

**NC Division of Medical Assistance, Community Alternatives Program for Children**  
**QUALITY MANAGEMENT STRATEGY 2010-2011**

SECTION 1: OVERVIEW

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**DEFINITION OF QUALITY**

CMS defines quality as the degree to which services and supports for individuals and populations increase the likelihood for desired health and quality of life outcomes and are consistent with professional knowledge.

**QUALITY MANAGEMENT**

Quality Management envelops both

- a. Quality Assurance, which is retrospective - after the fact assessments to make certain that **minimum** thresholds of acceptable quality are met, and
- b. Quality Improvement, which is prospective - initiatives that work to make certain that waiver programs are designed and organized to support the **best possible** outcome.

To be effective, a quality management strategy must include

- a. designing aspects of the program that are put into place before the actual delivery of care to enhance the likelihood that outcomes will be met,
- b. using discovery, remediation and improvement activities that make certain the program is working as intended,
- c. synthesizing information to determine what aspects of the program should be targets for improvement, identifying actions to achieve improvement, and monitoring and evaluating the outcomes of those efforts, and
- d. assuring that all administrative entities and stakeholders understand the roles they must play in managing and promoting quality.

**PURPOSE OF CAP/C QUALITY MANAGEMENT**

The overall purpose of the Quality Improvement Strategy (QIS) for CAP/C is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program for CAP/C that:

- 1.Ensures that the Division of Medical Assistance meets the Centers for Medicare and Medicaid Services' (CMS) assurances for the CAP/C waiver;
- 2.Implements the CMS Quality Framework in a manner that will meet all CMS requirements and assurances for waiver services;
- 3.Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of CAP/C services;
- 4.Identifies and sets appropriate performance and outcome measures to evaluate CAP/C services; and
- 5.Implements a Quality Management (QM) Program for CAP/C that focuses on family-centered outcomes related to:
  - a. Participant access
  - b. Participant-centered services planning and delivery
  - c. Provider capacities and capabilities
  - d. Participant safeguards
  - e. Participant rights and responsibilities
  - f. Participant outcomes and satisfaction and
  - g. System performance.

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**OVERVIEW OF THE QUALITY MANAGEMENT STRATEGY**

The CAP/C Quality Management Strategy is based on the CMS Quality. It draws upon resources including Medicaid policies; the Case Management Society of America's Standards of Practice; the National Association of Social Worker's Standards of Practice for Case Managers; the Key Values and Principles That Serve As the Foundation of A Person-Centered System for The Department of Health and Human Services; DHSR, Board of Nursing, and other licensure and certification entities; and other resources as available and pertinent to the program. The Quality Management Design is developed, approved, and implemented by the DMA CAP/C Quality Management Committee. (See below for a description of the Quality Management Committee.)

Major components of the Quality Management Strategy include Design, Discovery and Data Sources, Remediation, and Continuous Improvement. Each is described below:

**Design**

Program design sets the stage for achieving the desired outcomes for the CAP/C Program for CAP/C enrolled recipients. Design features include:

1. Identifying indicators and standards against which performance is measured;
2. Developing an approach to collect, synthesize, and share performance information; and
3. Develop a cohesive work plan that directs time, effort, and resources into the process.

CAP/C's program design, as outlined in this Quality Management Strategy, addresses such topics as level of care determinations, service planning, provider qualifications, monitoring participant health and welfare, administrative authority of the program, and financial accountability.

**Discovery Sources and Data Sources**

In this process, CAP/C data and direct participant experiences are collected to assess the ongoing implementation of the program and identify strengths and opportunities for improvement.

Discovery methods should ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and/or desired outcomes. CAP/C draws from several data sources to monitor CAP/C program performance, including:

**Remediation**

Remediation is the action taken to remedy specific problems or concerns that arise. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Subsequently, correction or remedial action is initiated to correct the root cause of the problem to improve performance in the weak area to prevent similar problems in the future.

**Continuous Improvement**

Finally, the CAP/C Quality Management Strategy determines how improvements in skill levels, processes, and systems can be established to initiate and sustain higher levels of performance.

The changes should, at a minimum, improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

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**STAKEHOLDERS IN QUALITY MANAGEMENT**

The North Carolina Division of Medical Assistance (DMA) is the state Medicaid agency responsible for the administration of the CAP/C Program. Services are delivered through a network of case management provider agencies. The following entities play key roles in the CAP/C service delivery system, as summarized below.

**CAP/C Participants and Families**

Participants and their families are the focus of the CAP/C Quality Management program. Program design and quality assurance activities are based in large part on the expressed needs of participants' families.

**The Medicaid CAP/C Unit**

The CAP/C unit is a long-term care unit within DMA's Facility and Community Care Section. The primary responsibilities of the CAP/C Unit include providing overall management oversight of the program, developing and implementing program policies and procedures, conducting the CAP/C quality management program, and providing training, consultation, and technical assistance to the case managers and providers.

**The local case management provider**

Local case management providers may be a department of social services (DSS), local health department, area agency for the aged, a home health agency, or a private provider. CAP/C case managers perform the following duties:

- a. Accept referrals
- b. Assess applicants for the program
- c. Manage wait lists if applicable
- d. Initiate the level of care determination
- e. Provide case management
- f. Submit claims for home and vehicle modifications and other waiver services and supplies not provided by an enrolled Medicaid provider
- g. Manage caseloads
- h. Develop Plans of Care (POC)
- i. Ensure quality services
- j. Ensure client freedom of choice
- k. Coordinate and monitor services
- l. Cooperate with monitoring and reporting activities

**Medicaid's fiscal agent**

Grants prior approval for nursing facility level of care, processes and pays provider claims, and provides training related to these activities to provider organizations.

**CAP/C provider organizations**

Provider organizations are enrolled with Medicaid to provide certain defined services, as specified in their enrollment contracts. Provider qualifications are specified in the CAP/C Clinical Coverage Policy.

**THE CAP/C QUALITY MANAGEMENT COMMITTEE**

The CAP/C Quality Management Committee is comprised of representatives of all of the above stakeholder groups, including recipients' families, Medicaid staff representing CAP/C and Program Integrity, Case Managers, and Provider Agencies (and MMIS?).

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Jennifer Brest	DMA, CAP/C		
Sandra Wheeler	DMA, CAP/C		
Teresa Piezzo	DMA, CAP/C		
Jennifer Ramsey	parent		
Mary Rollins	provider, PSA		
Glenyce Fulton	CM, Davidson (DPH)		
Donna Thompson	CM, Cumberland (hosp)		
Kim Stotz	CM (private)		
Susan Bostrom	DMA, QEHO		
Dora Boissy	DMA		
Joe Breen	DMA, CAP-DA and PCS		
Jon York	DMA, DSS's		
Susan Ryan	DMA, Eligibility		
TBD	DHSR		

Responsibilities of the Committee include:

1. Develop, approve, and amend as necessary a comprehensive Quality Management Strategy
2. Meet on a regular quarterly basis and additionally as needed to fulfill the responsibilities of the committee outlined in the Quality Management Strategy
3. Keep detailed minutes of all committee meetings to include agendas, minutes, attendance, and specimen copies of all documents and other materials distributed to or used by committee members.
4. Document all actions and votes taken by the committee
5. Ensure that all records, reports, and documentation of QM activities conducted by the QM Committee are maintained in an accessible location in a manner that will facilitate internal audits and reviews by authorized federal and state agencies.
6. Develop, update, and modify as necessary, all Quality Management policies and procedures
7. Review and approve all QM designs, monitoring activities, reviews, surveys, audits, evaluations, and other quality improvement activities before implementation.
8. Set quality standards and performance and outcome measures for CAP/C
9. Coordinate quality management activities with other DMA and/or waiver quality management activities
10. Develop, schedule, and implement regional and/or online training programs to address quality improvement and compliance issues, problems, and concerns.
11. Conduct an annual evaluation of the CAP/C QM Strategy and amend as necessary.

Quality Assurance is monitored by the CAP/C Quality Assurance Committee. The QA Committee monitors quality on an ongoing basis. Each year the QA Committee will conduct an annual evaluation of the QA Program and Develop an Annual QA Framework.

