

State of Kansas - SRS / HCP / CSS
TBI WAIVER - QUALITY ASSURANCE SURVEY DOCUMENT

L. Name	F. Name	Beneficiary ID #	SSN:
Gender: (Male) (Female)	Phone # ()	DOB (mm/dd/year)	Street address:
Apartment #	City:	ZIP:	County Code#: SRS Area Code #:
Case Managers Name	CM Code#	Date Services Started (mm/dd/year)	
Legal Guardian (yes) (no)	Guardian L. Name:	Guardian F. Name:	
Guardian Street Address:	Guardian City:	ZIP:	Phone: ()
Quality Review Date: (mm/dd/year)	Date of TBI: (mm/dd/year)		
Secondary Sources Interviewed:	L. Name:	F. Name:	Address:
	L. Name:	F. Name:	Address:
	L. Name:	F. Name:	Address:
	L. Name:	F. Name:	Address:
Name of Quality Reviewer:			

INSTRUCTIONS: The quality review process is to be a relaxed and open sharing of information. Reviewer is requested and encouraged NOT to read questions to the persons with whom you are doing the review. Please become familiar with the information to the degree that you will be comfortable with the questions as with the process. Should you need assistance please feel free to contact SRS, The Division of Health Care Policy/Community Supports & Services.

SECTION ONE: HEALTH & SAFETY

STANDARD: The person has adequate support to consistently identify and meet all health, medical and safety needs.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		Yes	No	N/A	does not know
1	Do you have access to needed health care providers <u>in their local community</u> .				
2	Do you feel safe and comfortable in your home?				
3	Do you feel safe in your neighborhood / community?				
9	(Reviewer) Do you observe through conversation that the person has a plan in place to ensure their safety?				
10	If YES to # 9 - Please describe the plan				
		mm	dd	year	
11	Date last assessment was completed (mm/dd/year)				
		Yes	No	N/A	Does Not Know
12	Do you have or need help to do your daily activities of living? (Reviewer should ask for examples, to ensure the person understands)				
14	Do you need assistance to take your medications?				
15	Do you receive Home Health Services?				
24	Do you have an evacuation plan for 'severe' emergencies?				
25	[Reviewers] In the reviewers opinion, can the person follow the evacuation plan?				
26	[Reviewers] Are the person's primary safety, health & medical needs consistently identified & met?				
	[Reviewer] If NOT, please describe:				
27	[Reviewer] Is the CM aware of this, and have they taken appropriate steps? [May require review of the file or contact with the case manager]				
	Describe:				

SECTION TWO: ABUSE, NEGLECT & EXPLOITATION

STANDARD: Adequate measures are in place to assist the person in preventing, identifying, reporting and addressing instances of abuse, neglect, exploitation or other mistreatment in his/her life.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		Yes	No	N/A	does not know
1	Was a background check offered for the persons that work with you?				
2.	If you declined the background check, do you want one now?				
4	What would you do if someone hurts you, yells at you or calls you names, takes your money or your personal things without asking?				
5	Where there any reported occurrences of abuse, neglect, exploitation against the person in the past year? (CHECK FILE)				
6	Check for reported and addressed incidents of abuse , neglect or exploitation to prevent recurrences. (CHECK WITH TCM, APS, ETC.)				

SECTION THREE

STANDARD: The person reports positive satisfaction with services & supports received, and is actively involved in the development of those services and supports.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		EXCELLENT	VERYGOOD	GOOD	FAIR	POOR	does not know
1	Please Rate your Transitional Living Skills provider? [Satisfaction]						
2.	Please rate your Personal Attendants? [Satisfaction]						
NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		yes	no	n/a			does not know
3.	Do your staff arrive on time for scheduled appointments with the person? [Attendants should not be present during interview...Confidentiality should be assured]						
4.	Do your attendants perform the tasks as listed on the Attendant Care worksheet? [Attendants should not be present during interview...Confidentiality should be assured]						

7	Do people take into account your wishes and preferences (CHOICES) when working with you?					
8.	Do you assist in the development of the <u>Plan of Care</u> [Reviewer may need to check case record to determine if POC / Choice form was signed]					
9	Are you involved in the development of your goals?					

SECTION FOUR: RESPONSIVENESS

STANDARD: The person has effective opportunities to express key needs and priorities, and services / supports are provided consistent with those expressed needs priorities.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !			yes - opportunities & are effective	yes - opportunities & sometimes effective	yes - opportunities BUT NOT effective	NO
2.	Do you have the opportunity to express your needs personally, and are those opportunities effective?					
		all the time	most of the time	only sometimes	rarely	never
3.	People who support you listen to you and assist you (or do not interfere with you) in fulfilling your needs and significant issues of life. Such as hiring / firing the staff you choose.					
		YES	NO	N/A	DOES NOT KNOW	
5.	Do you know how and who to contact if you have a complaint, grievance or concern regarding your services? Give me an example. <i>[Example is only a tool to ensure the reviewer is confident that the person understand the question]</i>					

SECTION FIVE: ACCESS & AVAILABILITY

STANDARD: The person effectively accesses and utilizes supports, both paid and natural, to meet his/her needs and priorities; barriers are identified and addressed.

	NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !	YES	NO	N/A					
1	Do you know the name of your case manager and how to contact that person?								
		ALWAYS AVAIL	USUALLY AVAIL	WITHIN ONE HOUR	RETURNED THAT DAY	RETURNED ONE WEEK	CM NOT AVAILABLE	CALL NOT RETURNED	N/A
2	Is your Case Manager available when you need him/her?								
		EXCELLENT	VERY GOOD	GOOD	FAIR	POOR	UNABLE TO DECIDE		
3	I rate my services provided by my case manager as:								
		YES	NO	N/A					
5.	Does your case manager help you locate and access the services you want?								
6.	Are there services that you requested, but do not receive?								
7.	Were you given choice of provider agencies in your area?								
8.	If service providers are not available, was something done to address this barrier?								

9.	Are there natural / informal supports (unpaid) such as, family, friends, church or civic groups, involved in this persons life?								
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SECTION SIX: CONSUMER CONTROL

STANDARD: The person has choice of where to live, services to receive (within waiver guidelines) and who provides those services. Person actively participates in all decisions regarding those choices.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		Yes	No	N/A	does not know
1.	Did you choose your home or apartment?				
2.	Do you make the decisions about how you spend your money?				
	If NO, why not?				
	If NO, who does?				
		Yes	No	N/A	Does not know
3.	Did you decide what services you would receive?				
4.	Did you choose the people who provide these services?				
5.	When a personal attendant is not doing their job or is disrespectful, do you feel you have the choice to change you service provider?				
6.	Are there things that you would like to learn, but have not been given the opportunity?				
	if YES, What would you like to learn?				
7.	Has your case manager been helpful when you wanted to change the services you receive?				
8.	Has your case manager explained your option to self-direct the supports provided by your personal attendants?				
9.	Have you made the choice to self-direct your services and supports?				

10.	Do you believe you were given enough information or training in order to successfully self-direct your personal care?				
11.	Do your personal attendants do what you ask them to do?				
12.	Do you choose what you eat?				
13.	Have you ever wanted to fire a personal attendant or service provider?				

SECTION SEVEN: TRANSITION PLAN

STANDARD: When a person first begins receiving HCBS/TBI Waiver services, all providers need to be conscience of continuous transition phase aimed toward the goal of completing the utilization of HCBS/TBI Waiver services.

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		Yes	No	N/A	does not know
1.	Has your case manager talked with you about your plans when you no longer receive HCBS/TBI Waiver services?				
3	Are working towards learning and maintaining independent living skills?				
4.	Are you using natural supports in the community?				
9.	Do you have a plan in place to stay independent after going off the HCBS/TBI waiver?				
10.	Do you need any further assistance for this plan?				
12.	Are you aware of the local Center for Independent Living (CIL)?				
13.	[Reviewer] Have there been discussions with the person regarding medical coverage when they go off of the HCBS/TBI Waiver, if they will not maintain Medicaid benefits? [Reviewer may need to consult the TCM of File]				

SECTION EIGHT: FILE REVIEW

NOTE THERE MUST BE A RESPONSE TO EVERY QUESTION !		Yes	No	N/A	does not know
1.	Is there evidence of training and support for family members / guardians while the persons is on the HCBS/TBI Waiver services?				
2.	Is there evidence of training and support for family members / guardians when the person transitions off the HCBS/TBI Waiver?				
3.	Is there evidence that an “Initial” UAI was completed?				
4.	Is there evidence that an UAI was completed in past 12 months?				
5.	Is there evidence that LTC threshold score meets eligibility criteria?				
6.	Is there evidence that a signed choice form has been signed?				
7.	Is there evidence that the plan of care addresses all participant needs (including health & safety risk factors) as well as personal goals?				
8.	Is there evidence that a background check has been completed on each employee, if requested?				
9.	Is there evidence that the CHOICE of having a background check as been made?				
10.	Is there evidence that each self- directed person has been provided in writing a description of services that will be provided to the attendant, including any benefits the attendant will receive?				
11.	Is there evidence that Abuse, Neglect & Exploitation training (reporting & prevention) has been provided to the person & family ?				
12.	Is there evidence that Abuse, Neglect & Exploitation training (reporting & prevention) has been provided to the attendants providing direct services?				

Reviewer: Please provide any explanations, comments or items of interest that presented themselves during the quality review. If you make note of something that requires immediate attention please highlight the comment, as well as e-mail the issue to Frank Stahl, Quality Enhancement Manger FZS@srskansas.org

Abuse, Neglect and/or Exploitation must be immediately reported to APS and or law enforcement and followed up with an e-mail to Frank Stahl, Quality Enhancement Manager FZS@srskansas.org

PLEASE NOTE: THE NUMBERING OF THE QUESTIONS IS CONSISTENT WITH THE CURRENT DATA BASE. DO NOT CHANGE THE QUESTION NUMBERS.