



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

JUL 24 2012

Mrs. Laura Deeghan, Controller  
United Disabilities Services  
1901 Olde Homestead Lane  
P.O. Box 10485  
Lancaster, Pennsylvania 17605

Dear Mrs. Deeghan:

I am enclosing the final report of the audit of United Disabilities Services as prepared by this office. Your response has been incorporated into the final report and is labeled Appendix A.

The final report will be forwarded to the Department's Office of Long Term Living (OLTL) to begin the Department's resolution process concerning the report contents. The staff from the OLTL may be in contact with you to follow up on the actions taken to comply with the report's recommendations.

I would like to extend my appreciation for the courtesy and cooperation extended to my staff during the course of fieldwork.

Please contact David Bryan, Audit Resolution Section, at 717-783-7217 if you have any questions concerning this audit.

Sincerely,

A handwritten signature in black ink that reads "Tina L. Long".

Tina L. Long, CPA  
Director

Enclosure

c: Mr. Timothy M. Costa  
Ms. Karen Deklinski  
Ms. Bonnie Rose  
Ms. Sallie Rowe  
Mr. Grant Witmer

bc: Mr. Alex Matolyak  
Ms. Kelly Leighty  
Mr. Dave Bryan (C1100)  
Ms. Kenya Mann Faulkner  
Ms. Shelley L. Lawrence  
CFO Audit File

Some information has been redacted from this audit report. The redaction is indicated by magic marker highlight. If you want to request an unredacted copy of this audit report, you should submit a written Right to Know Law (RTKL) request to DPW's RTKL Office. The request should identify the audit report and ask for an unredacted copy. The RTKL Office will consider your request and respond in accordance with the RTKL (65 P.S. §§ 67.101 et seq.). The DPW RTKL Office can be contacted by email at: [ra-dpwtkl@pa.gov](mailto:ra-dpwtkl@pa.gov).

JUL 24 2012

Mr. Timothy Costa  
Executive Deputy Secretary  
Health and Welfare Building, Room 333  
Harrisburg, Pennsylvania 17120

Dear Mr. Costa:

In response to a request from the Office of Long Term Living's (OLTL) Quality Management, Metrics and Analytics Office (QMMA), the Bureau of Financial Operations (BFO) completed an audit of United Disabilities Services (UDS). The audit was primarily directed to determine UDS' compliance with applicable regulations and management of its various programs. The audit focused on the period July 1, 2010 through June 30, 2011.

The report is currently in final form, and therefore, does contain UDS' views on the report findings, conclusions, and recommendations.

**United Disabilities Services**  
**Executive Summary**

UDS is a not-for-profit, social service organization that provides services and community education focusing on promoting and supporting independent living for persons with disabilities. UDS leases its main office at [REDACTED] and its satellite offices in [REDACTED]

UDS, through Federal Medicaid waiver programs administered by the Department of Public Welfare and the Department of Aging through the OLTL, provides services directly and subcontracts with other providers to furnish an array of home and community-based services that assist Waiver Participants (WP) to live in the community and avoid institutionalization. The Waiver programs in which UDS is currently enrolled to provide services are: Independence, OBRA, COMMCARE and Attendant Care.

FINDING NO. 1	SUMMARY
<p><b><i>Finding No.1 - Rates for Consumer Model Personal Assistance Services Provided \$1.8 Million in Excess Revenues.</i></b></p>	<p>Beginning January 1, 2011, the OLTL required providers to place Consumer Model Personal Assistance Service funds in a restricted account that could only be used for these services. During the period January 1 to June 30, 2011, UDS realized \$1.8 million in excess revenue for these services.</p> <p>UDS incurred losses in other Waiver services for FY 2010-2011 including Financial Management Services, Agency Directed Personal Assistance Services, Supports Coordination and Intake services.</p>

United Disabilities Services  
July 1, 2010 through June 30, 2011

**HIGHLIGHTS OF RECOMMENDATIONS**

OLTL should:

- Review the appropriateness of all the Waiver reimbursement rates and revise the rates accordingly.

**FINDING NO. 2**

**SUMMARY**

***Finding No 2 -  
Supports Coordinators'  
Time Records and  
Case Notes Did Not  
Substantiate Units  
Billed to PROMISE.***

The claims billed by UDS for Supports Coordination could not be verified because documentation was not present in case notes, Daily Activity Reports and /or timesheets. In addition, the dates for some service notes did not agree to the dates billed in PROMISE.

