements. Clients who have been identified as being potentially Medicaid Waiver eligible must be advised of their responsibility to apply for Waiver services as a condition of receiving CCE services.

11. DATA Inconsistencies Found when Comparing Vital Statistics Death Certificates with CIRTS-Open Enrollments Report
   a) Verify the client is deceased.
   b) Enter the client’s date of death (DOD) on the CIRTS demographics screen.
   c) The Provider must terminate the open enrollment in CIRTS for clients who have died. This includes APCL, APPL and ACTV enrollments. The Provider must enter the enrollment end date as the date of death and the termination code T_CD (client died).
   d) If a social security number (SSN) error in CIRTS caused a client to be listed, then the Provider must verify the accuracy of the SSN and correct CIRTS by transferring all client records from the incorrect SSN to the correct SSN. Once the information has been transferred from the incorrect SSN to the correct SSN, the Provider must send a request to the CIRTS Specialist to delete the incorrect record. Proof of the SSN must be submitted with the request. The CIRTS Specialist must verify that the information has been transferred entirely before requesting to delete the record.
   e) If a Vital Statistics SSN error caused a client to be listed, then the Provider must notify the CIRTS Data Specialist. The Alliance must then notify the DOEAA Contract Manager and contact Ken Jones, Deputy State Registrar, Florida Department of Health, Office of Vital Statistics, Post Office Box 210, Jacksonville, FL 32231, (904) 359-6982, Fax (904) 359-6931, Ken.Jones@doh.state.fl.us. The Provider should refer to DOEAA’s NOI #031408-1-I-SWCBS and CIRTS Data Integrity Policy Clarification, Notice #: NOTICE #070116-1-I-SWCBS. This report updates daily.

12. DATA Inconsistencies Found when Comparing Vital Statistics Death Certificates with CIRTS-Assessment after DOD Report
   a) Verify the client is deceased.
   b) Enter the client’s date of death (DOD) on the CIRTS demographics screen.
   c) For assessments reported after DOD, the Provider must submit a request to delete the assessment to the CIRTS Specialist with an explanation indicating how/why an assessment was conducted after the DOD. When the CIRTS Specialist receives the justification from the Provider, the Alliance will delete the assessment record from CIRTS. Copy of the

*Revised May, 2017*
justification must be submitted to the Director of Program Integrity and Accountability.

d) If a social security number (SSN) error in CIRTS caused a client to be listed, then the Provider must verify accuracy of the SSN, correct CIRTS by moving all client records from the incorrect SSN to the correct SSN. Once the information has been transferred from the incorrect to the correct SSN, the Provider must send a request to the CIRTS Specialist requesting to delete the incorrect record. Proof of the SSN must be submitted with the request.

e) If a Vital Statistics SSN error caused a client to be listed, then the Provider must notify the CIRTS Data Specialist. The CIRTS Specialist must then notify the DOEA Contract Manager and contact Ken Jones, Deputy State Registrar, Florida Department of Health, Office of Vital Statistics, Post Office Box 210, Jacksonville, FL 32231, (904) 359-6982, Fax (904) 359-6931, Ken.Jones@doh.state.fl.us. The Provider should refer to DOEA’s NOI #031408-1-I-SWCBS and CIRTS Data Integrity Policy Clarification, Notice #: NOTICE #070116-1-I-SWCBS. This report updates daily.


a) Verify the client is deceased.

b) Enter the client’s date of death (DOD) on the CIRTS demographics screen.

c) Regarding services reported after DOD, the data should be left in CIRTS if the Department paid for the service. The Provider should confirm that the client is no longer receiving services. The Provider must submit an explanation to the CIRTS Specialist indicating why/how services were provided after DOD. Copy of the justification must be submitted to the Director of Program Integrity and Accountability.

d) For case management (CM) or case aide (CA), the CIRTS Specialist must ensure that the PSA Case Closure-Billing code is entered in CIRTS. This code means that “Case Closure-Billing” after date of death was appropriate and allowable in order to close the client record. For services other than CM or CA, reported beyond 60 days of the DOD, the Alliance must obtain additional information from the service provider and document any reasons given, but NOT adjust CIRTS service records at this time.

e) If a social security number (SSN) error in CIRTS caused a client to be listed, then the Provider must verify accuracy of the SSN, correct CIRTS by moving all client records from the incorrect SSN to the correct SSN. Once the information has been transferred from the incorrect to the correct SSN, the Provider must send a request to the CIRTS Specialist requesting to delete the incorrect record. Proof of the SSN must be submitted with the request.

f) If a Vital Statistics SSN error caused a client to be listed, then the Provider must notify the CIRTS Data Specialist. The CIRTS Specialist must then notify the DOEA Contract Manager and contact Ken Jones, Deputy State Registrar, Florida Department of Health, Office of Vital Statistics, Post Office Box 210, Jacksonville, FL 32231, (904) 359-6982,
Fax (904) 359-6931, Ken Jones@doh.state.fl.us. The Provider should refer to DOEA’s NOI #031408-I-I-SWCBS and CIRTS Data Integrity Policy Clarification, Notice #: NOTICE #:070116-I-I-SWCBS. This report updates daily.

14. Active MLTC clients who are ACTV, APCL, or APPL in Another Program
   a) The Provider must contact clients active in MLTC and ACTV in a DOEA funded programs.
   b) The Provider must confirm with the client that they are active in the MLTC program and are receiving services before they terminate the client.
   c) The Provider must follow grievance procedures prior to service termination.
   d) The Provider has 30 days from the day the client is active in MLTC to transition services and terminate DOEA funded services.

15. CIRTS Data Clean-up Report
   a) This report identifies inconsistencies with data reported in CIRTS by Providers. In most situations, it will capture clients who have been terminated as deceased in one program, but still show active in another.
   b) The Provider must verify that the client is not deceased. If they are, the record must be closed. If they are not, the Provider must notify the CIRTS Specialist of the incorrect data entry which is causing the exception. The CIRTS Specialist will work with the Provider who entered the incorrect code in order to clear the exception. The Provider must address all exceptions captured in this report, and shows exceptions immediately after they are entered in CIRTS.

16. Active PACF Clients who are ACTV, APCL, or APPL with other Program
   a) Providers must give choice to the client between the PACE program and their existing program to clients identified on the report. Clients cannot be dually enrolled in PACE and any other DOEA funded program. All clients must be terminated in CIRTS if choosing to remain in the PACE program. The Provider must follow up accordingly to ensure a resolution is obtained.

B. The Provider must maintain a master file containing the above information for all CIRTS reports. Reports may be kept electronically.

C. All the above reports must be available at the time of monitoring or upon request by the Alliance. The following should be the parameters used to ensure that any and all outstanding exceptions are identified:
   a) Date, when requested, must include 1/1/2008 to current.
   b) Client status, when requested, must include “all” status (active, waitlist, etc.).
   c) Must include “Y” to unduplicated counts, when applicable.

Revised May, 2017
D. The Alliance’s CIRTS Specialist will review CIRTS reports monthly to ensure exceptions have cleared.
   a) Monthly emails will be sent to the Providers by the CIRTS Specialist notifying them of pending exceptions. The Providers will be given 2 weeks to clear the exceptions. The CIRTS Specialist will include the Contract Manager and the Director of Program Integrity in the communication with the Provider.
   b) A second notice/reminder of the pending exceptions will be sent to the Provider by the CIRTS Specialist if the exceptions are still pending after the 2 week period.
   c) If the Provider fails to correct the exceptions by the second reminder, the Contract Manager will follow up in writing with the Provider to determine if training and/or technical assistance is necessary.
   d) If the exceptions are not cleared, an email will be sent to the Provider by the Director of Program Integrity and Accountability to determine why the exceptions are still pending.
   e) All email correspondence with the Provider must be saved electronically by the CIRTS Specialist for DOEA monitoring purposes.

