**Instructions for Completing Care Management Monitoring Tool – HCCBG/CARES**

This tool has been modified to include monitoring for HCCBG funding of the service and for CARES funding.

**For HCCBG code 610 programmatic monitoring:**

Complete pages 2 – 4, page 5 - Fiscal Verification, and Client Record Review Excel Spreadsheet.

**Note:** Page 4, Summary of Client Record Review, for Item #9: “(number) indicated that at least a quarterly in-home visit was made.”

Insert a notation in the “Additional Comments” section that the Governor’s Executive Orders waived the “in-home” component and indicate whether quarterly visits were conducted by phone or video meeting.

**Note:** For items 9 and 10 on the Client Record Review Excel Spreadsheet, select “Remote” from the drop down box based on the Governor’s Executive Orders that waived the “in-home” component for quarterly visits and allowed visits to be conducted by phone or video meeting.

**For CARES monitoring:**

1. If the agency has used CARES code **961**, which is for consumable supplies (cleaning products and PPE) complete page 7, including the provider attestation statement.

2. If the agency has used CARES code **962** for Care Management Services:

For full programmatic monitoring, complete pages 2-4, page 5 - Fiscal Verification (including the provider attestation statement), and Client Record Review Excel Spreadsheet.

On page 4, Client Record Review summary, for Item #9: See guidance outlined above in the HCCBG monitoring instructions.

For items 9 and 10 on the Client Record Review Excel Spreadsheet, see guidance outlined above in the HCCBG monitoring instructions.

For non-unit fiscal verification only for low or moderate risk providers, complete page 6, including the provider attestation statement.

**Note:** A new provider of the Care Management service is High risk and must have full programmatic monitoring.

**For programmatic monitoring of both HCCBG code 610 and CARES code 962 simultaneously**

Complete pages 2-4, page 5 - Fiscal Verification (including provider attestation statement for CARES only), and the Client Record Review Excel Spreadsheet. See guidance outlined above in the **Notes** of the HCCBG monitoring instructions. Page 2: Check both funding boxes.

Page 4, Client Record Review summary: Make a second copy of the page and select appropriate funding source.

Page 5, Fiscal Verification HCCBG/CARES: Make a second copy of the page and select appropriate funding source.

The Client Record Review Excel Spreadsheet has two client record review tabs. Use one tab for HCCBG and the other for CARES. Identify the funding source in the “Comments” section of the spreadsheet.

**NC DIVISION OF AGING AND ADULT SERVICES**

**NC AREA AGENCIES ON AGING**

**CARE MANAGEMENT MONITORING TOOL – HCCBG and CARES**

**Part I: Program Verification**

Provider Agency:

Review Date:       State Fiscal Year:

Agency Staff Interviewed:

Signature of Reviewer(s):

Funding Source (check all that apply):  HCCBG  CARES

1. The Care Management unit has a Social Worker

and a Registered Nurse. Yes  No

* 1. The Registered Nurse holds a current license

issued by the North Carolina Board of Nursing. Yes  No

* 1. The Social Worker has a BSW or MSW or meets

State Personnel requirements for a Social Worker. Yes  No

(VIII.A. 1. & 2). (p. 8 Care Management Service Standards)

Documentation reviewed/Comments:

1. The agency completes a screening/intake instrument in

person or by phone that addresses the following:

* 1. Client’s identifying information Yes  No
  2. Client’s ability to perform activities

of daily living Yes  No

* 1. Client’s ability to perform instrumental

activities of daily living Yes  No

* 1. Client’s perception of health problems Yes  No
  2. Client’s perception of well-being

(e.g. happy, sad, forgetful, confused) Yes  No

* 1. Client’s living arrangement

(alone/with family) Yes  No

* 1. Availability of caregiver support Yes  No
  2. Services currently being received Yes  No

(V.A.1.a.-h.) (pp. 3-4 Care Management Service Standards)

Documentation reviewed/Comments:

1. The agency uses a comprehensive in-home\* assessment tool that addresses the following:
   1. Client’s identifying information Yes  No
   2. Client’s functional capacity (ADLs, IADLs) Yes  No
   3. Client’s medical status Yes  No
   4. Client’s social status Yes  No
   5. Client’s mental status Yes  No
   6. Client’s economic status Yes  No
   7. Client’s environmental status Yes  No

(V.A.2.a.-h.) (pp. 4-5 Care Management Service Standards)

\*Assessments may be conducted by phone or video meeting during the period

covered by the Governor’s Executive Order waiving in-person assessments.