The audit test results, as extrapolated, result in a disallowance of \$404,962.

**HIGHLIGHTS OF RECOMMENDATIONS**

OLTL should:

- Recover the \$404,962 relating to unsupported Supports Coordination claims.
- Clarify documentation requirements for Supports Coordination services and contacts.
- Develop and maintain a list of billable and non-billable Supports Coordination activities.
- Consider utilizing The Home and Community Services Information System for billing purposes of Supports Coordination claims.
- Consider standardizing the unit size for Supports Coordination to a 15 minute unit across all Waiver programs.

UDS should:

- Improve its Supports Coordination procedures to ensure all PROMISE billings are supported by the required service notes and that the billings correspond to the dates or periods the services were provided.

**FINDING NO. 3**

**SUMMARY**

***Finding No. 3 – Required  
Phone Calls and Personal  
Visits Were Not  
Documented to  
Substantiate that the  
Waiver Requirements  
Were Being Met.***

UDS did not maintain sufficient documentation of contacts with WPs for 30 of the 61 WPs tested to substantiate that they were meeting the Waiver requirements.

**HIGHLIGHTS OF RECOMMENDATIONS**

OLTL should:

- Ensure monitoring of this requirement is included in the QMMA review process.

UDS should:

- Monitor the edit checks incorporated into its Supports Coordination database and ensure the Waiver requirements are being met and are documented.
- Conduct refresher training for the SCs on service note documentation requirements and required WP contacts.

FINDING NO. 4	SUMMARY
<p><b><i>Finding No. 4 – ISP Comments by OLTL Need to be Enhanced.</i></b></p>	<p>The HCSIS comments by OLTL were often vague and did not provide detail as to the review and approval process for the purchases of Durable Medical Equipment and Home Modifications.</p>

**HIGHLIGHTS OF RECOMMENDATIONS**

OLTL should:

- Adequately document the review and approval of Durable Medical Equipment and Home Modification purchases in HCSIS.

**Background**

The OLTL is responsible for the overall management of programs that are designed to assist individuals with physical disabilities. This is done through waiver services that complement and/or supplement the services available to participants through the Medicaid State plan and other federal, state and local public programs.

Under the consumer model for personal care services, individuals with physical disabilities who are WPs are empowered to interview, hire, and fire their personal care assistants. UDS performs Financial Management Services (FMS) on behalf of WPs which includes issuing paychecks, withholding payroll taxes, remitting payroll tax liability, and doing background checks. The agency also assists WPs in purchasing participant-directed goods and services.

Individual Service Plans (ISPs) address possible natural supports in the participant's community, desired outcomes, appropriate types of services and service providers needed to achieve or realize those outcomes, and the frequency of needed goods or services. Supports Coordinators (SCs) communicate with WPs throughout the year on the phone and in person and meet with them annually to review prior year ISPs and amend them as needed. ISPs detail the type and amount of waiver services available to the WP and specify the units that can be billed through the PROMISE system.

## **Objective, Scope and Methodology**

The audit objectives were:

- To verify the accuracy and legitimacy of UDS' billings and determine if services were provided in accordance with the Waiver program requirements.
- To determine if UDS' cost allocation plan is reasonable and consistently applied.
- To determine if revenues and expenses are accurate and reimbursement rates are reasonable with respect to actual cost.

In pursuing our objectives, the BFO interviewed management and staff members from UDS. We also reviewed client case records, program monitoring reports, financial reports, and other pertinent documentation necessary to complete our objectives.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Government auditing standards also require that we obtain an understanding of internal controls that are relevant to the audit objectives described above. The applicable controls were examined to the extent necessary to provide reasonable assurance of the effectiveness of those controls. Based on our understanding of the controls, deficiencies were identified. These deficiencies and other areas where we noted an opportunity for an improvement in management's controls are addressed in the findings of this report.

Fieldwork for this audit took place intermittently between December 12, 2011 and January 18, 2012. The report, when presented in its final form, is available for public inspection.

## **Results of Fieldwork**

### **Finding No. 1 – Rates for Consumer Model of Personal Assistance Services Provided \$1.8 Million in Excess Funds.**

The Attendant Care Program (ACP) is funded through OLTL and encompasses two models, the Agency Directed Model and the Consumer Model. Each model has its own distinct fee-for-service rate depending upon the region in which the provider is located. The Agency Directed Model is structured for providers who directly hire employees to perform the direct care services for the consumer. The Consumer Model allows the consumer to employ his/her own attendants and have an organization provide the fiscal and administrative oversight for the consumer.

