SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

Section: FORMS

Subject: Provider Prepared Standards (SLTC-251)

PURPOSE

The purpose of the Self-Directed Provider Prepared Standards (SLTC-251) is to capture information about a provider agency's policy and procedure to ensure program compliance. Provider prepared standards are one component of provider agency quality assurance reporting. (Refer to CFC/PAS 610).

INSTRUCTIONS

1. Standard One: Serious Occurrence Report (SOR)- Complete the provider prepared section for the following criteria:

   a. List of SOR Reported Outside Timeframe: Run the "SOR Provider Agency Detail Timeline Report" in QAMS for July 1-December 31 and report the number of SOR your agency completed that did not meet the 10 working day criteria for submitting SOR.

   b. ➢Top Three SOR: Run an SOR Search for SOR from July 1-December 31 and click the report button. Determine the top three incident types by cause and subtype. Report the top three in each category. If there are more than three incident types that tie for the top three select the three the agency intends to focus on for future remediation.

   c. Agency Action and Follow-Up: In the space provided describe how the provider agency will utilize information on the number of SOR that were reported outside the required timeframe and the most frequent SOR cause and incident type for quality improvement.

      ➢If an agency runs the SOR reports outlined above (2.a and 2.b.) and no SORs are reported in the last six months, the agency must use the space in the Agency Action and Follow-up to document agency policy and procedure to educate members/personal representatives about the requirements of

SOR reporting to ensure appropriate reporting to the provider agency.

d. ➢If any of the following occurs the criteria is unmet:

i. The provider agency doesn't complete the Agency Action and Follow-up section.

2. Standard Two and Three: Plan Facilitator and Agency Oversight- Complete the provider prepared section for the following criteria:

a. List the full names of employee/contractors who performed the duties of a Plan Facilitator and/or Program Oversight staff from July 1-December 31. For each employee/contractor indicate the following information:

i. Role: By each person's name indicate the duties that the staff person performed- Plan Facilitator (PF), Agency Oversight (AO) or Both;

ii. Agency Verification: An agency representative must sign the box to verify that the person listed is free of the conflict of interest criteria outlined in policy (Refer to CFC/PAS 720);

➢NOTE: The person who signs off that the person is free of conflict of interest does not need to be the person who is listed on the form. It can be anyone employed at the agency who can verify that the person listed is free from the conflict of interest criteria.

iii. Number Years of Experience: Indicate the number of years of experience the person has in aging/disability related arena;

iv. Certification Training Date: If the person is a Plan Facilitator indicate the date the PF was certified (Refer to CBS 1103);

v. Date first PCP Form completed: If the person is a Plan Facilitator indicate the date the first PCP Form was completed; and

vi. Date Agency Oversight staff trained in CFC/PAS: If the person performs agency oversight staff duties indicate

the date CFC/PAS training was provided by the agency to the staff person.

b. ➢If any of the following occurs the criteria is unmet:

i. ➢Agency does not have a person who is able to sign off to verify that the person listed is free from conflict of interest criteria;

ii. Person listed has less than one year experience in the aging/disability arena the standard is unmet;

iii. The agency does not have a copy of the Plan Facilitator's training quiz; or

iv. Date Plan Facilitator completed first PCP form is after the date the person was certified.

3. Standard Four: Member Survey- Complete the provider prepared section for the following criteria:

a. ➢Member Survey- Attach a copy of the member survey that was distributed to members between January-December of the reporting year. If no survey is available the criteria is unmet.

b. Include the following information on the member survey:

i. Date Survey Distributed- Document the date the member survey was distributed to members;

ii. Number of Survey Distributed- Document the number of surveys that were distributed to members; and

iii. Response Rate Percent (%)- Calculate the number of surveys collected out of the total surveys distributed

c. Member Survey Summary and Future Action: In the space provided the provider agency must provide a written summary of the survey results.

d. ➢If any of the following occurs the criteria is unmet:

i. ➢No survey was completed in the reporting year.