**FUTURE QUALITY MANAGEMENT**

DMA's Home and Community Based Services Program, which includes CAP/C, CAP-DA, PCS/PCS+, PDN, and PACE, is in the process of developing a Home and Community Based Services Quality Improvement Program. The major components of this program include:

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1. Establishing a web-based reporting mechanism for program assessments, plans of care, and other program management forms and tools that builds a database that can be used by authorized individuals to search files, track authorizations, identify patterns and trends, communicate with local agencies and providers, and generate standard ad hoc MIS reports;
2. Conducting on-site quality and compliance reviews of HCBS provider organizations;
3. Conducting in-home assessments of program participants to validate the provider agency's current assessment (not applicable to CAP/C as this assessment is done by the case manager);
4. Completing program satisfaction surveys with program participants during the home visit;
5. Reviewing samples of paid claims and comparing billed services to the services authorized in the participant's POC and documented in the provider agency's service records;
6. Utilizing program and claims data to construct, track, and report performance measures pertaining to the seven quality focus areas in the HCBS Quality Framework and the six state assurance areas;
7. Providing monthly, quarterly, annual, and ad hoc reports with summary analyses and interpretations; and
8. Conducting regional and web-based training programs on quality and compliance topics for providers, case management agencies, and county agencies involved in the administration of the involved HCBS programs.

Initial development and implementation of this program is expected for CAP/C by July 2011.

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<b>Assurance: Participant's Safeguards: Health and Welfare</b>	
<i>The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.</i>	
<b>Sub Assurance 1:</b> The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	
<b>CMS Expectation:</b> State demonstrates that, on an ongoing basis, abuse, neglect, and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect, and exploitation trends and strategies it has implemented for prevention.	
<b>Performance Measure 1</b>	Percentage of case managers who have had abuse/neglect/exploitation training within the last year.
Performance Standard	80%
Data Source	Record reviews, off-site Case Manager Survey
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Quality Management Committee
Frequency of Data Collection/Generation	annually
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	annually
Method of Reporting	Deficiencies within individual agencies are reported to the agency's CAP/C supervisor as described below. Aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Agencies falling below the performance standard are notified in writing. They are given the links to the available trainings, and instructed to submit a follow-up statement of compliance once the case managers have completed the training.
<b>System Improvements</b> CAP/C provides annual training for case managers regarding abuse, neglect, and exploitation. The training includes risk factors, signs and symptoms, reporting, and working with Child Protective Services. This is also offered as part of the new case manager training curriculum. The assessment form now (effective September 1, 2010) contains questions for the family regarding abuse, neglect, and exploitation, including assessment of risk factors. The Case Manager is responsible for assuring that the need is addressed within the plan of care with attention to both the child's/family's safety and their preferences. DMA reviews all plans of care and situations in which the need seems to have been overlooked or improperly addressed. This individual remediation involves three progressive levels: 1) Individual training/counseling between case manager and consultant; 2) For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan that includes a mechanism for DMA to follow up to ensure that the plan has been implemented and is effective, and 3) Referral to Program Integrity, DHSR, or the appropriate licensure board. (The	

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exact wording of the waiver document has been condensed for inclusion here, but the content remains the same.) Incidences of abuse, neglect, and exploitation, and the case management plan of care/individual remediation regarding those instances, are reported on CAP/C's critical incident report. Data regarding the above performance measure, as well as trends identified through critical incident reports are analyzed, trended, and addressed by the QM committee for any possible system improvements.

<b>ASSURANCE: Participant Centered- Planning and Service Delivery: Service Plans</b>	
<i>The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i>	
<b>Sub Assurance 1:</b> Service plan addresses all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	
<u>CMS Expectation:</u> State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.	
<b>Performance Measure 1</b>	
Performance Standard	85%
Data Source	analyzed collected data (including surveys, focus group, interviews, etc) CAP/C Participant Satisfaction Survey
Sample	random sample of 200 (25%) of active participants
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	annually
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	annually
Method of Reporting	If a deficiency within a certain agency can be identified, that agency's CAP/C Supervisor is notified in writing and is instructed to submit a corrective action plan including time frame and mechanism for follow-up to make sure the plan has been implemented and is effective. Aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Surveys are confidential, so remediation on an individual level occurs only when the participants identify themselves and ask for the assistance. The results of the surveys are aggregated for review by the CAP/C QM Committee and any necessary remediation would occur at the systems level; i.e., if a majority of participants indicated a need for a particular type of equipment, that equipment might be added as a waiver supply.
<b>Performance Measure 2</b>	Percentage of participants reviewed for which the consultant stated that all of the needs identified in the assessment were addressed in the plan of care
Performance Standard	85%

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Data Source	record reviews, on-site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	<p>Remediation is conducted on three progressive levels:</p> <ol style="list-style-type: none"> <li>1. Individual training/counseling between case manager and consultant</li> <li>2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan that includes a mechanism for DMA to follow up to ensure that the plan has been implemented and is effective.</li> <li>3. Referral to Program Integrity, DHSR, or the appropriate licensure board</li> </ol> <p>Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements. The same is done with the annual CNR QA data.</p> <p>(The exact wording of the waiver document has been condensed for inclusion here, but the content remains the same.)</p>
System Improvements	<p>CAP/C New Case Manger training emphasizes that ANY identified need, want, or abnormal finding MUST have a corresponding plan for addressing the issue.</p> <p>This same training also emphasizes the use of personal, natural, and other formal supports besides Medicaid and the CAP/C program. Case Managers must document progress toward these goals at least quarterly.</p> <p>ALL assessments and plans of care are reviewed by a DMA CAP/C Nurse Consultant who uses the method for remediating individual problems as stated above.</p> <p>Information regarding Medicaid and non-Medicaid resources is available in writing to both case managers and to parents, and to case managers by individual consultation with a DMA CAP/C Nurse Consultant during the course of the assessment and plan of care review.</p> <p>Stakeholder meetings are held annually and help to 1) determine the needs of the recipients as identified by the recipients themselves, providers, physicians, and others; 2) identify if the program is or is not meeting those needs. Individual situations that are discovered are remediated as they arise.</p> <p>Minutes are aggregated for review by the CAP/C QM Committee for possible remediation activities at the system level.</p>

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<b>ASSURANCE: Participant Centered- Planning and Service Delivery: Service Plans</b>	
<i>The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i>	
<b>Sub Assurance 2:</b> The state monitors service plan development in accordance with its policies and procedures.	
<b>CMS Expectation:</b> State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.	
<b>Performance Measure 1</b>	Percentage of participants reviewed for which the consultant said “agree” or “yes” to proper documentation, correct level of care, no code or unit rate errors, specific caregiver availability, cost summary matches typical 24 hour coverage schedule, appropriate staffing level, hours determined according to policy, within budget.
Performance Standard	80%
Data Source	record reviews-on site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan that includes a mechanism for DMA to follow up to ensure that the plan has been implemented and is effective. 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements. (The exact wording of the waiver document has been condensed for inclusion here, but the content remains the same.)
<b>Performance Measure 2</b>	Percentage of participants who agree or strongly agree that they participated in the development of the plan of care.
Performance Standard	85%

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Data Source	analyzed collected data (including surveys, focus group, interviews, etc) CAP/C Participant Satisfaction Survey
Sample	random sample of 200 (25%) of active participants
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	annually
Party Responsible for Data Aggregation and Analysis	DMA Quality Management Committee
Frequency of Data Aggregation/Analysis	annually
Method of Reporting	If a deficiency within a certain agency can be identified, that agency's CAP/C Supervisor is notified in writing and is instructed to submit a corrective action plan including time frame and mechanism for follow-up to make sure the plan has been implemented and is effective. Aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Surveys are confidential, so remediation on an individual level occurs only when the participants identify themselves and ask for the assistance. The results of the surveys are aggregated for review by the CAP/C QM Committee and any necessary remediation would occur at the systems level.
<p>System Improvements</p> <p>ALL service plans are reviewed by a DMA CAP/C Nurse Consultant. DMA provides case manager training sessions as well as a CAP/C Manual in which case managers are instructed regarding service plan development. Training includes the technical aspects as well as theory of family-centered planning. Families receive a Parent handbook and sign (annually) a Client Statement of Understanding which includes their right to participate and direct service plan development.</p>	

<b>ASSURANCE: Participant Centered- Planning and Service Delivery: Service Plans</b>	
<i>The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i>	
<b>Sub Assurance 3:</b> Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	
<b>CMS Expectation:</b> State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.	
<b>Performance Measure 1</b>	Percentage of Continued Need Reviews received by due date
Performance Standard	80%
Data Source	Record reviews – on site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	continuously and ongoing

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Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
<b>Performance Measure 2</b>	Percentage of plan of care revisions which were submitted timely and appropriately: there was no instance when a revision should have been submitted prior to the CNR but was not.
Performance Standard	80%
Data Source	record reviews on- site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
<b>Performance Measure 3</b>	Percentage of recipients with all sections of the family-centered plan of care completed