E. Failure to maintain accurate CIRTS data may result in the following:
   a) As per the contract, the Provider must ensure CIRTS Data Integrity and must enter all required data following DOEA’s CIRTS policy guidelines for clients and services in CIRTS. Data must be entered into CIRTS before the Provider submits their request for payment.
   b) The Provider will be given technical assistance by the CIRTS Specialist and/or the Contract Manager if exceptions are not cleared within the required timeframe.
   c) Failure to rectify the noted deficiencies in a timely manner will result in the Provider being asked to submit a Corrective Action Plan (CAP) to address the deficiencies and state how the deficiencies will be remedied within a time period approved by the Contract Manager. As per the contract, the Alliance may assess a Financial Consequence for Non-Compliance on the Provider for each deficiency identified in the CAP which is not corrected pursuant to the CAP. The Alliance may also assess a Financial Consequence for failure to timely submit a CAP.
   d) If the Provider fails to meet the minimum level of service or performance, as defined in the contract, the Alliance may apply financial consequences commensurate with the deficiency. Financial consequences may include but are not limited to contract suspension, refusing payment, withholding payments until deficiency is cured, tendering only partial payments, and/or cancellation of contract and reacquiring services from an alternate source. The Provider must refer to the “Consequences for Noncompliance” section of their contract.

F. All report copies must be saved by the Provider, and provided to the Alliance upon request. Reports may be saved electronically. The Provider must notify any errors identified in the exception reports to the CIRTS Specialist in order to ensure all exceptions are corrected.

Revised May, 2017
III. CIRTS Change/Delete Requests
   A. Change or deletion of data may be requested by providers when data in CIRTS needs to be changed and/or deleted in order to correct a record. The following are examples of CIRTS requests that may be requested by the Providers:
      a. Deletion of incorrect assessments
      b. Change incorrect social security numbers
      c. Deletion of client records
      d. Change of provider ownership
   B. Provider inquiry on CIRTS access or CIRTS changes must be submitted to the Contract Manager on the AAA approved CIRTS Change/Delete Request Form. See Attachment A.
   C. CIRTS change/delete requests must be emailed by the Provider directly to the Contract Manager.
   D. The Contract Manager will review the forms for completeness and appropriateness prior to submitting the request to the CIRTS Specialist for completion.
   E. The CIRTS Specialist will notify the Provider that the changes have been made.
   F. It is the expectation that all change delete forms are to be completed within one work week.
# CIRTS CHANGE/DELETE REQUEST FORM

**Agency Name:**

**Date:**

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<tr>
<th>Client Name</th>
<th>Client ID</th>
<th>Current &quot;Owner&quot; Provider</th>
<th>New &quot;Owner&quot; Provider</th>
<th>Client Correct SSN</th>
<th>Entire Client Record</th>
<th>Service Record</th>
<th>Client Enrollment Record</th>
<th>Assessment (Indicate date of Assessment)</th>
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**Revised May, 2017**
ISSUE: Menus should be developed and provided to the Alliance for Aging for review by providers prior to implementation. Menu substitutions must be kept to a minimum.

POLICY: All menus must be reviewed by the AAA’s dietitian to verify that all menus comply with DOEAs menu standards.

PURPOSE: To ensure that meals served comply with Dietary Guidelines for Americans, 1/3 RDA, and that they meet Age 70+ Female Dietary Reference Intake/Adequate Intakes (DRI’s/AIs).

PROCEDURES:
I. Menu Development

1. Nutrition providers must obtain the services of a registered to assist in menu development. Menus should be developed after receiving client and project director input and meeting with caterer. A Florida licensed dietitian or licensed registered dietitian employed by the food vendor may not approve the menus because this is a conflict of interest.

2. A minimum of four weeks of menus must be developed semi-annually. Developed menus are analyzed for nutrient compliance. Each menu (page) must show dates menus will be in service and must be signed by the provider’s dietitian who has developed the menu with the date of her signature.

3. Dieticians attest to the fact that menus have been analyzed with appropriate software and that they appear to be in compliance with DOEAs requirements by signing the attestation statement. Any variations should be documented in the attestation statement by the dietician. Refer to Attachment A.

4. Menus, nutrient analysis and signed attestation statement must be submitted to the Alliance at least 4 weeks prior to implementation date for review.

5. Alliance’s Contract Manager forwards an electronic copy of the menus, attestations and the nutrient analysis to the AAA’s dietitian for review and approval. Originals are kept in the provider’s file.

6. After the AAA’s dietitian reviews the menus and confirm that they meet the requirements, an email confirming that the “menus have been reviewed by the AAA” is sent to the Provider by the Contract Manager with a copy to Director of Program Integrity and Accountability. A copy of the email is kept on file for monitoring purposes.

7. Extensions may be granted, as needed, in order to resolve any pending items in order to avoid gaps between menus.

8. If an extension to an existing menu is required, the Provider must make such request in writing to the Contract Manager at least 4 weeks prior to the expiration date of the current menu. Approvals will be made in writing to the Provider. Records must be kept
on file for monitoring purposes.

9. New menus must only be implemented after written confirmation is received from the AAA.

II. Menu Substitutions

1. A comprehensive menu substitution policy and procedure must be developed and approved by the nutrition program's qualified dietitian. The menu substitution policy and procedure must be available for site manager's use.

2. The provider's dietitian must develop and approve a comprehensive menu substitution policy and procedure. The menu substitution policy and procedure must be made available to the site manager and to the caterer. The policy must include a pre-approved substitution list that has been developed and approved by a registered dietician.

3. Menu substitutions must be from the same food group and must provide an equivalent nutritional value.

4. Substitutions must be documented on a log. The documentation must include the date of substitution, the original menu item, the substitution made, the reason for the substitution and the signature of the employee authorizing the substitution. Provider's may use sample substitution log, see Attachment B.

5. Documentation of all menu substitutions must be kept on file for at least two years for monitoring purposes.

6. In the event that a menu item is not available and must be substituted, the Caterer or Nutrition Provider must refer to the pre-approved substitution list to determine which food item has been approved as a substitution.

7. If the food item is not on the pre-approved substitution list, the Caterer or Nutrition Provider must obtain approval from a registered dietitian prior to making a substitution. The substitution must be reported to the Provider immediately. The Provider, in turn, must document the information in the substitution log. The substitution log must indicate why the substitution was made action taken by the Provider to include any corrective action if necessary. See Attachment A for menu substitution log template.

   a) If a dietitian is not available, the Nutrition Provider staff or caterer staff member will make the best choice available using the Substitution Guidelines. Again, the substitution must be reported to the Provider. The Provider must document the information in the substitution log. The substitution log must indicate why the substitution was made action taken by the Provider to include any corrective action if necessary.

8. Documentation of all menu substitutions must be kept on file for monitoring purposes. Copies of the Substitution Logs must also be submitted quarterly to the Contract Manager for review. The substitution log must include the following information:

   a) The date of substitution
   b) The original menu item
c) The substitution made
d) The reason for the substitution
e) The signature of the employee authorizing the substitution.
f) Action taken by the Provider to include any corrective action

9. If there are no substitutions for a given month, the substitution log for that month must still be created. The log will indicate “no substitutions this month”.

10. If the provider identifies that a menu item was substituted, and was not reported by the caterer, the site manager or designated staff must document the substitution in the substitution log, notify the caterer and document the action that took place to address the substitution.

11. The volume of substitutions must be justified by the reasons provided. Substitutions should be kept to a minimal and should be in accordance with the written policy.
Menu Attestation Statement

(Attach this form to the signed menus for submission to Alliance for Aging)

Nutrition Provider: __________________________ Date: ______________

RD’s Name (please print): __________________________

Instructions:
The purpose of this form is to assist the Alliance’s dietician in reviewing the menus approved by the Provider’s dietician. This attestation should include discussions and steps the RD has taken with the caterer to closely follow the Dietary Guidelines.

The dietician who developed the nutrient analysis must complete Section I of this attestation, even if it’s the Provider’s caterer that developed the nutrient analysis. Section II must be completed by the Provider’s RD only. Each page of the menu must be signed by the Provider’s RD ONLY.