4. Standard Five: Provider Enrollment - Attach current documentation to verify the following criteria:

a. General Liability Insurance- General liability insurance must include a minimum $1,000,000 per occurrence and $2,000,000 per aggregate;

b. Motor Vehicle Liability Insurance-Split limits of $500,000 per person for personal injury and $100,000 per accident occurrence for property damage; or combined single limits of $1,000,000 per occurrence to cover such claims as may be caused by any act, omission, or negligence of the provider or its agents, officers, representatives, assigns, or subcontractors;

c. Unemployment Insurance Coverage; and

d. Workers Compensation Coverage.

e. ➢If any of the following occurs the criteria is unmet:

i. The provider agency does not have documentation that verifies current coverage for the criteria 4.a-d.

5. Standard 6: Agency Organization Structure-Complete the section for the following criteria:

a. Submit a copy of the provider agency's organizational chart or a summary of the provider agency's organizational structure that identifies all of the staff who perform duties relevant to CFC/PAS.

6. Standard 7: Education- complete the section for the following criteria:

a. A provider agency representative must verify that the agency has written policy for educating members and Personal Representatives (PR) and evaluating their participation in the self-directed program. The policy must include:

i. Member/PR education and assessment for the following:

1. Service Profile;

2. Service Delivery;

3. Training of personal care attendants (PCA);

4. Supervision of workers;

5. Review of Service Delivery Records;

6. Health Care Professional authorization;

7. Liability; and

8. Back-up plan.

b. ➢A provider agency representative must verify that, when a PR is selected, the agency has a written policy to document that the PR meets the following criteria, as outlined in policy (Refer to SD CFC/PAS 716 pg. 1 2.a-d):

i. Is a person who is immediately involved in the daily care of the member;

ii. Is immediately available to provide assistance when attendants don't show up or is able to access back-up support;

iii. Is available to assume the responsibility of managing the member's care; and

iv. Is at least 18 years of age.

NOTE: The fact that a PR signs the PR Agreement is not sufficient to document how the agency ensured the PR met the criteria outlined above in 7.b.i-7.b.iv.

c. ➢Personal Representative Verification- The agency must complete the Personal Representative Verification table by selecting the three most recent Personal Representative Agreements forms (SLTC-166) that were completed. The agency must list the names of the PR (include the member's name), and for each of the PRs listed, an agency representative must ensure that there is documentation present to substantiate that the PR meets the criteria, outlined in 7.b.i-7.b.iv and confirm this with a signature.

d. ➢If any of the following occurs the criteria is unmet:

i. The agency doesn't have a written policy that addresses all of the items in 7.a. and/or 7.b; or

ii. The agency representative cannot locate documentation to substantiate the PR, identified on the report, meets the requirements outlined in 7.c.

7. Standard 8: Agency Intake Packet- A provider agency representative must verify that the agency intake packet includes documentation and a review of information as outlined in policy (Refer to SD CFC/PAS 702 pg. 5 a-j).

   a. ➢If any of the following occurs the criteria is unmet:

      i. ➢The provider agency intake doesn't include all of the required documentation.

8. Standard 9: Agency Action Plan- Provider agency must submit a written action plan when any of the criteria from the agency's Provider Prepared Standards or Internal Quality Assurance Review standards are unmet.

   For each unmet criteria, the agency must complete a minimum of one Specific, Measureable, Action-specific, Relevant and Time-specific (SMART) goal to address the unmet criteria.

REPORTING TIMEFRAME

The Provider Prepared Standards must be submitted to the Regional Program Officer by April 1st of each year in conjunction with the Internal Quality Assurance Review (SLTC-250).

A provider agency that has enrolled as a Community First Choice/Personal Assistance Service provider agency in the past year or a provider agency that has extenuating circumstances and needs additional time to complete the Provider Prepared Standards, may request one three-month extension to complete the Provider Prepared Standards. A provider agency must submit the request for an extension in writing to the Regional Program Officer by March 15.