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Performance Standard	at least annually and progress toward goals documented at least quarterly. 80%
Data Source	Record reviews, off-site Site Audits Record reviews, on-site CNR QA form
Sample	other: random for site audits (5% of census or minimum 5 charts) 100% for CNR QA form
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	other: random for site audits continuously and ongoing for CNR QA form
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Assurance Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually. The agency also receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements. For site audits, the agency receives a detailed report with recommendations and requirements for corrective action plans.
<b>Performance Measure 4</b>	Percentage of recipients for whom the plan of care was revised as needed based on trends such as frequent hospitalizations or ER visits, inappropriate resource utilization, frequent exacerbations of illness, occurrence of preventable illnesses/injuries, staffing issues, or change in goals/prognosis of recipient
Performance Standard	80%
Data Source	record reviews, off-site Site Audits record reviews on-site CNR QA form
Sample	other: random for site audits (5% of census or minimum 5 charts)

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	100% for CNR QA form
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	other: random for site audits (two agencies per quarter) continuously and ongoing for CNR QA form
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually. The agency also receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: <ol style="list-style-type: none"> <li>1. Individual training/counseling between case manager and consultant</li> <li>2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan</li> <li>3. Referral to Program Integrity, DHSR, or the appropriate licensure board</li> </ol> Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
System Improvements	Annual Continued Need Reviews are tracked and any that are not received by the due date are followed up on. When a letter is sent approving a plan of care, the date the next review is due is also indicated on that letter. Consultants are notified of changes in condition via critical incident reports, and will follow up with the case manager if a plan of care revision is needed but not received. During the continued needs review, part of the assessment includes an update of what has happened over the last year; consultants will also follow up via the individual remediation process if the plan of care should have been reviewed but was not. Education is provided to case managers regarding the role of the case manager in general and in specific circumstances such as repeat hospitalization.

<b>ASSURANCE: Participant Centered- Planning and Service Delivery: Service Plans</b>	
<i>The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i>	
<b>Sub Assurance 4:</b> Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan. <u>CMS expectation:</u> State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	
<b>Performance Measure 1</b>	Percentage of participants who agree or strongly agree that they receive the services in

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	their plan of care.
Performance Standard	85%
Data Source	Analyzed collected data (including surveys, focus group, interviews, etc) CAP/C Participant Survey
Sample	random sample of 200 (25%) of active participants
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	annually
Party Responsible for Data Aggregation and Analysis	DMA Quality Management Committee
Frequency of Data Aggregation/Analysis	annually
Method of Reporting	If a deficiency within a certain agency can be identified, that agency's CAP/C Supervisor is notified in writing and is instructed to submit a corrective action plan including time frame and mechanism for follow-up to make sure the plan has been implemented and is effective. Aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Surveys are confidential, so remediation on an individual level occurs only when the participants identify themselves and ask for the assistance. The results of the surveys are aggregated for review by the CAP/C QM Committee and any necessary remediation would occur at the systems level.
<b>Performance Measure 2</b>	Percentage of recipients for whom there is no significant difference between the services listed on the plan of care and the paid claims data for those services
Performance Standard	80%
Data Source	record reviews, on-site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Discrepancies are brought to the attention of the Case Manager who is responsible for contacting the provider agency(ies) involved /investigating the reason for the discrepancy. If a claims error on the part of the provider, the error is corrected. Repeated or apparently purposeful errors are reported to Program Integrity. The Plan of

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	Care is revised as necessary to promote the provision of services (i.e., therapies may be changed from outpatient to in-home because of scheduling or transportation issues).
System Improvements	

<b>ASSURANCE: Participant Centered- Planning and Service Delivery: Service Plans</b>	
<i>The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i>	
<b>Sub Assurance 5:</b> Participants are afforded the choice: 1) Between waiver services and institutional care; and 2) Between/among waiver services and providers	
<b>Performance Measure 1</b>	Percentage of agencies with a written policy allowing recipients' freedom of choice between CAP/C and institutionalization, and among Medicaid enrolled service providers.
Performance Standard	80%
Data Source	Record reviews, off-site Site Audits Analyzed collected data (including surveys, focus group, interviews, etc) CAP/C Case Manager Survey
Sample	other: random for site audits (5% or minimum 5 charts) 100% for Case Manager Survey
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant for site audits DMA CAP/C Quality Management Committee for Case Manager Survey
Frequency of Data Collection/Generation	other: random for site audits (two agencies per quarter) annually for Case Manager Survey
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	Quarterly annually for Case Manager survey
Method of Reporting	For surveys, deficiencies within individual agencies are reported to the agency's CAP/C supervisor as described below. Aggregated state-wide results are posted to the CAP/C website annually. For site audits, the agency receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Surveys are not confidential. Surveys are educational rather than punitive. Therefore, if deficiencies exist, the agency is contacted and educated and given the tools for

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	improvement as available (i.e., sample policies). The results of the surveys are aggregated for review by the CAP/C QM Committee and any necessary remediation would occur at the systems level. For site audits, the agency receives a detailed report with recommendations and requirements for corrective action plans.
<b>Performance Measure 2</b>	Percentage of case management provider agencies that provide a list to families of potential provider agencies and allows the family to choose
Performance Standard	80%
Data Source	Record reviews, off-site Site Audits Analyzed collected data (including surveys, focus group, interviews, etc) CAP/C Case Manager Survey
Sample	other: random for site audits (5% or minimum 5 charts) annually for Case Manager survey
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant for site audits DMA CAP/C Quality Management Committee for Case Manager Survey
Frequency of Data Collection/Generation	other: random for site audits (2 agencies per quarter) annually for Case Manager Survey
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	<b>Quarterly</b> annually for Case Manager survey
Method of Reporting	For surveys, deficiencies within individual agencies are reported to the agency's CAP/C supervisor as described below. Aggregated state-wide results are posted to the CAP/C website annually. For site audits, the agency receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Surveys are not confidential. Surveys are educational rather than punitive. Therefore, if deficiencies exist, the agency is contacted and educated and given the tools for improvement as available (i.e., sample policies). The results of the surveys are aggregated for review by the CAP/C QM Committee and any necessary remediation would occur at the systems level. For site audits, the agency receives a detailed report with recommendations and requirements for corrective action plans.
<b>Performance Measure 3</b>	Percentage of recipients who signed the plan of care letter of understanding indicating understanding of freedom of choice

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Performance Standard	80%
Data Source	record reviews, off-site site audits record reviews, on-site CNR QA forms
Sample	other: random for site audits (5% or minimum 5 charts) 100% for CNR QA form
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	other: random for site audits (two agencies per quarter) continuously and ongoing for CNR QA form
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Assurance Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	For site audits, the agency receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually. Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	For site audits, the agency receives a detailed report with recommendations and requirements for corrective action plans. Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
System Improvements	DMA Nurse Consultants review 100% of the assessments and plans of care. Recipient freedom of choice is emphasized in on-line and in-house case manager training.

**ASSURANCE: Provider Capacity and Capabilities: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

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<b>Sub Assurance 1:</b> The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services.	
<b>CMS Expectation:</b> State provides documentation of periodic review by licensing/certification entity.	
<b>Performance Measure 1</b>	Percentage of Case Managers reviewed who meet the qualifications of Case Manager as set forth in the CAP/C policy
Performance Standard	80%
Data Source	record reviews, on-site Site Reviews
Sample	random: 100% of case managers involved in site review
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	other: random (two agencies per quarter)
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	The agency receives a letter and detailed score report indicating their site audit results. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	The agency receives a detailed report with recommendations and requirements for corrective action plans.
<b>Performance Measure 2</b>	Percentage of agencies that were without deficiencies at their three year survey.
Performance Standard	80%
Data Source	
Sample	Each agency is reviewed every three years.
Party Responsible for Data Collection/Generation	CSC
Frequency of Data Collection/Generation	Surveys conducted continuously and ongoing, each agency surveyed Q 3 years
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	
Methods for Remediating Individual Problems	
System Improvements All provider agencies 'enroll' through CSC to obtain a CAP/C provider number. CSC verifies credentials (including certification, licensure, accreditation, and endorsement), assesses for exclusion criteria (including criminal offenses and previous Medicaid or Medicare sanctions or suspensions), and gives final say to DMA's CAP/C Supervisor. CSC may request verification of these items at any time throughout the provider's enrollment.	

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Case Managers issue service authorizations to home care agencies, which detail the level of staff (RN, LPN, Home Care Aide, NA I, NA I+, NA II) required to meet the needs of the recipient, and the specific tasks that staff is expected to perform. The service authorization is considered binding, and failure to provide services as authorized in that document is grounds for referral to the Program Integrity Unit at Medicaid.