SECTION I
I attest that the attached menus have been analyzed with computer software programming using ______________ (the name of the software). These menus meet DOHaD’s Computer-Assisted Menu Development requirements with the following specifics:

- Menus provide 33 1/3% of the Dietary Reference Intakes and approximately 600 calories per meal using the reference intakes for Age 70+ Females
- Analysis includes: Calories, Protein, Fat, Fiber, Calcium, Zinc, Sodium, Potassium, Magnesium, Vitamins B6, B12, C, and A
- Adequate amounts are provided daily of Calories, Protein, Fat, Fiber, Calcium, Vitamin B6 and Vitamin C
- Vitamins A and B12, Zinc, Magnesium, Sodium and Potassium are averaged over one week; however, no individual meal exceeds 1000 mg of Sodium
- These menus comply with the current Dietary Guidelines for Americans. The guidelines can be found at http://www.health.gov/DietaryGuidelines/

Registered/Licensed – Signature Date

SECTION II:

- Menus attested to are for the following (use date and title of menus):

- Dietitian’s comments:

Registered/Licensed – Signature Date

Menu Submission Guide

How to Have a Complete Submission for “Regular” Menus Approval

Attachment B

Revised May, 2017
A. Menus shall be planned and provided to a qualified RD no less than 6 calendar weeks in advance of implementation.
B. All menus must be approved, in writing by a RD, at least 4 calendar weeks prior to implementation.
C. Menus must be submitted to the Contract Manager at least 4 weeks prior to implementation.
D. Menus shall be no less than 4 weeks in rotation of different food combinations and shall run for a maximum of six months before changing. Food items should not be repeated on consecutive days or consecutive days of the week.
E. AAA will review approved menu and approve implementation

Submissions include the following 3 documents:

1) Menus
   - Nutrition Provider’s Name
   - Menu Name (includes where menu will be served, ex: Home Delivered, Congregate, box meals, etc.)
   - Date-range Menu is to be served (must not exceed 6 months)
   - Nutrition Provider’s Licensed Dietitian (LD): Name, LD number, Dietitian’s Signature and date of signature (on each page) NOTE: A RD employed by the food vendor may not approve the menus.

2) Computer Nutrition Analysis
   - Analysis should be completed on each “Daily Meal” with the foods listed so that analysis can be used to “improve” menus, as may be needed
   - If possible, a weekly summary page with these nutrients for ease in reviewing those nutrients that may be averaged over the week

3) Menu Attestation Statement
   - Name and dates of Menus being attested
   - LD’s typed name, signature, date, and license #
   - Nutrient variances noted in the "Comment" section by the Provider’s LD: Comments from Provider’s Dietitian should include discussions or steps she has taken with Caterer in order to continue to closely follow the Dietary Guidelines. Comments should include documentation that dietitian is following up on variances.

NOTES: Summary and Nutrient Analysis for menu meals:
- Include only nutrients identified for DOEA programs (2016 DOEA Manual)
- Whole grains and high fiber foods should be included as much as possible.
- Posted menus should be in a font size 14 or larger for easy review.
- Approved menus shall be followed as written
- Menu Substitutions: A comprehensive menu substitution policy and procedure must be developed and approved by the nutrition program’s qualified dietitian must be available for site manager’s use. Documentation of all menu substitutions must be kept on file for at least two years for monitoring purposes. Documentation must include the date of substitution, the original menu item, the substitution made, the reason for the substitution and the signature of the employee authorizing the substitution.
- Dessert may be provided as an option to satisfy the caloric requirements or for additional nutrients. However, effort must be made to limit the amount of added sugar in the food preparation. Preferred desserts include: Fresh, frozen or canned fruit packed in their own juice, and low-fat products made with whole grains and/or low-fat milk, pudding made

Revised May, 2017
with low-fat milk, low-fat ice cream, ice milk, or frozen yogurt may be served where feasible due to the increased calcium needed by the elderly. High-fat baked goods such as brownies, cakes, cobblers, cookies, pies, should be limited to once a week.
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<th>DATE</th>
<th>ORIGINAL MENU ITEM</th>
<th>SUBSTITUTION MADE</th>
<th>Pre-Approved Yes/No</th>
<th>REASON FOR THE SUBSTITUTION</th>
<th>Name and Signature of Person who approved the substitution</th>
<th>ACTION TAKEN</th>
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*Note: All substitutions must be listed on the log.*

Revised May, 2017
Issue: The Alliance for Aging (Alliance) is responsible for monitoring the Providers to ensure compliance with contract obligations.

Policy: The Alliance must perform fiscal, administrative and programmatic monitoring of all contracted Providers annually.

Purpose: The purpose of the monitoring is to ensure that contracted providers are adhering to contractual compliance, fiscal accountability, programmatic performance and compliance with applicable state and federal laws and regulations. The monitoring is a comprehensive approach of reviewing, assessing, evaluating, and improving the quality of services provided by service providers and their sub-contractors.

Procedures:

I. Types of Program Monitoring

A. 90 Day Visit: This visit will be conducted for new service providers or new project directors contracted by the Alliance. The purpose of the visit is to provide assistance to the provider/director, to assess services delivery standards, and to ensure that the provider/director has a good understanding of their contract responsibilities. The visit should also include the provider’s ability to meet projected service and spending targets. Technical assistance will be provided by the Alliance in an effort to correct deficiencies identified during this visit. This visit should be made no later than 90 days after the new program and/or hiring of a new project director.

B. Annual Monitoring Visit: All contracted Providers will be monitored annually to determine program and fiscal compliance.

The annual monitoring visit will include a review of the following areas: Previous compliance issues; provider governance to include policies and procedures; file reviews (OAA and GR, if applicable); service compliance based on application contents; prioritization/targeting and ADRC outsourced functions; quality assurance procedures and service sampling; nutrition compliance (if applicable); outcome measures; APS (if applicable), fiscal compliance, and Healthy Aging/Evidenced Based Programs (if applicable).

During the course of the year, GR file reviews will be conducted on a quarterly basis to ensure compliance with documentation requirements. Monthly CIERTS data integrity reviews will also be conducted to ensure compliance with CIERTS data integrity. If at any time during these reviews the Alliance identifies areas of concerns, additional on-site visits may be conducted.

During the Annual Monitoring visit, the Contract Manager, Fiscal Manager, and staff from the Healthy Aging unit (if applicable) will complete all necessary monitoring checklists, in addition to reviewing/completing the following items:

- Service Provider application(s)
- Previous compliance issues
- Action plan(s) and/or Corrective Action Plans (CAP) submitted

Alliance for Aging, Quality Assurance Department Policies and Procedures RV May, 2017
- Program and Fiscal Policies & Procedures
- Client complaint and grievance logs
- Outreach activities and outreach reports
- Subcontractor monitoring (if applicable)
- Satisfaction surveys (to include 8 survey samples, summary of the survey results, and follow-ups).
- Procurement procedures and list of most recent procurement actions, including dates, programs(s) and services bids.
- Pre-service and in-service staff and volunteer training documentation
- Surplus/Deficit Expenditures and reports
- CIRTS data integrity reports
- List of Case Managers and/or Assessors (to include date of hire, date of termination, credentials (resume & degrees), assigned caseload by programs, documentation of in-service training (to include training curriculum and proof of completion).
- Outcome Measures
- Service Sampling
- For nutrition Providers, sites visited will be monitored for the following items (some of these items are monitored as part of the quarterly nutrition document submission):
  - Daily congregate meal and refrigerator temperature logs
  - Annual caterer monitoring to include inspections from Divisions of Hotels and Restaurants and meal temperature checks
  - Approved menus and nutrient analysis
  - Current food service vendor contracts
  - Substitution logs and follow-ups
  - Staff, volunteer, and driver training on safe and sanitary handling of food during preparation, storage, and delivery.
  - Quarterly NPCR forms (once by RD, once by Project Director and twice by site manager to include documentation of corrective action for deficiencies noted)
  - Monthly nutrition education materials (including distribution lists and credential for the person conducting the education, if other than a dietician).
  - Certified Food Protection Manager certificate
  - Procedures for nutrition counseling and copies of nutrition care plans
  - Caterer’s invoices for the months selected to audit

- File Reviews (APS, CCE, HCE, ADI, OAA, and LSP): A total of 1% of the active case load (maximum 10 files) will be reviewed during the annual monitoring visit. Findings should be compared to the outcome of the quarterly file reviews to determine if previous compliance issues have been addressed by the Provider. The majority of the files selected should be for case managed programs, if applicable). A list of the selected files may be sent to the provider one week prior to the monitoring visit. The Alliance may request additional files on site, depending on the outcome of the review.
  - GR (CCE, HCE, and ADI) files will be reviewed using the Alliance’s GR file review checklist. Refer to ATTACHMENT B.
- APS files will be reviewed using the Alliance’s APS file review form. Refer to ATTACHMENT C.
- OAA and LSP files will be reviewed using the Alliance’s OAA/LSP file review checklist. Refer to ATTACHMENT D.