UDS' responsibilities under the Consumer Model are enrolling participants, providing orientation and training; conducting criminal background checks; distributing, collecting, and processing support worker timesheets. In addition, UDS also prepares and issues workers' payroll checks; withholds, files, and deposits federal, state, and local income taxes; brokers workers' compensation for all support workers; processes all judgments, garnishments, tax levies, or any related holds on workers' pay; and prepares and disburses Internal Revenue Service Forms W-2 and/or 1099.

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The ACP is a fee-for-service program. This allows for UDS to retain any excess revenue over expenses. The excess revenue was used prior to January 1, 2011 to cover cost shortfalls in other Waiver programs, fund administrative expenses and to increase reserve/fund balances. Beginning on January 1, 2011, the OLTL required providers to place Consumer Model Personal Assistance Service funds in a restricted account that could only be used for those services. During the period January 1 to June 30, 2011, UDS realized \$1.8 million in excess revenues for Consumer Model Personal Assistance Services.

It should be noted that UDS incurred losses in other Waiver services during Fiscal Year (FY) 2010-2011 including FMS, Agency Directed Personal Assistance Services, Supports Coordination and Intake services.

**Recommendations**

The BFO recommends the OLTL review the methodology used in establishing Waiver reimbursement rates and revise the rates accordingly.

**Finding No. 2 – Supports Coordinators' Time Records and Case Notes Did Not Substantiate Units Billed to PROMISE.**

**Service Notes Not Present**

Pursuant to the Department of Health and Human Services' interim rule published in the Federal Register on December 4, 2007, Vol. 72, No. 232, if a State plan provides for case management services, the "... case records must document for each individual ... the dates of case management services; the nature, content, units of case management services received, and whether the goals specified in the care plan have been achieved..." (42 CFR, Parts 431.107, 440.169, and 441.18). Also, 55 PA Code 1101.75 (5) states "an enrolled provider may not, either directly or indirectly...submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient."

UDS billed PROMISE for Supports Coordination services which were not substantiated by the service notes found in Home and Community Services Information System (HCSIS), UDS' Supports Coordination database, Daily Activity Reports and/or UDS' consumer files.

The variance between PROMISE billings and the specific units or hours documented in HCSIS and/or UDS' files resulted in an error rate of 32.3%. When the BFO extrapolates the percentage over the entire population of billings for Supports Coordination, it results in a disallowance of \$404,962.

Additionally, UDS has established policy and procedures in place for Supports Coordination documentation however they were not being consistently followed by the SC's. OLTL has not clarified documentation requirements for service notes. In addition, OLTL does not define billable and non-billable Supports Coordination activities.

Billing Procedures Need to Be Strengthened

Additionally, discrepancies were found between the service note dates in HCSIS and the dates used for billing purposes. As a result, the BFO could not always find a direct correlation between Supports Coordination service note dates and PROMISE billing dates.

Currently, UDS bills Supports Coordination services at the end of the month or pay period depending on the Waiver program. This is because the unit rate varies for Supports Coordination: Attendant Care is monthly, OBRA is weekly and Independence and COMMCARE are hourly. The disparity in the unit size between the waiver programs has resulted in UDS combining the dates of services into one date. In addition, the use of this method causes discrepancies between the date of the service note found in UDS' documentation and the date used for billing through PROMISE.

PROMISE allows the dates of services to be entered for each claim but the variation in unit size drives the provider to unconventional billing practices. The current method utilized by UDS for the Independence and COMMCARE Waivers is an accumulator which is established within their billing system to track unbilled time. When a full hour of service has been provided, one unit will be billed. While this could cause units provided to be unbilled, testing indicated the methodology was functioning correctly. Any unused minutes at the end of the FY are deleted and the accumulator is reset to zero.

The Office of Developmental Programs (ODP) has a function built into HCSIS that allows the SCs to enter service notes and bill directly from HCSIS. PROMISE performs a sweep of the activities twice a month. Currently, OLTL does not utilize HCSIS for that function. The ODP does not reimburse a provider for Supports Coordination unless a note is present from the provider in HCSIS. The potential problem with OLTL is the variation of the unit sizes. In order to fully utilize the HCSIS billing function, OLTL should consider standardizing the SC unit size comparable to the ODP, which would be a 15 minute unit.

