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December 31, 2013

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[x] Clarification Requested by One or More Counties
[x] Initiated by CDSS

ALL-COUNTY LETTER (ACL) NO.: 13-110

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: RELEASE OF CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS) IN-HOME SUPPORTIVE SERVICES (IHSS) QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) POLICY MANUAL

REFERENCE: ALL-COUNTY INFORMATION NOTICE (ACIN) NO. I-69-04, DATED SEPTEMBER 30, 2004; ACIN NO. I-24-05, DATED MAY 20, 2005; ACIN NO. I-64-05, DATED OCTOBER 6, 2005; ACL NO. 06-35, DATED SEPTEMBER 1, 2006; ACL NO. 10-39, DATED AUGUST 19, 2010; ACL NO. 13-23, DATED APRIL 2, 2013; WELFARE AND INSTITUTIONS CODE (W&IC) SECTIONS 12305.7; DEPARTMENT OF SOCIAL SERVICES MANUAL OF POLICIES AND PROCEDURES (MPP) 12-30-702; STATE PLAN AMENDMENT (SPA) NUMBER 13 - EFFECTIVE DATE JULY, 2013

Background:
The California W&IC Section 12305.71 mandates that each county have a dedicated QA function or unit that performs specific activities. The policies set forth in the CDSS IHSS QA/QI Policy Manual are the minimum requirements necessary to fulfill that mandate.

Purpose:
This ACL accompanies the release of a new CDSS IHSS QA/QI Policy Manual (attached). The IHSS QA/QI Policy Manual consolidates all previously released guidance into one comprehensive manual and replaces the IHSS QA/QI Procedures Manual, released as Attachment C to ACL No. 06-35.

Overview of the CDSS IHSS QA/QI Policy Manual:
- The manual provides State policy only; all procedures must be defined at the county level in *county specific* QA/QI Policy and Procedures.

- Analysts from the CDSS Quality Assurance and Improvement Bureau reviewed all previous QA/QI related ACLs, ACINs, W&IC sections, MPP, SPAs, and compiled the pertinent guidance into a single, comprehensive manual.

- Sections are organized into logical groupings of similar activities. For example:

  - Discovery: Different methods used to ascertain quality of work and identify errors and areas for improvement (Desk Reviews, Home Visits, Targeted Reviews and Error Rate Studies)

  - Remediation: Steps taken to fix errors and educate case workers and supervisors on areas for improvement (Corrective Action and System Improvement)

- The manual includes information on Quality Improvement Action Plans (QIAPs) as outlined in the Community First Choice Option (CFCO) SPA. The QIAPs provide structure for CDSS and counties to collaborate on implementing corrective action plans which address areas of concern.

- The number of desk reviews and home visits required by a county are determined using the sampling methodology from the CFCO SPA. This new minimum case review requirement will result in reduced workload for counties, while still providing for the review of a representative sample of each county's IHSS caseload, statistically valid to within the parameters established in the CFCO SPA (see Appendix A of the attachment).

- Timeframes have been included in the maximum turnaround times for corrective action.

- A definition for critical incidents is provided and is in compliance with the CFCO SPA. This section includes specific information regarding county-wide incidents, such as severe weather.

- The Third-Party Liability section provides a much more robust definition of what constitutes third-party liability.

- The Joint Case Reviews and CDSS Monitoring Section are based on clear guidance from W&IC and the CFCO SPA. The manual provides clear steps, expectations and commitments of the CDSS QA Monitoring Unit.

- The Annual County QA/QI Plan section reflects changes to the annual QA/QI Plan requirements implemented in ACL No. 13-105. This change is in compliance with federal requirements in the CFCO SPA.

- When CDSS releases new information or guidance for IHSS QA/QI, the CDSS IHSS QA/QI Policy Manual will be updated, keeping it the sole source for all guidance pertaining to IHSS QA/QI activities.

If you have questions or comments regarding this ACL, please contact the Program Integrity Training Unit at (916) 651-3494, or via e-mail at IHSS-PI@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Enclosure

c: CWDA

Attachment

IN-HOME SUPPORTIVE SERVICES (IHSS)

Quality Assurance/ Quality Improvement (QA/QI) Policy Manual

California Department of Social Services

Adult Programs Division

2013

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INTRODUCTION

Background

The Senate Bill (SB) 1104 Quality Assurance (QA) Initiative added Sections 12305.7 and 12305.71 to the Welfare and Institutions Code (WIC), which mandated a number of enhanced activities to be performed by the California Department of Social Services (CDSS), the counties, and the California Department of Health Care Services (DHCS) to improve the quality of In-Home Supportive Services (IHSS).

Section 30-702 of the CDSS Manual of Policies and Procedures (MPP) was added to implement WIC Section 12305.71. WIC Section 12305.71 required the counties to establish a dedicated Quality Assurance/Quality Improvement (QA/QI) function with specific core activities. Additionally, the statute required CDSS and county welfare departments to develop policies, procedures, and instructions under which county QA/QI programs perform mandated activities. CDSS established core QA/QI monitoring policies required for all 58 counties with State monitoring oversight.

This manual incorporates all previous guidance concerning IHSS QA/QI and replaces the IHSS QA/QI Procedures Manual, Attachment C of All County Letter (ACL) 06-35.

Purpose

The purpose of county QA is to ensure that all workers consistently follow the IHSS State and county policies and procedures, and to ensure the safety and wellbeing of recipients.