- Alliance staff may request some of these documents for desk review prior to the monitoring visit. Refer to ATTACHMENT E, Documents Availability List.

C. Special Visit. A special visit can be made at any time by the Alliance during the funding period and may be announced or unannounced. The purpose of the visit should be to follow-up on a corrective action, client complaints, or to follow-up on concerns identified during a monitoring.

D. Quarterly Nutrition Document Review: The Contract Managers assigned to nutrition providers will review, at a minimum, the following nutrition documents quarterly:
   1. Nutrition Program Compliance Review (NPCR) for the site(s) selected
   2. Monthly CNML and HDM nutrition education for the site(s) selected
   3. Substitution logs for the site(s) selected
   4. Daily congregate temperature logs for the site(s) selected
   5. Monthly HDM temperature logs

The following are the minimum number of meal sites that will be monitored quarterly:

1. Providers with 1-4 sites or less: Review at least 1 site semi-annually
2. Providers with 5-9 sites or less: Review at least 1 site per quarter
3. Providers with 10 or more sites: Review at least 2 sites per quarter

Sites should be selected at random. Sites identified with issues should be selected quarterly for review, in addition to regular quarterly selection.

E. Quarterly Case File Reviews: Contract Managers will conduct GR (CCE, HCE, APS and ADI) quarterly file reviews in order to ensure Providers are adhering to programmatic requirements. OAA and LSP files will be reviewed annually during the annual monitoring visit.

Contract Managers shall review client files utilizing the Alliance’s file review checklist. See Attachments B and C. The purpose of this review is to determine if the Case Management Agencies are in compliance with program requirements and if they are addressing the client’s needs. Providers should also review their own files utilizing the Alliance’s file review checklist.

1. For CCE and HCE: Contract Managers will review, at a minimum, 5 active client files quarterly. Additional files may be requested or reviews may be conducted more often if compliance issues are identified. The selection must include at least 3 APS files served during that quarter, as well as clients identified through exceptions (APS, CIRTS data integrity, and outcome measures).
2. For ADI: Contract Managers will review at least 5 files semi-annually. Reviews must be conducted more frequently if compliance issues related to eligibility are identified.

Alliance for Aging, Quality Assurance Department Policies and Procedures RV May, 2017
3. Files may be reviewed either as a desk review or on site. If on site, the list of files may be sent to the Provider within 5 days prior to the visit.

4. Files requested must be reviewed within 2 weeks of receiving the files from the Provider. A report indicating the findings must be sent to the Provider no later than 10 working days from the date of the review. Providers will be asked to respond to the report within 15 working days of the date of the report. The issues identified through client file reviews may also be used by the Alliance for training purposes.

F. CIRTS Data Integrity Monitoring: The CIRTS Specialist will monitor CIRTS data integrity on a monthly basis, or more often if necessary, to ensure that all CIRTS exceptions are cleared. Refer to CIRTS Data Integrity Policy for a list of reports ran by the CIRTS Specialists. Providers with exceptions will receive written notification from the CIRTS Specialist of pending exceptions. The Provider will be given technical assistance by the CIRTS Specialists on how to correct the exceptions, if necessary. The Provider will be asked to clear the exceptions within 2 weeks of the Alliance identifying the problem.

If the Provider fails to correct the exceptions by the 2 week time frame, a second reminder will be sent by the CIRTS Specialist giving the Provider an additional 2 weeks to clear the exception.

If the Provider fails to respond to the second reminder, the Contract Manager will send an email to the Provider reminding them of their contractual obligations to ensure CIRTS Data Integrity. If the Provider fails to correct the exceptions, a follow-up email will be sent to the Program Directory by the Director of Program Integrity & Accountability.

If the Provider fails to correctly, completely, or adequately correct the deficiencies (exceptions), the Provider will have 10 working days to submit a Corrective Action Plan ("CAP") to the Contract Manager that addresses the deficiencies and states how the deficiencies will be remedied within a time period approved by the Contract Manager, as referenced in the contract.

As referenced in the contract, the Alliance shall assess a Financial Consequence for Non-Compliance on the Provider for each deficiency listed on the CAP which is not corrected pursuant to the CAP. The Alliance will also assess a Financial Consequences for failure to timely submit a CAP.

If the Provider fails to meet the minimum level of service or performance, as defined in the contract, the AAA may apply financial consequences commensurate with the deficiency. Financial consequences may include but are not limited to contract suspension, refusing payment, withholding payments until deficiency is cured, tendering only partial payments, corrective action and/or cancellation of contract and reacquiring services from an alternate source. The Provider must refer to the "Consequences for Noncompliance" section in their contract.

A CIRTS folder containing all reports ran and all working documents to clear the exceptions should be kept by the Provider for monitoring purposes.

II. Annual Provider Monitoring:
A. At least 6 weeks prior to the monitoring, a scheduling letter and the “Documents
Availability Lists” must be sent to the Provider’s Executive Director.

B. At least 4 weeks prior to the monitoring, the Contract Manager in coordination with
Fiscal staff must schedule a “briefing” telephone call with the Provider to review the
“Documents Availability List” and discuss the documents that are needed for desk review
to be reviewed on site. At the time of the briefing call, the list of employee files and
months/services selected for the CIRTS audit must be shared with the Provider. The
Provider will be given 2 weeks to submit the documents necessary for desk review. All
desk review documents submitted by the Provider must be reviewed by the Contract
Manager prior to the monitoring.

C. To ensure sensible testing and to ensure consistency in the monitoring sample selections, the
Contract Manager and Fiscal staff will determine the monitoring selection based on the
following criteria:
   1. No more than three services should be selected by provider, unless there are
      concerns identified.
   2. Two of the services selected should be the services with large volume of units
      billed.
   3. One of the services selected should be the service with small volume of units
      billed.
   4. Each year, different services should be selected, UNLESS there are concerns
      uncovered in a service during the contract year or in the previous year monitoring.

D. For the services selected, each should be tested in different months.
   1. The same services provided in different programs (contracts) should be tested
      within the same month chosen for review. This will support in the testing of
duplicate billing. The following should be considered when selecting months:
      a. Months with high billing (or spikes)
      b. Current Contract years as to prevent potential concerns over a contract
         year-end closing.
   2. If concerns are discovered, the scope should be expanded to a different non-
      consecutive month (either forward or back). In selecting and expansion month,
      keep in mind the timing of the current contract period.

E. As part of the annual monitoring, a CIRTS Audit will be completed to verify the units billed
by the providers to the source documentation on site to ensure services were provided as
 billed to the Alliance. Client enrollment in CIRTS will also be verified to ensure that clients
billed were appropriately assessed, enrolled, and determined eligible for services before
services were provided.