In our opinion this would improve the accuracy of the billings as providers would not be reimbursed unless a note was present and it would allow for the billing of all services provided within the month of delivery. This also allows greater oversight from management at the providers as well as OLTL.

Recommendation

The BFO recommends the OLTL recover the \$404,962 relating to unsupported Supports Coordination claims.

The BFO also recommends the OLTL clarify standards for documenting Supports Coordination services and contacts.

The BFO also recommends the OLTL create a list of billable and non-billable Supports Coordination activities.

The BFO further recommends the OLTL consider utilizing HCSIS to bill for Supports Coordination claims.

The BFO finally recommends that OLTL consider standardizing the Supports Coordination unit size to 15 minutes.

The BFO recommends that UDS improve its supports coordination procedures to ensure all PROMISE billings are supported by the required service notes and that the billings correspond to the dates or periods the services were provided.

**Finding No. 3 - Required Phone Calls and Personal Visits Were Not Documented to Substantiate that the Waiver Requirements Were Being Met.**

The Waivers require providers to monitor the health and safety of the participant and the quality of services provided through face-to-face visits at a minimum of twice per year and telephone calls at least quarterly or monthly depending on the waiver program. These Waiver requirements were not met for 30 of the 61 (49%) consumers tested. UDS informed BFO at the closing conference that edit checks have been incorporated into their Supports Coordination database to address this problem. The BFO did not test the new edits in UDS' system.

Our review of the Durable Medical Equipment (DME) and Home Modification (HM) contacts substantiates the SCs are meeting the Waiver requirements.

**Recommendation**

The BFO recommends the OLTL ensure an assessment of the required contacts is included and completed in their QMMA monitoring process.

The BFO recommends UDS monitor the edit checks incorporated into the Supports Coordination database and ensure the Waiver requirements are being met and are documented. This can be accomplished by conducting periodic monitoring of the WPs files. The new procedures should be included in UDS' SC policies.

The BFO finally recommends UDS conduct refresher training to the SCs on service note documentation requirements and required WP contacts.

**Finding No. 4 - ISP Comments by OLTL Need to be Enhanced.**

The OLTL approval is required prior to the purchase of DME and HM, which allow WP's to maintain self-sufficiency in their homes. The HCSIS comments by OLTL were often vague and did not provide detail as to the review and approval process for the purchases.

**Recommendation**

The BFO recommends the OLTL adequately document the review and approval of DME and HM purchases in HCSIS.

**Other – Cost Allocation Plan**

The BFO identified three minor concerns with UDS' cost allocation plan that were not considered material enough to include as a finding in the report. The allocation for UDS' time and attendance

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software, satellite office costs and vehicle usage were not appropriate. At the closing conference, UDS management indicated the allocations were revised.

**Auditors Commentary**

In accordance with our procedures, UDS was given the opportunity to have an exit conference to discuss the findings and recommendations included in the draft audit report. UDS elected not to have an exit conference.

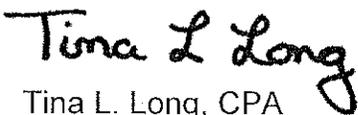
In the agency's response to Finding No. 2, UDS contends that the regulations used to audit the documentation requirements for Supports Coordination services are not applicable to 1915(c) Waiver providers. The BFO disagrees with this contention and believes that the standards applied were the various federal Waiver requirements agreed to by UDS when executing the provider agreements.

UDS also disputes the disallowance of \$404,962 and contends that a complete audit, not a random sample, is needed to determine a final disallowance. The BFO disagrees with this contention. The BFO used a statistically valid random sample (SVRS) to perform the audit testing. This method requires the auditor to pull the sample from a set population. Since the sample was an SVRS, the results are representative of the characteristics of the set population. The contention that the Independence Waiver sample amount needs to be eliminated from the extrapolation would skew the results of the sampling. When extrapolation is performed, the error rate represents the characteristics of the total population, which includes claims from the Independence Waiver. As such, it is the BFO's position that the extrapolation and disallowance of Supports Coordination claims is appropriate. It must be noted that using an SVRS and extrapolating the results is a common and accepted auditing technique.