Case Managers ensure that any non-Medicaid providers meet CAP/C criteria for qualifications; i.e., someone performing home modifications would be a licensed contractor complying with state and local building codes.

The North Carolina Division of Health Services Regulation monitors home care agencies as per Home Care Licensure rules. These licensure rules include criminal background checks, competency evaluations and training, quality of care monitoring, and RN supervision of Nurse Aides.

**ASSURANCE: Provider Capacity and Capabilities: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**Sub Assurance 2:** The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

**CMS Expectation:** State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protection to waiver participants.

Performance Measure	This assurance is not applicable to NC Medicaid. North Carolina does not permit non-licensed or non-certified providers to furnish services to Medicaid recipients.
Performance Standard	
Data Source	
Sample	
Party Responsible for Data Collection/Generation	
Frequency of Data Collection/Generation	
Party Responsible for Data Aggregation and Analysis	
Frequency of Data Aggregation/Analysis	
Method of Reporting	
Methods for Remediating Individual Problems	
System Improvements	

**ASSURANCE: Provider Capacity and Capabilities: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**Sub Assurance 3:** The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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<b>CMS Expectation:</b> State provides documentation of monitoring and training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).	
<b>Performance Measure 1</b>	Percentage of active Case Managers who have received DMA-sponsored or required training.
Performance Standard	80%
Data Source	training verification records training database, case manager survey
Sample	100%
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA
Frequency of Data Aggregation/Analysis	annually
Method of Reporting	
Methods for Remediating Individual Problems	Individual problems are addressed via 'discovery/remediation' letters, in which a case manager's supervisor is notified of a potential violation of a waiver assurance and asked to submit a corrective action plan. The letter is written by the DMA Consultant or CAP/C Supervisor, and kept on file. General information such as involved assurance is tracked and aggregated data is analyzed quarterly.
<b>System Improvements</b> DMA offers training for case managers in the form of an on-line self study with a competency test submitted to DMA. DMA also offers in-house training to new case managers, 'refresher' training for experienced case managers, and occasional training for all case managers on other topics such as abuse and neglect or non-Medicaid resources. DMA also issues bimonthly memos to case managers which include a training topic; for example, the role of the Case Manager when a recipient is hospitalized, and family-centered planning.	

<b>ASSURANCE: Participant Access: Level of Care Determinations</b> <i>The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.</i>
<b>Sub Assurance 1:</b> An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
<b>CMS Expectation:</b> State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted.

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<b>Performance Measure 1</b>	Number of “closed” referrals in which the FL-2 was not obtained and the recipient did not withdraw the referral.
Performance Standard	80%
Data Source	record reviews, on-site. DMA Nurse Consultant will contact Case Manager to follow up on any individuals with referrals pending greater than 4 months old when there is not known to be a waiting list.
Sample	100% review
Party Responsible for Data Collection/Generation	DMA Nurse Consultant, Case Manager
Frequency of Data Collection/Generation	semi-annually, 2 <sup>nd</sup> and 4 <sup>th</sup> quarter
Party Responsible for Data Aggregation and Analysis	DMA Quality Management Committee
Frequency of Data Aggregation/Analysis	semi-annually, 2 <sup>nd</sup> and 4 <sup>th</sup> quarter
Method of Reporting	The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Case Manager will contact family to determine interest in pursuing referral. Referral form or Withdrawal of Referral Form will be submitted to Nurse Consultant. If the problem is repeated by a certain case manager or case management agency, a letter with requirement for corrective action plan will be issued.
System Improvements	Case Managers receive training via the CAP/C Manual, new case manager trainings, refresher trainings, memos, and individual counseling that they do not have authority to approve or deny services to an applicant or participant. They are advised at the time of the CAP/C initial assessment/POC development that they must complete an FL-2; if they feel it is unlikely to be approved they may advise the applicant of such, but they may not go against the recipient's wishes and refuse to submit it for DMA's review.

**ASSURANCE: Participant Access: Level of Care Determinations**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.*

**Sub Assurance 2:** The level of care of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

**CMS Expectation:** State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted annually or as specified in the approved waiver.

<b>Performance Measure 1</b>	Percentage of CNRs for which the annual level of care was completed in a timely manner (FL-2 approved by the prior approval agent if applicable or signed by the
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	physician on or before the date approved/signed the previous year).
Performance Standard	80%
Data Source	Record reviews, on-site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
System Improvements	Case Managers are also trained regarding the importance of timely annual re-evaluations. They obtain the FL-2 on or before the last year's approval date, and make accommodations to complete it by the due date. DMA Consultants track the timeliness of the FL-2s as they review the assessments and plans of care.

**ASSURANCE: Participant Access: Level of Care Determinations**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.*

**Sub Assurance 3:** The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

**CMS Expectation:** State submits that it regularly reviews participant files to verify that the instrument described in approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in the approved waiver, and the process/instruments are applied appropriately.

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<b>Performance Measure 1</b>	Percentage of evaluations/reevaluations in which the FL-2 was properly completed AND the Medicaid reviewer (DMA CAP/C Nurse Consultant) agreed with the level of care determination made by the prior approval agent
Performance Standard	80%
Data Source	record reviews, on-site CNR QA form
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Assurance Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Remediation is conducted on three progressive levels: 1. Individual training/counseling between case manager and consultant 2. For repeated or serious errors, a discovery/remediation letter with development of a written corrective action plan 3. Referral to Program Integrity, DHSR, or the appropriate licensure board Items 2 and 3 are recorded and aggregated quarterly for review by the CAP/C QM Committee and possible remediation through systems improvements.
System Improvements	When the contract agency evaluates an FL-2 for level of care determination, the results of that determination are posted to the prior approval section of the Medicaid Management Information System (MMIS).

**ASSURANCE: System Performance: Administrative Authority**

*The state demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.*

**Sub Assurance 1:** The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. **CMS Expectation:** State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.

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Performance Measure	This assurance is not applicable to the CAP/C waiver. DMA does not delegate authority to contracted entities. Contracted entities follow policies and procedures prescribed by DMA. They make a determination based on these policies and procedures. DMA makes the final decision regarding the determination.
Performance Standard	
Data Source	
Sample	
Party Responsible for Data Collection/Generation	
Frequency of Data Collection/Generation	
Party Responsible for Data Aggregation and Analysis	
Frequency of Data Aggregation/Analysis	
Method of Reporting	
Methods for Remediating Individual Problems	
System Improvements	

**ASSURANCE: Financial Accountability**  
*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

<b>Performance Measure 1</b>	Percentage of CNR QA audits in which there were no discrepancies found between the services on the plan of care and the services for which there were paid claims data in MMIS.
Performance Standard	80%
Data Source	record reviews, on-site CNR QA forms
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Nurse Consultant
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	Each case management agency receives an annual written report showing their CNR QA results as compared to the statewide averages. The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	DMA Consultants inform case managers of discrepancies between the plan of care and the paid claims; the case manager then works to resolve the issue with the provider, or

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	the plan of care is revised as needed.
<b>Performance Measure 2</b>	Percentage of failed MMIS edit checks of rate
Performance Standard	80%
Data Source	Financial records (including expenditures)
Sample	100%
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	
Methods for Remediating Individual Problems	
<b>Performance Measure 3</b>	Percentage of failed MMIS checks for participant enrolled on date of service
Performance Standard	80%
Data Source	Financial audits
Sample	100%
Party Responsible for Data Collection/Generation	DMA
Frequency of Data Collection/Generation	continuously and ongoing
Party Responsible for Data Aggregation and Analysis	DMA
Frequency of Data Aggregation/Analysis	quarterly
Method of Reporting	
Methods for Remediating Individual Problems	
<b>Performance Measure 4</b>	Percentage of CAP indicator codes correctly entered
Performance Standard	
Data Source	Comparison of CAP/C database to MMIS eligibility screen
Sample	100%
Party Responsible for Data Collection/Generation	DMA CAP/C Quality Management Committee
Frequency of Data Collection/Generation	annually
Party Responsible for Data Aggregation and Analysis	DMA CAP/C Quality Management Committee
Frequency of Data Aggregation/Analysis	annually

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Method of Reporting	The aggregated state-wide results are posted to the CAP/C website annually.
Methods for Remediating Individual Problems	Letters are sent first to the Case Manager, County DSS, and Consultant. If the error is not corrected, a follow-up letter is sent to the MPR. If the error remains uncorrected, it is reported to (what is John York's title?). DMA offers education as needed or requested. Aggregated results are given to (John York) for review and possible remediation at the systems level.
<p><b>System Improvements</b></p> <p>Medicaid's fiscal agent is responsible for ensuring that claims are paid correctly. All services are appropriately coded and audits and edits within the system ensure that claims are paid correctly.</p> <p>Case Managers review claims to ensure that they are coded and paid correctly and that they correspond to the approved services in each participant's plan of care. They track services to ensure that the limits are not exceeded.</p> <p>DMA Consultants, during the process of the Continued Needs review, compare cost summary information with paid claims information.</p> <p>Case Managers review claims and if errors are found require correction prior to submission to the fiscal agent. They also ensure billed services are provided in accordance with Medicaid and CAP/C policies and the Service Authorization.</p>	