F. The CIRTS Audit is comprised of two components; Units Billed and CIRTS Program
Enrollment.
   1. Units Billed
      a. Services billed by client should be monitored using the following sampling
         methodology:
         i. 10 Clients or less - All client records should be reviewed
         ii. 11-50 Clients - 7 client records should be sampled
         iii. 51-75 Clients - 8 Clients should be sampled

Alliance for Aging, Quality Assurance Department Policies and Procedures       RV May, 2017
iv. 76-100 Clients - 10 Clients should be sampled
v. 101-250 Clients - 10% of Clients should be sampled, not to exceed 20 records.
vi. 250 and greater - up to, but not to exceed 5% of the total client records should be sampled

b. Services billed aggregately should be monitored at 100% tested for units billed.

c. The following services should not be selected for a CIRTS – Units Billed Audit. These services require a file narrative and are audit as a part of a client file review by the Contract Manager.
   1. Case Management (CM)
   2. Counseling (CNSL)
   3. Screening & Assessment (SCAS)
   4. Nutrition Counseling (NTCOI)
   5. Nutrition Screening (NTSC)

d. Services billed aggregately, not by client, must be monitored at 100% of the billing.

e. For Congregate Meals – The following criteria will be used in randomly selecting Meals Sites:
   1. If a provider has 1-5 Sites, select 1 site to review
   2. If a provider has 6-10 Sites, select 2 sites to review
   3. If a provider has 11-15 Sites, select 3 sites to review
   4. If a provider has more than 15 Sites, select 4 sites to review

f. For all Meal Service, the Caterer Invoice must be compared to total Units Billed to ensure the following:
   1. Units billed to the Alliance do not exceed Caterer invoice
   2. Units billed to the Alliance should be reasonable and likely be lower than Caterer Invoice due to:
      i. Likelihood that not all clients received a meal
      ii. Other funding source for meals are also part of the invoice from the caterer
      iii. Meal costs being paid for by NSIP

2. CIRTS Program Enrollment: Sample Size for all Services is the same as the Sample size for Units Billed by Client above. To support and facilitate the Program Enrollment Audit, print the following CIRTS report prior to the on-site monitoring: “ALL ACTIVE CLIENTS by PROVIDER OR PROGRAM (includes clients who are now terminated)”. This report should be for each program (contract) – not for each service. Clients billed must be enrolled in CIRTS for the time period monitored, if it’s a registered service.
   a. Expanding the score: If concerns are identified with the CIRTS audit and CIRTS Program Enrollment, the scope (or the number of months) should be expanded by 10% of the units or clients tested. The following is an example:
      1. Services with 10 clients- 10% of All clients (or 1 concern)
      2. Services with 11-50 clients- 10% of 7 clients (or 1 concern)
      3. Services with 51-75 clients- 10% of 8 clients (or 1 concern)
4. Services with 76-100 clients-10% of 10 clients (or 1 concern)
5. Services with 101-250 clients-10% of the lesser of 10% of the clients or 20 clients
6. Services with greater than 250 clients-10% of 5% tested

b. The expanded audit for Units Billed and Program Enrollment will utilize the same source documentation already being tested. The expansion will encompass choosing different clients from the same source document already received and using the same criteria listed under the CIRTS Audit Units Billed testing sampling size.

c. For Units Billed Aggregately: Select another Month to test based on the criteria described above in Months & Service Section 2.c.

III. Visit:

A. A monitoring team led by the Contract Manager will conduct the visit.

B. As stipulated in the contract, the Provider will permit persons duly authorized by the Alliance to inspect and copy any records, papers, documents, facilities, goods and services of the contractor which are relevant to this contract, and to interview any clients, employees and subcontractor employees of the contractor to assure the Alliance of the satisfactory performance.

C. Staff must bring the following documents to the visit:

   a. Applicable monitoring checklists
   b. Copy of the Provider's Application
   c. Copy of the previous monitoring reports
   d. Previous action plans or CAP submitted
   e. Scale, thermometer and measuring cups (if applicable)
   f. Alliance’s GR and OAA/LSP file review & APS checklists
   g. Summary of CIRTS data integrity reports
   h. Outcome measure reports
   i. CIRTS report indicating newly active cases

2. During the visit Alliance staff will:

   a. Review monitoring agenda with the Executive/Project Director during the entrance interview.
   b. Complete all appropriate programmatic and fiscal reviews.
   c. Review the Service Provider Application to make sure the Provider is adhering to its contents.
   d. Review previous monitoring report to ensure all follow-up items have been addressed.
   e. Complete file reviews to determine if services provided are in the Clients’ best interest, are the most cost effective, of high quality, and are responsive and appropriate to the client’s assessed needs. The Contract Manager will also review CIRTS units billed in comparison to the services authorized,
when reviewing case managed services. The Contract Manager must also verify that there is no duplication of services.

f. For case managed programs, the Contract Manager will conduct a CIRTS audit for case management and case aide services. The review will verify that the documentation in the file is billable and supports the billing in CIRTS.

g. A CIRTS audit for all other services shall be conducted by the Fiscal Manager to verify invoice payments and CIRTS reports to source documentation in order to validate that services billed to the Alliance were provided and properly documented by the Provider. Inconsistencies or trends should also be identified and discussed at the daily debriefings and at the exit interview with the Provider. NOTE: As part of the CIRTS audit, the Contract Managers must review the source documents to ensure they meet the requirements of the program as specified in the DOEA Programs & Services Handbook.

h. Interview clients to determine level of satisfaction.

i. Sample services

j. Conduct site visits (sites should be alternated to ensure all sites are visited)

k. Review the provider’s waiting list and recent activations to determine if clients were made active pursuant to targeting or prioritization criteria.

l. Schedule a daily debriefing with the Provider to discuss the status of the monitoring and request any pending documentation. If possible, the Contract Manager should send daily emails to the Provider summarizing pending items.

m. Review findings and best practices with the Executive Director and Project Director during the exit interview.

IV. Compiling, Reviewing and Submitting the Report

A. Following the monitoring visit, the Contract Manager completes the report. See ATTACHMENT A.

B. The report must be addressed to the Provider's Board Chairperson and/or President.

C. The report must be submitted to the Provider no later than (45) working days from the day of the monitoring exit.

D. The Contract Manager must track the Provider’s monitoring response. Action plans and/or CAP requested must be monitored closely to ensure that compliance issues are resolved prior to the next monitoring visit. Updates must be provided to the Supervisor, as necessary.

E. Contract Managers must submit the monitoring tracking log to the Supervisor once the Provider’s response has been received and reviewed.

F. Significant findings are shared monthly with the Alliance’s Programs and Services Committee.

G. DOEA must be notified of any Provider placed on Corrective Action status.

V. Follow Up on Pending Items

A. Providers will be given 15 working days to submit a response to the monitoring report. This includes responses to a monitoring visit, file reviews or any other special visits.

B. If corrections are not made or the required documentation is not received within the stipulated 15 day period, a second notice will be sent to the Provider by the Contract Manager.
C. If the Provider has failed to correctly, completely, or adequately correct the deficiencies, the Provider will have 10 working days to submit a Corrective Action Plan ("CAP") to the Alliance's Contract Manager that addresses the deficiencies and states how the deficiencies will be remedied within a time period approved by the Contract Manager, as referenced in the contract. The Contract Manager will monitor the CAP to ensure compliance.

D. The Provider will be placed on Corrective Action for repeat deficiencies that may affect the Provider's ability to deliver services, for failure to correct previously identified deficiencies, for failure to follow its action plan, and/or for being non-responsive.

E. A copy of the monitoring report, action plan and/or CAP, Provider's monitoring report response and the Alliance's response must be scanned to the v drive and filed in the Provider's contract folder.

F. If the Provider fails to meet the minimum level of service or performance, as defined in the contract, the Alliance will apply financial consequences commensurate with the deficiency. Financial consequences may include but are not limited to contract suspension, refusing payment, withholding payments until deficiency is cured, tendering only partial payments, corrective action and/or cancellation of contract and reacquiring services from an alternate source. The Provider must refer to the "Consequences for Noncompliance" section in their contract.

G. Letters placing a Provider on Corrective Action must be signed by the Alliance's President & CEO.

H. A letter shall be sent to the Provider by the CEO once all Corrective Action items have been resolved advising the Provider that the Corrective Action status has been lifted. Copy of the letter will be sent to DOEA, scanned and saved on the v drive and placed in the Provider's contract file.