In accordance with our established procedures, an audit response matrix will be provided to the OLTL. The OLTL will be responsible for completing the matrix and forwarding it to the DPW Audit Resolution Section within 60 days. The response to each recommendation should indicate OLTL's concurrence or non-concurrence, the corrective action to be taken, the staff responsible for the corrective action, the expected date that the corrective action will be completed, and any related comments.

Please contact David Bryan, Audit Resolution Section at (717) 783-7217 if you have any questions concerning this audit or if we can be of any further assistance in this matter.

Sincerely,



Tina L. Long, CPA  
Director

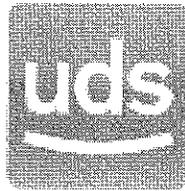
c: Ms. Karen Deklinski      Mrs. Laura Deeghan  
    Ms. Bonnie Rose         Mr. Grant Witmer  
    Ms. Sallie Rowe

United Disabilities Services  
July 1, 2010 through June 30, 2011

bc: Mr. Alex Matolyak  
Ms. Kelly Leighty  
Mr. Dave Bryan (C1100)  
Ms. Kenya Mann Faulkner  
Ms. Shelley L. Lawrence  
CFO Audit File

**UNITED DISABILITIES SERVICES  
RESPONSE TO THE DRAFT REPORT**

**APPENDIX A**



*your way of living*

June 27, 2012

Ms. Bonnie Rose  
Deputy Secretary for Office of Long Term Living  
555 Walnut Street, 5<sup>th</sup> Floor  
Harrisburg, PA 17101

Dear Ms. Rose:

This letter is in response to the Bureau of Financial Operations (BFO) findings for the audit focused on the period July 1, 2010 through June 30, 2011.

In response to Finding No. 1, the findings detail the excess revenue once achieved through the Consumer Model PAS. It does not detail the losses incurred in other Waiver services for FY2010-2011. The BFO did verify to us their concern regarding the reimbursement rates outside of the Consumer Model PAS rates.

Overall UDS incurred income losses of (\$85,077) for all combined waiver direct services and are at a run rate of (\$1.431M) in waiver direct services income losses for FY 2011-2012.

In response to Finding No. 2, UDS has always received extremely favorable results from QMET monitoring over the years. It should be noted that UDS had never been cited for not documenting services performed on a consumer's behalf as part of their Service Coordination responsibilities. Nor has UDS ever been told that this documentation was required to validate monthly and weekly billing of Service Coordination in the Attendant Care and OBRA waivers. Up until January 1, 2011 the Service Coordinators (SC) were required to validate visits and time sheets for all consumers on a weekly basis and compare to authorized plan hours. This service was a part of the roles and responsibilities of every SC, and was a vital part of the processing of payroll for those consumer's employees. This role was then transitioned to the Fiscal Management Service (FMS) January 1, 2011.

As noted in the regulations provided by Mr. Welker, the requirements utilized to audit UDS were specific to 1915(g) ODP providers of case management and are NOT the regulations and audit tools for 1915(c) waivers providers for supports coordination. UDS is not a provider of the 1915 (g) state plan and does not offer case management through the 1915 (g)-ODP state plan. UDS is a 1915 (c) provider offering service/support coordination services. 1915 (c) providers, including UDS, do not bill per unit of services except in the Independence Waiver. The OLTL waivers, 1915 (c) waivers bill on a per member per month fee scale

It should also be noted that in the Independence Waiver, where documentation was a requirement, 100% of the sample had no errors. This speaks to UDS's commitment to compliance. Although the waiver does not specify the requirement indicated, UDS immediately implemented a process and outlined procedures to insure that documentation met the communicated requirement. A copy of this policy has been provided for your reference. (see attached)

UDS disputes the entire disallowance of \$404,962 recommended by the BFO, on the basis that the claim that UDS lacks documentation for billing is not supported anywhere in writing. Any final disallowance total would have to be the result of a complete audit, not this random sample. However, UDS would also like to address the disallowance calculation. The billing attributable to the 92 consumers in the sample amounted to \$14,746. Of that amount \$2,136 was from the Independence Waiver, \$6,296 was AC and \$6,314 was OBRA. From that sample, \$4,768 is attributable to lack of documentation; \$3,144 in AC and \$1,624 in OBRA. Since \$0 is attributable to Independence Waiver, this billing (\$2,136) needs to be eliminated from the calculation, both in the percentage and the total revenue billed used to calculate the disallowed. After following the methodology applied by DPW and dividing by 2 in order to account for the first six months of payroll responsibilities fulfilled by the service coordinators, the calculation result is \$98,112, not \$404,962. A schedule of this calculation is provided