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<b>SUMMARY CALENDAR OF QUALITY MANAGEMENT ACTIVITIES</b>	
On-site audits and reviews	Two case management provider agencies reviewed each quarter
Participant Satisfaction survey	4th quarter
Case Manager provider survey	4th quarter
Stakeholders meetings	2 <sup>nd</sup> quarter
The Medicaid Fiscal Agent's MMIS	continuously, results aggregated quarterly
NC Division of Health Services Regulation for licensure/certification records	continuously, results aggregated quarterly
DMA Program Integrity Unit for audits, reviews, and investigations	continuously, results aggregated quarterly
Consultant reviews of case manager documentation and plans of care	continuously, results aggregated quarterly
Critical incident reports	continuously, results aggregated quarterly
Complaint Log	continuously, results aggregated quarterly
Audit of CAP Indicator Codes	2 <sup>nd</sup> quarter
Training verification records	Continuously; abuse/neglect/exploitation training 4 <sup>th</sup> quarter
Referral updates	1 <sup>st</sup> and 3 <sup>rd</sup> quarter

<b>CASE MANAGEMENT PROVIDER AGENCIES WITH <u>NO</u> PREVIOUS SITE OR DESK AUDIT</b>				
<b>Agency</b>	<b>Counties</b>	<b>Apr. Census</b>	<b>Consultant</b>	<b>Scheduled for....</b>
N/A	Alleghany	N/A	Trish	N/A
N/A	Hyde	N/A	Pat	N/A
N/A	Montgomery	N/A	Pat	N/A
N/A	Tyrrell	N/A	Pat	N/A
N/A	Washington	N/A	Pat	N/A
University Home Health And Hospice	Bertie	0	Trish	
Davie County Hospital	Davie	0	Sandra M.	postpone – changing agency
Graham County DSS	Graham	0	Sandra M.	
Greene County DSS	Greene	0	Sandra M.	
Hertford County DSS	Hertford	0	Sandra W.	
West care Home Health and Hospice	Jackson	0	Sandra M.	
Martin County DSS	Martin	0	Pat	
Pamlico County Senior Services	Pamlico	0	Sandra W.	
Brothers Community Resources	Warren	0	Pat	
Families Together	Buncombe, Madison,	37	Trish	3 <sup>rd</sup> quarter

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	Henderson, Polk, Yancey, Transylvania, McDowell			
RHA/Howell	Wake, Johnson, Durham, Orange, Catawba, Iredell, Forsyth	181	Sandra W. /Trish	1 <sup>st</sup> quarter
Ashe Services for Aging	Ashe	1	Sandra M.	
Beaufort County DSS	Beaufort	4	Pat	
Carteret County DSS	Carteret	9	Trish	3 <sup>rd</sup> quarter
Caswell County Home Health Department	Caswell	3	Sandra M.	
Dare County DPH	Dare	6	Pat	
Granville Health System	Granville/Franklin/Person	18	Pat	2nd quarter
Halifax County DSS	Halifax	2	Pat	
Haywood County DSS	Haywood	1	Sandra M	4 <sup>th</sup> quarter
Jones County DSS	Jones	1	Pat	
Lincoln County DSS	Lincoln	1	Sandra M.	
Angel Home Health and Hospice	Macon, Swain	5	Sandra M.	4 <sup>th</sup> quarter
Mitchell County DSS	Mitchell	3	Pat	
Northampton County DSS	Northampton	2	Pat	
Eastern Carolina Case Management	Pitt	6	Pat	2 <sup>nd</sup> quarter
Rutherford Hospital Carolina Community Care	Rutherford	2	Pat	
Woody's Mom, Inc	Wake, Durham	7	Sandra W./ Trish	postpone – new agency

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**INITIAL AND CONTINUED NEEDS REVIEW QUALITY ASSURANCE QUESTIONS**

<b>1</b>	Date received
<b>2</b>	Date Started
<b>3</b>	Date Completed
<b>4</b>	CNR due date is correct- CASE MANAGER
<b>5</b>	CNR due date is correct- DMA DATABASE
<b>6</b>	CNR received by due date
<b>7-12</b>	All applicable documentation submitted (FL-2, Physician's request, MAR, CMS-485, employment verification, school request form)
<b>13</b>	Correct CAP Indicator Code- DMA DATABASE
<b>14</b>	Correct CAP Indicator Code- MMIS
<b>15</b>	All discrepancies between FL-2, CMS-485, and assessment have documentation of RESOLUTION
<b>16</b>	Assessment involved consultation with all pertinent natural, informal, and formal support systems as directed by family.
<b>17</b>	There was no significant information about the recipient or family missing from or misrepresented on the assessment (except as withheld by family).
<b>18</b>	Any need identified during the assessment has a documented plan for meeting the need.
<b>19</b>	Goals and Interventions were appropriate to assessed needs
<b>20</b>	There are no discrepancies between the assessment and plan of care (amount of formula, number of diapers, number of weekly hours)
<b>21</b>	Claims data matches the plan of care, or deviations are noted and addressed by the Case Manager.
<b>22</b>	There is no duplication of services, including case management, either on the POC or as reflected by claims data.
<b>23</b>	Revisions were submitted timely and appropriately. There was no instance when a revision should have been submitted prior to the CNR but was not.
<b>24</b>	The plan of care reflects the appropriate staffing level: Nurse, Pediatric Nurse Aide, Personal Care aide, or Attendant
<b>25</b>	Plan of care includes non-Medicaid resources and funding
<b>26</b>	Plan of care developed to enhance independence rather than fostering reliance on formal support systems.
<b>27-40</b>	The case manager identified and addressed : compromised safety, ineffective treatment plan, alteration in functioning, high cost injuries/illnesses; non-adherence/non-compliance; onset of a new medical or psychological problem related to illness; need for teaching; lack of family/social support; lack of financial resources to meet healthcare needs; equipment, supplies, and services, preparation for transitions.
<b>41</b>	The plan of care is developed according to the policies for hours and limits that are stated in the manual
<b>42</b>	The plan of care is submitted within cost limits for services.
<b>43</b>	Progress toward goals is documented quarterly.
<b>44</b>	Recipient/responsible party has signed the plan of care agreement indicating understanding of freedom to choose between CAP/C services and institutionalization, and among enrolled Medicaid providers.

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**PARTICIPANT SATISFACTION SURVEY**

	County (optional): _____ Child's Name (optional): _____	Strongly Agree/ Always	Agree/ Frequently	Neutral/ Sometimes	Disagree/ Rarely	Strongly Disagree/ Never
1	Our family has enough services that the demands of caring for our child do not cause undue strain on our family's relationships with each other, our friends, or our supports.					
2	Our family is able to participate in the community individually and as a family – for example: work, school, church, community events. My child participates in family activities and has a chance to be around people/places outside our home (if medically able)					
3-8	Our Case Manager :					
	is available when we need him/her.					
	has knowledge and skills regarding our child's health condition and child growth and development					
	treats me and my family with dignity and respect					
	assists us with all aspects of our child's health; for example, ensuring proper preventive care, or intervening when we have been in the emergency room many times.					
	has a reasonable understanding of what our life is like and what support our family needs.					
6-9	searches for other resources when there is something we need that CAP/C or Medicaid does not cover					
	The staff that come to my home:					
	treat me and my family with dignity and respect					
	are competent					
6-9	provide care that is customized to my child's and family's unique needs and preferences					
	are consistent; we have little or no staff turnover and the staff arrive for their shifts as scheduled					
10	My child has all of the services that he or she needs (if not, list below.)					
11	My child has all of the equipment or supplies that he or she needs. (If not, please list below.)					
12	We participate in the development of the Plan of Care for our child as much as we wish to.					

**Please turn over to the other side**

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13	We feel knowledgeable about available services and community supports. (If no, please list below what you would like to learn.)					
14	We are given a choice of providers (list of agencies).					
15	Our child receives all of the services in the plan of care.					
16	We know how and who to contact if we have a complaint or concern regarding our child's services.					
17	I have received a copy of or the link to the CAP/C Parent Handbook.	Yes		No		

Do you have any suggestions or comments? Are there any changes you would like to see in the CAP-C program? (You can use additional sheets of paper to write comments.)