Attachment A

Alliance for Aging, Inc.
MONITORING REPORT

I. PROVIDER NAME AND ADDRESS

II. FUNDING PERIOD, SOURCE and CONTRACT NUMBER

III. PURPOSE OF THE VISIT
☐ 90 Day ☐ Annual Monitoring Review ☐ Special

IV. DATE(S) OF MONITORING VISIT

V. NAME & TITLE OF THOSE INVOLVED IN THE VISIT

VI. SITES VISITED
Alliance for Aging, Quality Assurance Department Policies and Procedures RV May, 2017
VII. SCOPE/MONITORING PURPOSE

VIII. PROVIDER OVERVIEW

IX. PROGRAM FINDINGS & RECOMMENDATIONS

A. PREVIOUS PROGRAM COMPLIANCE

1. All Previous compliance issues resolved. □ Yes □ No
   Follow up required □ Yes □ No
   Action plan required □ Yes □ No

Observations/Comments:

B. PROVIDER GOVERNANCE

1. All required DOEA program policies and procedures were on file: □ Yes □ No
2. Policies were in compliance with DOEA’s program requirements: □ Yes □ No
3. The following DOEA program policies and procedures were not in compliance with
   the program requirements:
4. Staff/volunteer trainings were conducted: □ Yes □ No
5. Subcontractor monitorings were completed, to include follows ups: □ Yes □ No □ N/A
6. Disaster and COOP Plans were submitted: □ Yes □ No
   Follow up required □ Yes □ No
   Action plan required □ Yes □ No

Issue Identified/Actions to be taken:

C. FILE REVIEWS

1. Number of Files Reviewed:
2. Programs Reviewed:
3. Compliance issues identified: □ Yes □ No
4. If yes, identify which program were out of compliance:
5. If yes, identify which areas were out of compliance:
   □ Assessments □ Care Plans
   □ CIRTS Billing □ Service Authorizations
   □ CIRTS Transference Errors □ APS services were not provided within 72 hours
   □ APS Requirements □ Narratives
   □ Other

   Follow up required □ Yes □ No
   Action plan required □ Yes □ No

Issue Identified/Actions to be taken:

D. PRIORITIZATION/OUTREACH/ADRC OUTSOURCED FUNCTIONS

Alliance for Aging, Programs & Services Department Policies and Procedures     RV May, 2017
1. Provider conducted outreach activities: 
   □ Yes □ No
2. Provider submitted required outreach reports: 
   □ Yes □ No
3. Recent activations meet targeting and prioritization requirements: 
   □ Yes □ No
4. Provider is in compliance with CIRTS data integrity requirements: 
   □ Yes □ No
   □ N/A
5. Provider has a wait list in CIRTS and follows wait list protocols: 
   □ Yes □ No
   □ N/A
6. Provider reports monthly ADRC contacts: 
   □ N/A
   □ Yes □ No
Follow up required: 
   □ Yes □ No
Action plan required: 
   □ Yes □ No

Issue Identified/Actions to be taken:

E. QUALITY ASSURANCE

1. Annual client satisfaction surveys were conducted: 
   □ Yes □ No
2. Provider followed up on survey results: 
   □ Yes □ No
3. Provider has complaint logs in place: 
   □ Yes □ No
4. Complaint logs show date, complaint, and resolution: 
   □ Yes □ No
5. Client/staff/volunteer interviews conducted: 
   □ Yes □ No
6. Outcome of the interviews were positive: 
   □ Yes □ No
7. Services were observed during the monitoring: 
   □ Yes □ No
8. Outcome of the service observation was positive: 
   □ Yes □ No
   □ N/A
   Services observed:
Follow up required: 
   □ Yes □ No
Action plan required: 
   □ Yes □ No

Issue Identified/Actions to be taken:

F. NUTRITION COMPLIANCE

1. Nutrition documents are complete and accurate: 
   □ Yes □ No
   □ N/A
2. Meal temperature issues identified: 
   □ Yes □ No
   □ N/A
3. Excessive and/or unapproved substitutions identified: 
   □ Yes □ No
   □ N/A
Follow up required: 
   □ Yes □ No
Action plan required: 
   □ Yes □ No

Issue Identified/Actions to be taken:

G. OUTCOME MEASURES

In keeping with legislatively mandated requirements for performance-based budgeting, DOEA has identified key goals for which all area agencies on aging and service provider agencies are required to develop implementation strategies in order to assist the department in achieving the statewide outcome and output measures it has identified for the aging Alliance for Aging, Quality Assurance Department Policies and Procedures  RV May, 2017
network. The outcome measure report compares a new client’s score from the prior fiscal year to the score at reassessment for each of the areas listed below. The measurement evaluates the percent of clients with maintained or improved scores from initial assessment to reassessment. The result is compared to the legislatively approved performance target defined for the fiscal year. Scores that do not improve from one year to the next require an intervention from the Provider on how they will address the client’s needs.

1. **Provider met the following required outcome measures:**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider Rate</th>
<th>Legislatively Approved Target</th>
<th>Status (Met/Not Met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APS Referrals Receiving Service within 3 Days</td>
<td>98.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of elders assessed with high or moderate risk environments who improve their environment score</td>
<td>79.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of new service recipients whose ADL assessment score has been maintained or improved</td>
<td>65%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of new service recipients whose IADL assessment score has been maintained or improved</td>
<td>62.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of new service recipients with high risk nutrition scores whose nutritional status improved</td>
<td>66%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N/A = No new client for the FY 2015/2016 had a need identified for the specific outcome referenced.

2. **If outcome measures were not met, Provider implemented action steps identified in its Service Provider Application (SPA):**

   □ Yes □ No □ N/A

   Follow up required □ Yes □ No
   Action plan required □ Yes □ No

   **Issue Identified/Actions to be taken:**

X. **FISCAL FINDINGS & RECOMMENDATIONS:**

   a. **Fiscal Audit**
   i. A fiscal audit was conducted during this visit: □ Yes □ No
   ii. Were there findings in the fiscal audit? □ Yes □ No

   Follow up required □ Yes □ No
   Action plan required □ Yes □ No

   **Issue Identified/Actions to be taken:**

   b. **CIERTS/Billing Audit**
   i. Was a CIERTS audit conducted as part of the fiscal audit? □ Yes □ No
   ii. If yes, please indicate the services that were audited: □ Yes □ No
   iii. Were there discrepancies identified in the CIERTS audit? □ Yes □ No

   Follow up required □ Yes □ No

*Alliance for Aging, Programs & Services Department Policies and Procedures  RV May, 2017*
Action plan required  □Yes □No

Issue Identified/Actions to be taken:

C. Surplus/Deficit Reports
1. Provider submits monthly surplus/deficit reports on time: □Yes □No
2. Monthly surplus/deficit reports include spending plans: □Yes □No

Follow up required  □Yes □No
Action plan required  □Yes □No

Issue Identified/Actions to be taken:

D. Personnel Files
1. Personnel files reviewed contained all required information: □Yes □No

Follow up required  □Yes □No
Action plan required  □Yes □No

Issue Identified/Actions to be taken:

XI. CORRECTIVE ACTION REQUIRED
□Yes □No

XI. MATTERS TO BE FOLLOWED UP BY THE PROVIDER

The section(s) identified below require follow-up from the Provider detailing the steps that will be implemented to resolve the issues. The Provider must refer to the specific sections within the report for details.