**Schedule of Disallowable Portion**

OBRA Billing Sample	6,314	
AC Billing Sample	6,296	
Total		12,610
OBRA Billing in error	1,624	
AC Billing in error	3,144	
Error/Sample %		
OBRA (1,624 / 12,610)	12.88%	
AC (3,144 / 12,610)	24.93%	
Total Billing		
OBRA	\$574,198	
AC	480,429	
		\$1,054,617
Total Billing as % Error		
OBRA	\$ 73,948	
AC	122,277	
Disallowable Portion		\$ 196,224

Divide by 2 Due to Payroll Responsibilities

**Disallowable Portion** \$ 98,112

Our Recommendation: OLTL needs to improve directives, communication and trainings on DPW mandates to SC providers. There is lack of direction in writing and training on documentation requirements in HCSIS service notes. The waiver 1915 (c) mandates make no mention of HCSIS service note documentation specific to billing and as stated earlier, are requirements for case management for 1915 (g) which do not apply to

providers of 1915 (c) waivers. For example, review of the OBRA waiver indicates no specific requirement for weekly documentation in HCSIS service notes to justify weekly billing. (Page 111-114 of the OBRA Waivers spells out the requirements for SC documentation). The Long Term Living Training Institute (LTLT) is in process of creating a SC Training Manual. Page 31 of the SC Training Manual: "Maintaining Notes and Documentation" makes no mention of "require documentation" specific to waiver service billing per the audit tool utilized by DPW to audit UDS Supports Coordination.

In response to Finding No. 3, since the end of the audit period, UDS has developed monitoring software that is helping SC's and management insure Waiver requirements are documented. All SC's have also received re-training on note documentation.

In response to Finding No. 4, as noted by the BFO, UDS management has revised the cost allocations, as recommended by the BFO. We incorporated the Administrative Staff usage of the HALO system into the calculation and this is now applied.

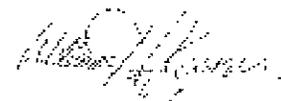
The Williamsport office was allocated based on SC time attributable to the waivers, as this is consistent with the billing. However, we have implemented DPW's recommendation and now allocate the Williamsport office (and any other office we might add) by consumer numbers in each Waiver.

UDS implemented a process for logging mileage for van usage; however, the process fell by the wayside. Since UDS is no longer providing Community Integration and Skills Instruction due to inadequate rates, no further action is required.

In summary, UDS has always maintained an excellent track record of accuracy, legitimacy and compliance. Despite six weeks of intense scrutiny, overall we believe the BFO found UDS to be in excellent compliance regarding our cost allocations. They were also able to verify to us that our revenues and expenses were extremely accurate and that reimbursement rates outside of the Consumer Model PAS are lacking and inadequate as evidenced by our sizeable losses. We strongly dispute the disallowance they are reporting for lack of SC documentation as it is in conflict with the directives, communication and audit findings we have received previously from OLTL and QMET.

If you have any questions or need additional clarification please contact me.  
Thank you for your consideration and the opportunity to respond.

Sincerely,



William Kepner  
CEO

## **UNITED DISABILITIES SERVICES**

### **Policy: Documentation on Service Notes**

**Pages: 6**

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#### **Purpose:**

The Support Coordinator and their Supervisor are responsible to reflect, through documentation, the intervention of support coordination. The service notes should represent a picture of the service that has been provided to the consumer. The documentation is to reflect the quality of supports coordination and service delivery that has been provided to the consumer by the Staff at United Disabilities Services.

#### **Procedure:**

Using the HCSIS System, the Support Coordinator is to enter the service notes as outlined in the HCSIS Data Entry Guidebook.

Documentation on service notes needs to provide a summary of any visit, meeting, and phone contact with the consumer, family or with formal or informal service providers.

The note needs to have the following format:

- Number of units of service provided (assure a match with your DAR)
- Purpose of the contact
- Narrative Section to describe the service(s) provided on behalf of the consumer
- Assessment of the situation
- Plan for follow up
- Support Coordinator's name

Service notes of the home visit, meeting or phone contact should be completed immediately following the contact. Document any communication regarding service plan changes to the participant and the appropriate service provider(s). All service notes must be entered into HCSIS within 24 hours/or the next business day the Support Coordinator is at the UDS Office.