Your answers will be kept confidential and any suggestions you make will be taken into consideration. Thank you for participating in this important survey.

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**PROVIDER SATISFACTION SURVEY**

CAP/C Provider Satisfaction Survey

Case Manager Name \_\_\_\_\_

Key

SA: Strongly Agree

A: Agree

N: Neutral

D: Disagree

SD: Strongly Disagree

1) Case Manager is easily accessible; returns calls within 24 hours.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
2) Case Manager communicates family/staff concerns to agency to assist in follow-up plan.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
3) Case Manager communicates changes in the service authorization in a timely manner.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
4) Case Manager performs monthly client updates with agency in a timely manner.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
5) Agency receives claims back from Case Manger in a timely manner.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
6) Service Authorizations are easily understood by agency.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
7) Case Manager and agency collaborate on tracking the use of respite hours in a timely manner.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
8) State level CAP/C staff is responsive to agency's concerns and questions.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD
9) CAP/C meets the needs of our patients.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> SD

Additional Comments

**Thank you for completing this survey.**

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**SECTION 3 QUALITY MANAGEMENT TOOLS**

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**SITE AUDIT TOOL**

Each indicator is scored as a 'yes' (or 'agree'), 'no' (or 'disagree'), or 'not applicable'.

\* A 'yes (agree)' response is always a positive response, and yields a score of 1.

\* A 'no' (disagree) response is always a negative response, and yields a score of 0.

\* A 'not applicable' response does not count in scoring.

Each indicator is then ranked on a scale of 1-3.

1 indicates a basic, clerical type function; i.e., a document is present in the chart, or a signature is present on a form.

2 indicates a basic case management activity; i.e., quarterly home visit, or review of nurses notes.

3 indicates a higher, more global function; i.e., outreach activities, quality assurance activities, or policy development.

Scores are weighted according to these rankings.

The goal for all indicators is a score of 100%. For most indicators, a score below 80% indicates the need for corrective action.

Some indicators, however, may have a different threshold depending upon the relative importance/consequence to the client or to the program.

The following recipients were included in this review:

Recipient A:

Recipient B:

Recipient C:

Recipient D

Recipient E:

Agency policy and procedure manual, personnel records, inquiry log, wait list, case management notes

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**SECTION 3 QUALITY MANAGEMENT TOOLS**

Indicator 1

The agency has written policies regarding the processing of referrals, admissions, transfers, and discharges; management of wait lists, billing 'assessment only' claims; billing; record retention and safekeeping; personnel; case loads; free choice; documentation; monitoring visits; QM program; communicable disease reporting; and HIPAA/confidentiality; AND those policies are in accordance with DMA/CAP-C policies and regulations.

	No policy (0)	Policy not in accordance (0.5)	Policy in accordance (1)		No policy (0)	Policy not in accordance (0.5)	Policy in accordance (1)
referrals, admissions, transfers, and discharges				billing, including assessment only			
wait list management				documentation requirements			
case manager caseload				record retention and safekeeping			
free choice, including list of providers				Quality Management			
monitoring visits				communicable disease reporting and prevention			
HIPAA/confidentiality				personnel			
language access plan							
Agency Raw Score _____ ÷ Potential Raw Score <u>13</u> = Agency Percentage _____ %							
Rank: 3				Threshold _____ %			

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Indicator 2

Each Case Manager meets the qualifications as set forth in the policy.

	CM Name		CM Name		CM Name		CM Name		CM Name		CM Name		CM Name		CM Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
education																
experience																
pediatrics																
program																
HCBS train																
	CM Name		CM Name		CM Name		CM Name		CM Name		CM Name		CM Name		CM Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
education																
experience																
pediatrics																
program																
HCBS train																
Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____%																
Rank: 3 Threshold _____%																

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Indicator 3

The agency maintains a log of inquiries and results.

No (0)	Yes (1)

Agency Raw Score _____ ÷ Potential Raw Score <u>1</u> = <b>Agency Percentage</b> _____ %
Rank: 2 <span style="float:right">Threshold _____ %</span>

Indicator 4

The agency makes contact with potential recipients whose referrals have been approved within 2 weeks of receipt of referral approved letter.

Participant		Participant		Participant		Participant		Participant	
No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %					Rank: 2 <span style="float:right">Threshold _____ %</span>				

Indicator 5

If the agency has a wait list, the list is reported to DMA, and contact is made with the recipients on a regular basis in order to ascertain their continued interest in the program and inform them of their place on the wait list, and the recipients receive services for which they are eligible while they wait.

	Participant			Participant			Participant			Participant			Participant		
	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A
reported															
regular contact															
Interim services															
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %													Rank: 2 <span style="float:right">Threshold _____ %</span>		

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Indicator 6

Each recipient record contains the following forms, which are the CURRENT (as of the time generated) forms for CAP/C.

	Participant Name				Participant Name				Participant Name				Participant Name				Participant Name				
	no	Old or not CAP/C	yes	N/A	no	Old or not CAP/C	yes	N/A	no	Old or not CAP/C	yes	N/A	no	Old or not CAP/C	yes	N/A	no	Old or not CAP/C	yes	N/A	
referral																					
stamped/controlling FL-2																					
most recent FL-2																					
physicians request form																					
assessment																					
plan of care																					
service auth with task sheet																					
participation notice																					
approval/denial letters from DMA																					
CM notes																					
quotes/invoices																					
claims																					
physician orders																					
Agency Raw Score _____	÷ Potential Raw Score _____				= Agency Percentage _____								%								
	Rank: 1				Threshold								%								

**NC Division of Medical Assistance, Community Alternatives Program for Children**  
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Indicator 7

Evidence of monthly case manager contact with recipient/family which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
type of contact										
provision of services										
satisfaction with services										
legal signature and title										
result/plan										
in record within 5 business days										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 2 Threshold _____ %</b>										

Indicator 8

Agency has system of verifying participants' Medicaid eligibility.

Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>									
<b>Rank: 2 Threshold _____ %</b>									

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Indicator 9

Evidence of quarterly face to face contact with recipient/family which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
time										
total minutes										
documentation of persons present										
RN was present or was consulted										
review of Medicaid eligibility										
review of private insurance										
child's health and care needs										
caregiver availability/informal support										
equipment/supplies/orthotics										
staffing										
coordination of care										
result/plan										
legal signature and title										
in record within 5 business days										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____%</b> <b>Rank: 2 Threshold _____%</b>										

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Indicator 10

Evidence of annual face to face visit with recipient/family and direct care staff which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
persons present										
RN was present or was consulted										
review of Medicaid eligibility										
review of private insurance										
child's health and care needs										
caregiver availability/informal support										
equipment/supplies/orthotics										
staffing										
provision of care										
coordination of care										
result/plan										
legal signature and title										
in record within 5 business days										
<b>Agency Raw Score</b> _____	<b>÷ Potential Raw Score</b> _____				<b>= Agency Percentage</b> _____				<b>%</b>	
	<b>Rank: 2</b>				<b>Threshold</b>				<b>%</b>	



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Indicator 12

Evidence of quarterly contact with providers of non-waiver services and supplies which included and documented:  
(or documentation of multiple unsuccessful attempts to reach provider)

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
name of provider										
type of contact										
provision of service										
review of findings										
result/plan										
legal signature and title										
in record within 5 business days										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 2 Threshold _____ %</b>										

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Indicator 13

Evidence of contact with the recipient/family within 72 hours of discharge from a hospital or rehabilitation facility which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
type of contact										
child's health and care needs										
service provision										
result/plan										
legal signature and title										
in record within 5 business days										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 2 Threshold _____ %</b>										

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Indicator 14

Evidence of visit with the recipient/family following construction or installation of home modifications which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
time										
total minutes										
type of contact										
safety of mod										
training re use										
result/plan										
legal signature and title										
in record within 5 business days										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 2 Threshold _____ %</b>										

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Indicator 15

Evidence of quarterly review of random sample of service notes(nurses notes, supervisors notes) which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
name of provider										
dates of notes										
types of notes										
services provided according to POC?										
support assessment data ?										
appropriate staff level ?										
no policy violations?										
agency meeting all needs?										
result/plan										
legal signature and title										
In record within 5 business days										
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %										
Rank: 2 _____ Threshold _____ %										

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Indicator 16

Evidence of review of claims from waiver service providers, which included and documented:

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
recipient name										
recipient MID										
date										
total minutes										
name of provider										
dates of claims										
appropriate level of staff										
appropriate amount of service										
correctly coded										
pattern of staff absences, participant refusal of service...										
appropriate follow up of claims not received										
appropriate follow up of incorrect claims										
result/plan										
legal signature and title										
in record within 5 business days										

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Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %
Rank: 2 Threshold %

Indicator 17

The case manager reviewed and revised the plan of care as needed based upon events or trends such as frequent hospitalizations, frequent emergency room use, inappropriate use of emergency room versus primary care physician, lack of a primary care physician, frequent exacerbations of illness, occurrence of preventable injury/illness (i.e., decubitus, weight loss), lack of or unreliable staffing, or change in goals based on change in prognosis or client condition.