□Previous Compliance Issues  □Outcome Measures
□Provider Governance  □Fiscal Audit
□File Review  □CIRTS/Billing Audit
□Prioritization/Outreach/ADRC  □Surplus/Deficit Reports
□Quality Assurance  □Personnel Files
□Nutrition  □Healthy Aging/Evidenced Based

XII. PROVIDER HIGHLIGHTS/BEST PRACTICES

XIV. EXIT INTERVIEW

XII. REPORT DATE AND SIGNATURES

Alliance for Aging, Quality Assurance Department Policies and Procedures  RV May, 2017
Provider:

Date of Review:

Purpose of Review:

<table>
<thead>
<tr>
<th>ADI, HCE, CCE FILE REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>701B assessment was current (at least annually) and signed by the GM</td>
</tr>
<tr>
<td>Client meets program eligibility</td>
</tr>
<tr>
<td>Client is 60 or older (18 yrs or older if ADI)</td>
</tr>
<tr>
<td>All information on the assessment was entered in CIRTS correctly.</td>
</tr>
<tr>
<td><strong>Care Plan, CIRTS Enrollment &amp; Billing</strong></td>
</tr>
<tr>
<td>There was a current care plan on file.</td>
</tr>
<tr>
<td>The care plan on file was completed entirely and accurately and addressed all of the consumer’s and/or caregiver’s needs as identified on the assessment.</td>
</tr>
<tr>
<td>Care plan was dated &amp; signed by client &amp; case mgmt (within 14 days of client)</td>
</tr>
<tr>
<td>Care Plan had been entered and updated, at least annually in CIRTS</td>
</tr>
<tr>
<td>Client is enrolled in CIRTS for the program billed</td>
</tr>
<tr>
<td>All PROGRAMS listed in the CIRTS Client Enrollment printout also on Care Plan</td>
</tr>
<tr>
<td>All services billed in CIRTS are also on the Care Plan</td>
</tr>
<tr>
<td>Service units billed in CIRTS match the frequency authorized on the care plan</td>
</tr>
<tr>
<td><strong>Narratives</strong></td>
</tr>
<tr>
<td>Case management service units billed match the documented case narrative units</td>
</tr>
<tr>
<td>QM conducted 14-day follow up to ensure services began after initiated or increased. Contact was initiated by the QM and addresses each specific service and the date they began</td>
</tr>
</tbody>
</table>

Alliance for Aging, Quality Assurance Department Policies and Procedures  RV May, 2017
<table>
<thead>
<tr>
<th>Client is not dually enrolled in Medicaid capitated LTC programs</th>
<th>0 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case narratives are signed and legible</td>
<td>0 0%</td>
</tr>
<tr>
<td>Case narratives reflect SS form given to client and/or SS assessment form is signed</td>
<td>0 0%</td>
</tr>
<tr>
<td>The CM addressed the changing needs of the client timely</td>
<td>0 0%</td>
</tr>
<tr>
<td>The narratives and care plan document at least one semi-annual home visit</td>
<td>0 0%</td>
</tr>
<tr>
<td>Narratives have enough detail to justify the time billed</td>
<td>0 0%</td>
</tr>
<tr>
<td>All CM and CA activities were billable</td>
<td>0 0%</td>
</tr>
<tr>
<td>If services were reduced or terminated or if the consumer transferred to another program, does the file contain evidence that the consumer was notified prior to the changes in writing of their right to grieve.</td>
<td>0 0%</td>
</tr>
</tbody>
</table>

**Forms**
- File contains Release of Information (annually) forms
- File contains signed HIPAA (once)

**Worker Logs**
- Units of service clearly indicated on worker logs
- Service type clearly indicated on worker logs
- Funding source clearly indicated on worker logs
- Date of service clearly indicated on worker logs
- Number of units on log match number of units reported in CIRTS (by client)
- Client name is listed on worker logs
- Client or caregiver has signed logs
- Worker/Driver has signed logs
- Worker/Driver has dated logs
- Time in & out is listed on worker logs

**Alzheimer's Disease Initiative Program Specifics**
- Records indicate client has medically diagnosed memory disorder
- File contains a completed co-pay form w/ client income info

**Community Care for the Elderly Program Specifics**
- File contains a completed co-pay form w/ client income info or documentation if copy was waived
- Narratives document that the services program prevent, reduce or delay institutionalization

**Home Care for the Elderly Program Specifics**
- Financial worksheet/docs shows income below LCP standard
<table>
<thead>
<tr>
<th>Caregiver lives with the client and is an adult caregiver age 18 years or older who is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Willing and able to provide care and assist in arranged services for the client; and</td>
</tr>
<tr>
<td>2. Qualified as an HCE caregiver based on the client’s choice and the case manager’s assessment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client is at risk of nursing home placement (documentation should reflect that without the assistance of the caregiver and the HCE program, the client is at risk of HHC placement).</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>File contains Affidavit of Compliance-Employee (5 pages). Caregivers that are relatives (as per NOHBM 1512-1-11-A dated 4/10/12) of the client are exempt from the Level 2 background screening but have to complete the Affidavit of Compliance- Employee form indicating the reason for the exemption (see page 4). Caregivers that are not exempt have successfully completed a Level 2 background screening.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>File has Notice of Case action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>There is monthly eligibility verification of services in the file.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If services, other than consumable, were provided documentation indicates why the caregiver was unable to provide. (Services must not be available for the client through Medicare, Medicaid, Veterans Administration (VA) or other insurance.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care plan was signed by caregiver (Note “HCE” next to the caregiver’s signature if the individual is an HCE caregiver).</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

**Outcome Measures**

<table>
<thead>
<tr>
<th>All outcome measures were met. Compare scores for last 2 assessments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If outcomes were not met, documentation indicates how the CM addressed the issue and the interventions made to address it. The interventions must match the action steps listed for that outcome on their Service Provider Application (SPA).</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The client is eating at least 2 meals per day. If not, documentation shows how the case manager addressed the issue.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>
**Attachment C**

**OAA/LSP FILE REVIEW**

<table>
<thead>
<tr>
<th>Administrative</th>
<th>Total Number</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Number</td>
<td>Client Total</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment was current (at least annually) and signed by the assessor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client is 60, meets program eligibility, and was activated based on targeting criteria. Activation date in CRITS was after the assessment date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the assessment justify the need for the services authorized?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All assessment information was completed and entered in CRITS correctly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the file contain emergency care/contact information?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of file transference errors (Compare file copy of assessment to the reviewer's copy of the tumoraround document).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of priority score errors: (Errors on items that contribute to the priority score, i.e. if 24, 25, 37, 38, 40, 41, 42, 43, 48, 47, 48, 49, 83 (caregivers health), 84,85, )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All sections of the assessment were completed entirely and without inconsistencies (including information in the comment boxes)-see tab for assessment guide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All client needs were addressed. The assessor addressed all of the consumer's and/or caregiver's needs as identified in all sections of the assessment by either providing services or referring to other agencies. Documentation reflects how the needs were address to include referrals made on behalf of the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening &amp; Assessment units billed match assessor’s documented time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client is not dually enrolled in Medicaid capitated LTC programs, except for congregate meals and transportation to the meal site (if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service billed in CRITS match the needs identified on the assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The unduplicated count for the HDM or CNML service is entered in CRITS for the current year in January for OAA and July for LSP or for new clients entered reflecting the enrollment date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For OAA, IIE program: The 701A documents the required frailty level for eligibility with &quot;two (2) or more ADL deficits or “Yes” to the question, “Does client need supervision?” (Only applies to ADC/ADHC and Respite services.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>File contains Release of Information (annually) forms dated and signed by the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>File contains HIPAA Notice acknowledgment form dated and signed by the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>File contains either the SSN disclosures signed by the client or confirmation of providing this to the client in the notes/narratives of the file.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If services were reduced or terminated or if the consumer transferred to another program, does the file contain evidence that the consumer was notified prior to the changes in writing of their right to grieve rights and was notified prior to the changes in writing of their right to grieve.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measures**

All outcome measures were met (ADL, IADL, Nutrition). Compare scores for last 2 assessments.
If outcomes were not met, documentation indicates how the assessor addressed the issue.
The client is eating at least 2 meals per day. If not, documentation shows how the case manager addressed the issue.