#### **Monthly Documentation**

**ACW/ACT 150** require monthly HCSIS service note documentation and at least quarterly phone contact with each consumer. **OBRA** requires weekly HCSIS service note documentation and at least quarterly phone contact with each consumer. **AAW** requires monthly telephone contact documented in HCSIS. For **Independence Waiver and COMMCare**, services are documented as provided with at least quarterly phone contact with each consumer. **Monitoring can be more frequent, but not less frequent than specified.**

## Waiver Mandated Phone Contact with Consumers

When documenting a phone conversation with a consumer, the following information is to be included in the service note narrative:

- Documentation of the consumer's satisfaction with services. Should the consumer have issues, problems or concerns with services, include this in your service note. Document your response to handling issues with services. It is important that the service note reflect your role in service coordination.
- Documentation of the consumer's agreement that services are meeting their needs. Ensure the amount and frequency of services in the ISP are being provided. If not, explain the plan to follow up and reevaluate the service delivery.
- Documentation noting any changes or events in the consumer's life that have impacted their health & safety. Address any new barriers or risks identified as a result of those changes and develop mitigation strategies. Some examples include hospitalization, falls, or a change in caregiver.
- Documentation noting review of the consumer's emergency backup plan, and any risk agreement negotiated by the consumer. Indicate that the question was asked and the consumer's response. Note any changes to the plan. Note if the back-up plan has been utilized since the last review.
- Document that the toll free participant helpline phone number was reviewed with the consumer; the Consumer Advisory Committee was discussed; provider choice options were reviewed.
- Documentation should close the service note with a plan to handle any issues that were identified during the call.

Sample:

\_\_\_\_\_ SC hours: SC spoke with consumer for a monitoring telephone call. Consumer reported (he/she) is satisfied with current services. They reported there (are/are no) problems with services. (Document follow-up to problems, if needed). Hours are meeting consumer's needs and are sufficient. All hours are filled. Consumer reports no recent changes in health. Consumer's back-up remains the same. The back-up plan is \_\_\_\_\_ and consumer stated that this person is aware that they are listed as back-up. Provider choice was reviewed. Consumer has toll free participant helpline phone number. Consumer (is/isn't) interested in participating in the HCBS Advisory Committee. SC will follow up by \_\_\_\_\_ within (i.e. 2 weeks).

Support Coordinator's Legal Name, Position

### Home Visit Note

When documenting a quarterly home visit the following information needs to be included in the service note:

- Documentation of the consumer's satisfaction with services. Should the consumer have issues, problems or concerns with services, include this in your service note. Document your response to handling issues with services. It is important that the service note reflect your role in service coordination.
- Documentation of the consumer's agreement that services are meeting their needs. Ensure the amount and frequency of services in the ISP are being provided. If not, explain the plan to follow up and reevaluate the service delivery.
- Documentation noting any changes or events in the consumer's life that have impacted their health & safety. Address any new barriers or risks identified as a result of these changes and develop mitigation strategies. Some examples include hospitalization, falls, or a change in caregiver.
- Documentation needs to include a discussion of the impact of the ISP on the consumer's functional level and quality of life.
- Documentation of your review of the consumer's emergency backup plan and any risk agreement negotiated by the consumer. The Support Coordinator must note if the strategies and backup plan are working. Indicate that the question was asked and the consumer's response. Note any changes to the plan.
- Documentation of observations of the consumer and their environment are an important aspect of your home visit.
- Documentation indicating the plan to handle any issues identified at the visit and when the next visit is scheduled. The exact date is not needed but a timeframe should be indicated (i.e. "next quarterly home visit to be completed in 3 months").

Sample:

\_\_\_\_ SC hours; SC met with (consumer's name) in his/her home. Consumer reported he/she is satisfied with the current services. (Or document any concerns and SC's planned follow-up). The current services are meeting consumer's needs and he/she is receiving the services specified in the ISP. (If not, explain what will be done to ensure services are provided at the frequency listed in the ISP). Consumer reported no recent changes in health so there are no new barriers or risks to address at this time. Services enable consumer to live safely and independently at home. Consumer's back-up plan is \_\_\_\_\_. The last time this plan was used, consumer reported it worked well.

\*Note any observations of the consumer and environment here.\* SC will follow up by  
\_\_ within (i.e. 2 weeks) \_\_.