	Participant Name			Participant Name			Participant Name			Participant Name			Participant Name		
	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A
frequent hospitalizations															
frequent ER use															
inappropriate use of emergency room vs. PCP															
lack of a PCP															
frequent exacerbations of illness															
occurrence of preventable injury/illness															
lack of or unreliable staffing															
change in goals															
change in condition															
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %															
Rank: 2 Threshold %															

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Indicator 18

Annual assessment activities include, at a minimum, contact with the primary care physician, interview with the primary caregivers, observation of the client, contact with provider agencies if applicable, and interview of other informal support/caregivers.

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
contact with physician										
Interview with primary caregivers										
Observation of client										
Contact with provider agencies										
Interview of other informal support/caregivers as determined by family										
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %										
Rank: 2 <span style="margin-left: 300px;">Threshold</span> _____ %										

**NC Division of Medical Assistance, Community Alternatives Program for Children**  
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Indicator 19

The Case Manager acts as a client advocate as needed and desired by the family within the school system, the private insurance company if applicable, Medicaid, and with other resources and supports.

Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
Agency Raw Score _____		÷ Potential Raw Score _____		= Agency Percentage _____				%	
		Rank: 2				Threshold		%	

Indicator 20

Evidence of attention to all aspects of the child's care including preventative care, resource utilization, and cost containment.

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
preventative care										
resource utilization										
cost containment										
Agency Raw Score _____		÷ Potential Raw Score _____		= Agency Percentage _____						%
		Rank: 2				Threshold				%

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**SECTION 3 QUALITY MANAGEMENT TOOLS**

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Indicator 21

Service authorization contains task sheet. Service auth and participation notice are updated annually and more often as needed due to changes in the plan of care.

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
task sheet present										
SA updated annually										
SA updated with changes										
PN updated annually										
PN updated with changes										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 1 Threshold _____ %</b>										

Indicator 22

The case management agency provides its families with the CAP/C Parent Handbook, the CAP/C website for consumers, and other pertinent information and resources.

	Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)	No (0)	Yes (1)
Parent Handbook										
website										
other										
<b>Agency Raw Score _____ ÷ Potential Raw Score _____ = Agency Percentage _____ %</b>										
<b>Rank: 1 Threshold _____ %</b>										

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Indicator 23

No violations of due process; as in no case manager denials. All changes in waiver services were submitted in a plan of care and approved by DMA. There are no instances of a case manager approving or denying services or potential services

Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)
Agency Raw Score _____		÷ Potential Raw Score _____		= Agency Percentage _____		%			
		Rank: 2				Threshold		%	

Indicator 24

Attention to participant safeguards

	Participant Name			Participant Name			Participant Name			Participant Name			Participant Name		
	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A
risk and safety planning															
critical incident management															
housing and environment															
behavior interventions															
medication management															
natural disasters and other public emergencies															
Agency Raw Score _____		÷ Potential Raw Score _____		= Agency Percentage _____		%									
		Rank: 2				Threshold		%							

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Indicator 25

Assessment, Plan of Care, and CM notes demonstrate knowledge of cultural beliefs, values, and practices, and that care incorporates those beliefs, values, and practices (for example, Jehova's Witness, nutrition plan incorporating cultural diet).

Participant Name			Participant Name			Participant Name			Participant Name			Participant Name		
No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A	No (0)	Yes (1)	N/A
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %														
Rank: 2 Threshold _____ %														

Indicator 26

Notes corresponding to claims for CAP/C case management show that no non-billable services were claimed.

Participant Name		Participant Name		Participant Name		Participant Name		Participant Name	
Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)	Disagree (0)	Agree (1)
Agency Raw Score _____ ÷ Potential Raw Score _____ = <b>Agency Percentage</b> _____ %									
Rank: 1 Threshold _____ %									

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Indicator 1_____%	Indicator 5_____%	Indicator 10_____%	Indicator 15_____%	Indicator 20_____%
Indicator 1_____%	Indicator 5_____%	Indicator 11_____%	Indicator 16_____%	Indicator 21_____%
Indicator 1_____%	Indicator 6_____%	Indicator 11_____%	Indicator 16_____%	Indicator 22_____%
Indicator 2_____%	Indicator 7_____%	Indicator 12_____%	Indicator 17_____%	Indicator 23_____%
Indicator 2_____%	Indicator 7_____%	Indicator 12_____%	Indicator 17_____%	Indicator 23_____%
Indicator 2_____%	Indicator 8_____%	Indicator 13_____%	Indicator 18_____%	Indicator 24_____%
Indicator 3_____%	Indicator 8_____%	Indicator 13_____%	Indicator 18_____%	Indicator 24_____%
Indicator 3_____%	Indicator 9_____%	Indicator 14_____%	Indicator 19_____%	Indicator 25_____%
Indicator 4_____%	Indicator 9_____%	Indicator 14_____%	Indicator 19_____%	Indicator 25_____%
Indicator 4_____%	Indicator 10_____%	Indicator 15_____%	Indicator 20_____%	Indicator 26_____%

<b>OVERALL AVERAGE _____%</b>
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North Carolina Department of Health and Human Services – Division of Medical Assistance		
<i>CONFIDENTIAL</i>	<b>CRITICAL INCIDENT REPORT</b>	<i>CONFIDENTIAL</i>
<b>COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP-C)</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes, for: _____		

Recipient's Name \_\_\_\_\_ Recipient's MID \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

<b>Incident Information, continued</b>	<p align="center"><b>INCIDENT DESCRIPTION</b></p> <p><i>Describe what happened, in detail, including any events leading up to or resulting from it. Attach additional pages if needed.</i> _____</p>												
<b>Provider Response</b>	<p align="center"><b>INCIDENT CAUSE</b></p> <p><i>Describe the cause of the incident. Check all that apply. Attach additional pages if needed.</i></p> <p> <input type="checkbox"/> non-adherence to medication, dietary, or treatment regimen or precautions  <input type="checkbox"/> lack of adequate supervision    <input type="checkbox"/> inappropriate resource utilization    <input type="checkbox"/> expected course of disease  <input type="checkbox"/> lack of knowledge    <input type="checkbox"/> inadequate supports    <input type="checkbox"/> other, _____       </p> <p>Please describe the specific cause: _____</p> <p align="center"><b>INCIDENT PREVENTION</b></p> <p><i>Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of this incident Check all that apply. Attach additional pages if needed.</i></p> <p> <input type="checkbox"/> caregiver or staff teaching/training    <input type="checkbox"/> change in hours    <input type="checkbox"/> new FL-2  <input type="checkbox"/> change in medication regimen    <input type="checkbox"/> change in level of in-home staff    <input type="checkbox"/> POC revision  <input type="checkbox"/> change in treatment regimen    <input type="checkbox"/> referral to other services/supports  <input type="checkbox"/> infection control measures    <input type="checkbox"/> other, _____       </p> <p>Please describe the specific change: _____</p>												
<b>Reporting Information</b>	<p align="center"><b>NOTIFICATIONS</b></p> <p><i>Indicate authorities or persons aware of the incident (as applicable).</i></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> CAP-C Case Manager Name _____ Contact Info _____</td> <td><input type="checkbox"/> Parent/Guardian Name _____ Contact Info _____</td> </tr> <tr> <td><input type="checkbox"/> CAP-C Home Health/Home Care Agency Name _____ Contact Info _____</td> <td><input type="checkbox"/> NC DFS Complaint Unit Name _____ Contact Info <u>1 800 624 3004</u></td> </tr> <tr> <td><input type="checkbox"/> Physician * must be notified for medication errors Name _____ Contact Info _____</td> <td><input type="checkbox"/> Board of Nursing Name _____ Contact Info <u>919 782 3211</u></td> </tr> <tr> <td><input type="checkbox"/> Law enforcement Name _____ Contact Info _____</td> <td><input type="checkbox"/> Program Integrity Name _____ Contact Info <u>919 647 8000</u></td> </tr> <tr> <td><input type="checkbox"/> Child Protective Services * must be notified for alleged or actual abuse, neglect, or exploitation Name _____ Contact Info _____</td> <td><input type="checkbox"/> Health Care Personnel Registry Name _____ Contact Info <u>919 855 3968</u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other, _____ Name _____ Contact Info _____</td> </tr> </table>	<input type="checkbox"/> CAP-C Case Manager Name _____ Contact Info _____	<input type="checkbox"/> Parent/Guardian Name _____ Contact Info _____	<input type="checkbox"/> CAP-C Home Health/Home Care Agency Name _____ Contact Info _____	<input type="checkbox"/> NC DFS Complaint Unit Name _____ Contact Info <u>1 800 624 3004</u>	<input type="checkbox"/> Physician * must be notified for medication errors Name _____ Contact Info _____	<input type="checkbox"/> Board of Nursing Name _____ Contact Info <u>919 782 3211</u>	<input type="checkbox"/> Law enforcement Name _____ Contact Info _____	<input type="checkbox"/> Program Integrity Name _____ Contact Info <u>919 647 8000</u>	<input type="checkbox"/> Child Protective Services * must be notified for alleged or actual abuse, neglect, or exploitation Name _____ Contact Info _____	<input type="checkbox"/> Health Care Personnel Registry Name _____ Contact Info <u>919 855 3968</u>		<input type="checkbox"/> Other, _____ Name _____ Contact Info _____
<input type="checkbox"/> CAP-C Case Manager Name _____ Contact Info _____	<input type="checkbox"/> Parent/Guardian Name _____ Contact Info _____												
<input type="checkbox"/> CAP-C Home Health/Home Care Agency Name _____ Contact Info _____	<input type="checkbox"/> NC DFS Complaint Unit Name _____ Contact Info <u>1 800 624 3004</u>												
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<input type="checkbox"/> Child Protective Services * must be notified for alleged or actual abuse, neglect, or exploitation Name _____ Contact Info _____	<input type="checkbox"/> Health Care Personnel Registry Name _____ Contact Info <u>919 855 3968</u>												
	<input type="checkbox"/> Other, _____ Name _____ Contact Info _____												