<table>
<thead>
<tr>
<th>Worker Logs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Units of service clearly indicated on worker logs</td>
</tr>
<tr>
<td>2. Services were clearly indicated on worker logs</td>
</tr>
<tr>
<td>3. Funding source clearly indicated on worker logs</td>
</tr>
<tr>
<td>4. Date of service clearly indicated on worker logs</td>
</tr>
<tr>
<td>5. Number of units on log match number of units reported in CHART (or client)</td>
</tr>
<tr>
<td>6. Client name is listed on worker logs</td>
</tr>
<tr>
<td>7. Client or caregiver has signed logs</td>
</tr>
<tr>
<td>8. Worker or caregiver signed logs</td>
</tr>
<tr>
<td>9. Worker or driver has listed logs</td>
</tr>
<tr>
<td>10. Time in &amp; out is listed on worker logs</td>
</tr>
</tbody>
</table>
**FILE REVIEW CHECKLIST FOR APS PROGRAM**

**Provider:**

**Date of Review:**

**Purpose of Review:**

**APS FILE REVIEW**

<table>
<thead>
<tr>
<th>Standards</th>
<th>Client Initials</th>
<th>Total Number of Files Reviewed</th>
<th>Total Percentage of Errors on Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete referral packet is in the file. (Referral Form; Adult Safety Assessment; Capacity to Consent Assessment; Provision of Voluntary Adult Protective Services CF-AA 1112 form if the individual being referred does not have capacity to consent, but a caregiver or guardian has given consent for services to be provided; and Court Order (if services were court ordered).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation confirming proof that the ADRG acknowledgment receipt of the referral in ARRT on the same day the referral packet was received and is in the file (copy of print screen was included with the referral packet).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 701B assessment was completed in person by the lead agency within 72 hours of receipt of the ARRT referral packet.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCE co-payment was waived for high-risk referrals during the first 31 days of services or until the adult's crisis situation has been resolved.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was this a repeat referral? If yes, documentation justifies why the case was a repeat referral.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The CM notified the client that services may be limited to 31 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CCB Lead Agency initiated the emergency or crisis resolving service(s) recommended or agreed to by APS (not just case management) within 72 hours of receipt of referral packet. Narratives confirm CM spoke to the client/caregiver to confirm the specific services that were provided within the 72 hours. (The narrative must be services specific). (Narratives, CCRS and timesheets must confirm service delivery during the first 72 hours. Time sheets confirming services during the first 72 hours must be filed in the client's file.)

If the case agency did not order the services that were recommended by the APS Protective Investigator, did APS and CM staff the case to resolve the issues? Was staffing documented?

701B Assessment was entered in CIRTS within 14 days of receiving the referral (includes setting the referral date to the date the referral packet was received, if referral source set to "abuse/neglect" and the risk level set as "high"); Dated turnaround form is in the file.

Enrollment information was entered in CIRTS within 14 days of receiving the referral.

Care plan information was entered in CIRTS by the end of the month in which services were provided, if services were approved.

**Attachment C**
Services provided for high risk referrals were entered in CI RTS by the end of the month in which services were provided. Units of services for CM and services entered in CI RTS using the date-specific method of the 72 hour period following the referral. This includes existing services and services that may normally be reported in aggregate such as OAA services. For the next 28 days, services must be aggregated weekly. After the 31 day period, CM agency may return to enter up to 31 services in CI RTS in compliance with CI RTS reporting requirements. Informal services arranged by the CM are also entered in CI RTS using date-specific method by setting the program to “NDP” and the units cost to “0”.

Delay/Refusal of services: If the client refused to be assessed, refused one or more services (throughout the 31 days) or there was a delay in service provision, the CM agency contacted DGF within 24 hours to determine the next course of action, entered the basic demographic information in CI RTS, and entered the necessary NDP code in the “received services screen” (for case management andors.

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<table>
<thead>
<tr>
<th>Did the Lead CM Agency enter the required fields in ARTT within 5 calendar days?</th>
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</thead>
<tbody>
<tr>
<td>Action taken by provider (to include the specific services that were provided within 72 hours of receiving the referral). (Field 30 in ARTT)</td>
</tr>
<tr>
<td>Staffing of additional comments (to include additional services that were not provided within 72 hours but were requested by DGF) (Field 31 in ARTT)</td>
</tr>
<tr>
<td>Service provider’s signature (Field 30 in ARTT)</td>
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<tr>
<td>Indicate staffing date (Field 27 in ARTT)</td>
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| Does documentation include the case manager followed up with client or caregiver within 31 calendar days on service arrangements and referrals? (Assuring services had begun?) (Narrative must be service and date specific) |

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<table>
<thead>
<tr>
<th>Is the care plan complete, detailed, legible and reflect the services assessed and delivered?</th>
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</thead>
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| Before services were terminated after 31 days, the client was seen face-to-face by the CM, a 761B form was entered in CI RTS if not listed for services, and APS designation removed. A new 761B form was entered in CI RTS if the client was well listed for services with referred sources set to “Other,” and respond to the follow-up question, “What is the purpose of this assessment?”, with an appropriate response, based upon the initial referral from APS, indicating the area(s) where the change occurred, i.e., health, living situation, caregiver, environment, income. |

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| Case was staffed with DGF after the face-to-face visit to determine that services can be safely terminated. |

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| Case Manager received annual training on the following: ARTT and the APS Operations Guide. |

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**Attachment D**

**Alliance for Aging, Quality Assurance Department Policies and Procedures**

**RV May, 2017**
# FILE REVIEW CHECKLIST FOR OAA & LSP PROGRAMS

## Administrative
- **Assessment was current (at least annually) and signed by the assessor?**
- **Client is 60, meets program eligibility, and was activated based on targeting criteria. Activation date in CIRTS was after the assessment date.**
- **Does the assessment justify the need for the services authorized?**
- **All assessment information was completed and entered in CIRTS correctly.**
- **Does the file contain emergency care/contact information?**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date of Review</th>
<th>OAA/LSP FILE REVIEW</th>
<th>Client</th>
<th>Client</th>
<th>Client</th>
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## Screening & Assessment
- **The unduplicated count for the HDM or CNML service is entered in CIRTS for the current year on 1/1 for OAA and 7/1 for LSP or for new clients entered reflecting the enrollment date.**

## For OAA, IIIE program: The 701A documents the required frailty level for eligibility with "two (2) or more ADL deficits or "Yes" to the question, "Does client need supervision?" (Only applies to ADC/ADHC and Respite services.)

## File contains Release of Information (annually) forms dated and signed by the client.

## File contains HIPAA Notice acknowledgement form dated and signed by the client.
File contains either the SSN disclosures signed by the client or confirmation of providing this to the client in the notes/narratives of the file.

If services were reduced or terminated or if the consumer transferred to another program, does the file contain evidence that the consumer was notified prior to the changes in writing of their right to grieve rights and was notified prior to the changes in writing of their right to grieve?

**Outcome Measures**

All outcome measures were met (ADL, IADL, Nutrition). Compare scores for last 2 assessments.

If outcomes were not met, documentation indicates how the assessor addressed the issue.

The client is eating at least 2 meals per day. If not, documentation shows how the case manager addressed the issue.
**Issue:** Outcome Measures

**Policy:** Outcome measures consistent with those developed by DOE will be implemented in order to meet targets established as required by state legislature.

**Purpose:** To ensure that legislatively mandated outcome measures are met.

**Procedure:**

A. Outcome measures to include goals, objectives, strategies/action steps, outcomes and output will be addressed annually by each agency in its service provider application.

B. CIRTS Specialist will run the DOE monitored Outcome Measures at least quarterly and send communication to providers with copy to the Contract Manager and the Director of Program Integrity & Accountability.

C. Contract Managers will review and analyze outcome measure reports and request files to review based on exceptions to determine why the client did not meet the outcome measures. Suggestions and technical assistance may be provided in order to achieve outcomes as appropriate.

D. The Provider will ensure that the documentation addressing the client needs and the interventions are written in the client’s file.

E. The Contract Manager will select sample files identified as exceptions in the outcome measure reports for review to determine why the client did not meet the outcome. The Contract Manager will confirm, based on the documentation, if the provider addressed the clients' needs and made appropriate referrals. The Contract Manager will also verify that the Provider is following the action steps identified in the Service Provider Application (SPA).

F. The CIRTS Specialist will maintain electronic copies of all email communication with the provider in an effort to address the exception.