Documentation reviewed/Comments:

1. Care plan forms contain the following elements:
2. Outcome oriented goal statements and conditions

for case closure Yes  No

b. Both informal and formal services to be provided Yes  No

c. Agencies responsible for service provision Yes  No

d. Frequency of service provision Yes  No

e. Duration of service provision Yes  No

f. Signature of the client/designated representative

indicating agreement with the care plan Yes  No

1. Signature of the Registered Nurse and the

Social Worker developing the care plan Yes  No

1. Date of the care plan development Yes  No

(V.A.3.a.-h.) (pp. 5-6 Care Management Service Standards)

Documentation reviewed/Comments:

**Part II: SUMMARY OF CLIENT RECORD REVIEW**

For the client record review section, pull a random sample of based on Section 308.2 B. and Administrative Letter No. 20-21. Attach ZGA-542 for Code 610 and Code 962 as applicable. Use the accompanying Client Record Review Worksheet to record results of each client file review. After reviewing the client files, complete the questions listed below to summarize the client record information.

Check one:  HCCBG  CARES

Of the       (number) client files reviewed,

1. Out of       (number) clients needing registration information updated,        (number) had registration information updated. (IX A.) (p. 9)

1. (number) contained a completed screening/intake instrument. (V.A.1.) (pp. 3-4)

1. (number) contained a completed comprehensive multidimensional assessment signed and dated by the Registered Nurse and the Social Worker. (V.A.2.) (pp. 4-5)
2. Out of       (number) clients needing reassessments,      (number) were completed, signed and dated by the Registered Nurse and the Social Worker. (V.A.2.) (p. 5)

1. (number) care plans were developed within 12 working days of the initial screening/intake. (V.A.3.) (p. 5)
2. (number) care plans were signed and dated by the Registered Nurse and the Social Worker.

1. (number) care plans were reviewed quarterly by the Registered Nurse and the Social Worker. (V.A.3.) (p. 6)

1. (number) indicated that monthly contacts to the client were made. (V.A.4.a.) (p. 6)
2. (number) indicated that at least a quarterly in-home visit was made. (V.A.4.a) (p. 6)
3. Out of      (number) clients having health related needs,       (number) had the Registered Nurse conducting the quarterly home visits. (V.A.4.b.) (p. 6)

11.       (number) clients were made aware of Client/Patient Rights. (VI.) (p. 8)

12. Out of       (number) clients referred for service,       (number) had

signed a Release of Information form.

Additional Comments:

**Fiscal Verification- Part III – HCCBG or CARES funds**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer(s):

Check one:  HCCBG  CARES

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

1. Agency budget (e.g., DAAS 732 A) shows monies

(including match) are used to support the Care

Management service.Yes  No  N/A

Documentation reviewed/Comments:

2. If positions are funded, Agency budget (e.g., DAAS 732 A1)

shows Care Management designated position(s) and

% of position(s) funded for Care Management. Yes  No  N/A

Documentation reviewed/Comments:

3. If the agency has collected consumer contributions,

the ZGA 370 YTD matches the agency’s YTD

financial records.Yes  No  N/A

Documentation reviewed/Comments:

4. At the time of the review, the % utilization rate is

consistent with budget projections for the fiscal year.

*(E.g., ZGA 370-YTD)*  Yes  No  N/A

Documentation reviewed/Comments:

If not, describe any extenuating circumstances and/or

planned adjustments.

5. Any expenses for Care Management (e.g., payroll

records, invoice for purchases) can be attached to a

function of the Care Management service.

*(Select a month of reimbursement in ARMS and*

*document that reimbursement correlates with actual*

*expenses.)*  Yes  No  N/A

Documentation reviewed/Comments:

6. For CARES funding only: The provider attests that use

of CARES Act funding was for pandemic recovery and

future emergency preparedness of this service. Yes  No

**Fiscal Verification Only - Part III-1-CARES Funds-Code 962**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer(s):

1. The provider attests that use of CARES Act funding

was for pandemic recovery and future emergency

preparedness of this service. Yes  No

2. Any CARES expenses for Care Management (e.g., payroll

records, invoices for purchases) can be attached to a

function of the Care Management service.

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

*that reimbursement correlates with actual expenses, and*

*verify that client was eligible for the service.)* Yes  No  N/A

a. Sample month selected in ARMS:

b. Reimbursement amount:

c. Actual month’s expenses:

|  |  |
| --- | --- |
| Type of Expense | Amount |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Total |  |

d. Source Documentation reviewed/Comments:

**Fiscal Verification- Part III-2-CARES Funds-Code 961**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer(s):

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

1. The provider attests that use of CARES Act funding

was for pandemic recovery and future emergency

preparedness of this service. Yes  No

For expenses related to CARES code **961**, select a month of reimbursement in ARMS and the same month of expenses reported in the tracking spreadsheet.

2. Reimbursement correlates with actual expenses.

*(E.g. payments documented in the provider’s*

*general ledger or receipts and other proof of*

*purchases, etc.)*  Yes  No  N/A

Documentation reviewed/Comments

3. Selected month’s reimbursement matches the

reporting of expenses in the tracking worksheet

for the same month. Yes  No  N/A

Documentation reviewed/Comments