Support Coordinator's Legal Name, Position

### **Reassessment Visit**

When documenting a reassessment visit, the following information needs to be included in the service note:

- Reviewed Individualized Service Plan ensuring barriers/risks were identified, mitigation strategies were discussed and consumer agrees and accepts risks identified; reviewed and discussed Individualized back up plan and emergency back-up plan (severe weather, etc.); reviewed available supports (both waiver program and non waiver program).
- Whether the participant reported receiving the amount of goods and services specified in the ISP; whether the participant reported receiving the amount and frequency of services in ISP; whether the participant confirmed that the services indicated in the ISP are appropriate in supporting the participant with reaching his/her goals; and whether the participant confirmed that and/or SC concluded that the duration of services in the ISP needs to be continued, extended or concluded. Ensure PERS is operational (if that service is in the consumer's ISP) and available to participants.
- Whether the participant reported any health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes that might impact his/her ability to perform activities of daily living that prompt a need for temporary or permanent changes to service delivery or other follow-up to identify what discharge services are and are not being provided through the participant's health insurance.
- There is no duplication of services including waiver and non-waiver services.
- Any reminders or prompts given to the participant of what happens next and/or his/her responsibilities; review MA Fraud; review and provided the Toll free participant helpline phone number; informed participant of Consumer Advisory Committee.
- Confirming the participant's eligibility for waiver services.
- Note that the following were reviewed and discussed with the participant: Notification of Right to Appeal, Provider Choice Form and Freedom of Choice form, and how to report incidents of abuse, neglect and exploitation.

**Sample:**

\_\_\_\_\_. SChours:SC met with (consumer's name) in his/her home to complete an annual reassessment. SC reviewed the Individualized Service Plan with the consumer. Barriers and risks were discussed. (Consumer's name) agrees/disagrees with the mitigation strategies. SC reviewed the current back-up plan which is \_\_\_\_\_. Consumer confirmed this remains current. When asked, consumer reported he/she is receiving the frequency and duration of services specified in his/her ISP. These services continue to support consumer in reaching his/her goals. SC and consumer reviewed the services and determined the current level of services should be (continued, extended or concluded). (If PERS is in the ISP, ensure the unit is operational.) Consumer reported no recent changes in health. (Note any hospitalizations or surgeries in the last year and the impact on the level of service needed. Address any new barriers or risks and mitigation strategies.) SC reviewed all current services with consumer and there is no duplication of services. SC reviewed MA fraud and consumer's rights and responsibilities in order to continue to receive waiver services. SC reviewed the toll free participant helpline phone number and informed consumer of the Consumer Advisory Committee. He/she does/doesn't wish to participate at this time. SC confirmed the consumer remains eligible for waiver services. SC reviewed and discussed the Notification of Right to Appeal and how to report incidents of abuse, neglect and exploitation. SC also reviewed the Provider Choice Form and Freedom of Choice form which consumer signed.

Support Coordinator's Legal Name, Position

**Refusal of a Service**

When documenting a refusal of services by the consumer the following information must be included in the service note:

- Documentation of what service or intervention the consumer is refusing.
- Documentation of why the consumer is refusing the service. Whenever a consumer refuses a service that will have a negative impact on their well-being it needs to be clearly documented. Include how the Support Coordinator counseled the consumer and their understanding of the risk involved in refusing the service. Depending on the severity of risk involved, the Supports Coordinator may also need to document that discussion with their supervisor. The supervisor must then document what steps were recommended for follow up. The note needs to close with a plan. The plan should include what steps are being taken to monitor the consumer.
- If indicated, the Dignity of Risk Form may need to be completed by the Support Coordinator and signed by the consumer. If a consumer is refusing all services, a Freedom of Choice form must be signed by the consumer indicating their choice. The original is filed in the consumer file.

Sample:

\_\_\_\_SC hours: SC spoke with (consumer's name). He/she does not wish to receive the following service \_\_\_\_\_ because \_\_\_\_\_. SC explained it is his/her right to refuse the service, although we do not believe it is in his/her best interest. Consumer accepts the risk that is involved in refusing the service. SC will inform the provider that consumer has chosen not to receive this service any longer. SC will continue to monitor consumer's health and safety by \_\_\_\_\_. (If appropriate, note that a Dignity of Risk form has been completed and signed by the consumer.)

Support Coordinator's Legal Name, Position