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REPORTED BY	
Name/title of person documenting incident _____	Name of RN reviewing incident _____ (optional, but recommended if incident was medical in nature)
Contact Info _____	Contact Info _____
Signature _____	Signature _____
Date ____/____/____	Date ____/____/____

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**CMS ASSURANCES**

See Quality Management Strategy

**CMS QUALITY FRAMEWORK**

Domain	Associated Sub-domains
I. Participant access	A. Information/referral B. Intake and Eligibility 1. User-friendly processes 2. Eligibility determination 3. Referral to Community Resources 4. Individual choice of HCBS 5. Prompt Initiation
II. Participant-centered service planning and delivery	A. Participant-centered service planning 1. Assessment 2. Participant decision making 3. Free choice of providers 4. Service plan 5. Participant direction B. Service delivery 1. Ongoing service and support coordination 2. Service provision 3. Ongoing monitoring 4. Responsiveness to changing needs
III. Provider capacity and capabilities	A. Provider networks and availability B. Provider qualifications C. Provider performance
IV. Participant safeguards	A. Risk and safety planning B. Critical incident management C. Housing and environment D. Behavior interventions E. Medication management F. Natural disasters and other public emergencies
V. Participant rights and responsibilities	A. Civic and human rights B. Participant decision making authority C. Alternate decision making D. Due process E. Grievances
VI. Participant outcomes and satisfaction	A. Participant satisfaction B. Participant outcomes
VII. System performance	A. System performance appraisal B. Quality improvement C. Cultural competency D. Participant & stakeholder involvement E. Financial integrity

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**CMSA STANDARDS OF PRACTICE**

**A. STANDARD: CLIENT SELECTION PROCESS FOR CASE MANAGEMENT**

The case manager should identify and select clients who can most benefit from case management services available in a particular practice setting.

**B. STANDARD: CLIENT ASSESSMENT**

The case manager should complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client.

**C. STANDARD: PROBLEM/OPPORTUNITY IDENTIFICATION**

The case manager should identify problems or opportunities that would benefit from case management intervention.

**D. STANDARD: PLANNING**

The case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs.

**E. STANDARD: MONITORING**

The case manager should employ ongoing assessment and documentation to measure the client's response to the plan of care.

**F. STANDARD: OUTCOMES**

The case manager should maximize the client's health, wellness, safety, adaptation, and self-care through quality case management, client satisfaction, and cost-efficiency.

**G. STANDARD: TERMINATION OF CASE MANAGEMENT SERVICES**

The case manager should appropriately terminate case management services based upon established case closure guidelines. These guidelines may differ in various case management practice settings.

**H. STANDARD: FACILITATION, COORDINATION, AND COLLABORATION**

The case manager should facilitate coordination, communication, and collaboration with the client and other stakeholders in order to achieve goals and maximize positive client outcomes.

**I. STANDARD: QUALIFICATIONS FOR CASE MANAGERS**

Case managers should maintain competence in their area(s) of practice by having one of the following:

a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; and/or

b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

**J. STANDARD: LEGAL**

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing all aspects of case management practice, including

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client privacy and confidentiality rights. It is the responsibility of the case manager to work within the scope of his/her licensure.

**1. Standard: Confidentiality and Client Privacy**

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights and act in a manner consistent with the client's best interest.

**2. Standard: Consent for Case Management Services**

The case manager should obtain appropriate and informed client consent before case management services are implemented.

**K. STANDARD: ETHICS**

Case managers should behave and practice ethically, adhering to the tenets of the code of ethics that underlies his/her professional credential (e.g., nursing, social work, rehabilitation counseling, etc.).

**L. STANDARD: ADVOCACY**

The case manager should advocate for the client at the service-delivery, benefits-administration, and policy-making levels.

**M. STANDARD: CULTURAL COMPETENCY**

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

**N. STANDARD: RESOURCE MANAGEMENT AND STEWARDSHIP**

The case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, monitoring, and evaluating resources for the client's care.

**O. STANDARD: RESEARCH AND RESEARCH UTILIZATION**

The case manager should maintain familiarity with current research findings and be able to apply them, as appropriate, in his/her practice.

Additional information including how these standards are demonstrated in case management practice:  
<http://www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf>.

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**NASW STANDARDS FOR SOCIAL WORK CASE MANAGEMENT**

**Standard 1.** The social work case manager shall have a baccalaureate or graduate degree from a social work program accredited by the Council on Social Work Education and shall possess the knowledge, skills, and experience necessary to competently perform case management activities.

**Standard 2.** The social work case manager shall use his or her professional skills and competence to serve the client whose interests are of primary concern.

**Standard 3.** The social work case manager shall ensure that clients are involved in all phases of case management practice to the greatest extent possible.

**Standard 4.** The social work case manager shall ensure the client's right to privacy and ensure appropriate confidentiality when information about the client is released to others.

**Standard 5.** The social work case manager shall intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families.

**Standard 6.** The social work case manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services.

**Standard 7.** The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities.

**Standard 8.** The social work case manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability.

**Standard 9.** The social work case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks related to client and system interventions.

**Standard 10.** The social work case manager shall treat colleagues with courtesy and respect and strive to enhance interprofessional, intraprofessional, and interagency cooperation on behalf of the client.

Additional information and interpretation at:

[http://www.naswdc.org/practice/standards/sw\\_case\\_mgmt.asp#intro](http://www.naswdc.org/practice/standards/sw_case_mgmt.asp#intro).

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**Key Values and Principles of a Person-centered System**

A person-centered system involves person-centered thinking, planning, and organizations. These guiding principles apply to the system serving all people who need long-term services and supports, and their families. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

To be person-centered means:

- Treating individuals and family members with dignity and respect
- Helping individuals and families become empowered to set and reach their personal goals
- Recognizing the right of individuals to make informed choices, and take responsibility for those choices and related risks
- Building on the strengths, gifts, talents, skills, and contributions of the individual and those who know and care about the individual
- Fostering community connections in which individuals can develop relationships, learn, work/produce income, actively participate in community life and achieve their full potential
- Promising to listen and to act on what the individual communicates
- Pledging to be honest when trying to balance what is important to and important for the person
- Seeking to understand individuals in the context of their age, gender, culture, ethnicity, belief system, social and income status, education, family, and any other factors that make them unique
- Acknowledging and valuing families and supporting their efforts to assist family members
- Recognizing and supporting mutually respectful partnerships among individuals, their families, communities, providers, and professionals
- Advocating for laws, rules, and procedures for providing services, treatment, and supports that meet an individual's needs and honor personal goals
- Endorsing responsible use of public resources to assure that qualified individuals are served fairly and according to need

*Adopted by the DHHS Long Term Services and Supports Cabinet, January 10, 2008*