This manual provides State policy as it pertains to IHSS QA/QI. Counties may have additional county specific policies but they cannot conflict with State policy. Counties must maintain detailed procedures documenting their steps to accomplish all State and county QA policies. Please refer to the section on County QA Policy and Procedure Manuals in this Manual for further information.

Terminology

- **The CDSS IHSS QA/QI Policy Manual** hereinafter referred to as “the Manual”
- **County QA** is used to describe those who participate in QA activities at the county, regardless of their job title or the title of their unit/team
- **Case Worker** is used to describe any county employee who conducts initial assessments and/or reassessments of IHSS recipients
- **System Improvement** is the term used in State Plan Amendment (SPA) 11-034 and SPA 13-007 to describe the activities called Quality Improvement in SB 1104. The terms are used interchangeably herein
- **A policy** is a written statement defining State regulations and/or statute and county guidance

- **County IHSS QA procedures** are the step-by-step instructions defining how county QA accomplishes activities in order to fulfill all policy requirements
- **IHSS QA/QI Activities Report** hereinafter referred to as the quarterly SOC 824 report. Please see APPENDIX B. Actual SOC 824 form and instructions can be found on the CDSS website.
- **Findings** – the documented results from a QA case review
- **Recommendations** – recommended remediation steps based on findings. County QA will request case workers and/or supervisors to make changes to a case to address issues identified in the findings. Each recommendation will be classified as either "Immediate Action Required" or "Action Required"
    - Immediate Action Required:
        - any instance of an unresolved critical incident
        - any case without a Health Care Certification Form (SOC 873)
        - any case with authorized paramedical services without a Request for Order and Consent – Paramedical Services form (SOC 821)
        - any other finding specified in the county's Policy and Procedures Manual to require immediate action
    - Action Required – all other recommendations which are not classified as Immediate Action Required

  Recommendations must either be successfully disputed or implemented within the appropriate timeframes, as specified in the section titled "Remediation" subsection "Corrective Action."
- **Resolution** – when county QA has confirmed all identified findings have been corrected or successfully disputed by program staff and rescinded by QA

Training for County QA/QI Staff

As county QA will be responsible for reviewing the work of the county case workers, it is recommended that all county QA attend the State sponsored IHSS Social Worker Training Academy.

CDSS Quality Assurance and Improvement Bureau Technical Assistance

CDSS Quality Assurance & Improvement Bureau (QA&IB) will work with county QA by providing on-going technical assistance which includes but is not limited to:

- Reviewing quarterly SOC 824 reports
- Assistance with County QA Policy and Procedures Manuals
- Assistance with Quality Improvement Action Plan (QIAP)
- Assistance with System Improvement (Quality Improvement) activities

QUALITY IMPROVEMENT ACTION PLAN

When CDSS determines that a county is out of compliance, CDSS will issue a QIAP request. When CDSS requests a QIAP from a county, the county must include in its QIAP how and when an issue will be resolved. The QIAP is due to CDSS from the county within 30 days of receipt of the request. The QIAPs are reviewed by CDSS QA staff and approved or returned for re-write within 15 working days of CDSS' receipt of the QIAP. County progress toward continuous improvement is monitored via regular communication between the county and CDSS QA staff.

Areas which could result in a QIAP request include, but are not limited to:

- Failure to meet minimum case review requirements
- Failure to maintain at least 80% compliance with timely reassessment rate based on a 12 month rolling average of CMIPS II reassessments data
- Failure to submit accurate reports to CDSS in a timely fashion
- Failure to create and maintain adequate written policies and procedures
- Non-compliance to State and county policies and procedures
- Failure to participate in State-sponsored Social Worker Training Academy
- Trends identified during CDSS QA monitoring visits which require action

NOTE: Authority: SPA Number 13-007 Effective Date July, 2013

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DISCOVERY

Scheduled Reviews (Desk Reviews and Home Visits)

Routine scheduled reviews confirm whether or not 1) recipient needs are correctly assessed, and, 2) the documentation is in compliance with State and county requirements. Routine scheduled reviews consist of desk reviews and home visits, and must include cases from all district offices and all case workers involved in assessments and/or reassessments. The cases chosen for a home visit must have already received a full desk review as part of a routine scheduled case review.

Counties are required to complete a minimum number of case reviews each year. CDSS notifies counties of their minimum required number of desk reviews for the next fiscal year each April. The required number is based on a county's caseload and QA staffing allocation. The minimum required number of home visits is 20% of the required desk reviews. For more information on the methodology CDSS uses in determining a meaningful sample size per county, please refer to Appendix A in this Manual.

During a State monitoring visit, any cases CDSS reviews other than those previously reviewed by county QA and denied applications can be counted towards the county's total QA desk review requirement.

If the county is unable to meet the requirements for the minimum number of scheduled reviews, the county shall submit a written alternative proposal to CDSS outlining the reason, as well as an alternative plan. CDSS shall review the proposal and determine if it is in compliance with MPP Section 30-702.122(b).

County QA must use standardized forms and follow the same policies and procedures for each desk review and home visit conducted. Upon completion of routine scheduled reviews, county QA, supervisors and case workers must follow all State and county policies and procedures with regards to corrective action steps. Please refer to the section on Corrective Action in this Manual for further information.

Based on the findings of the reviews, county QA will work with supervisors to ensure each case worker has the training needed to meet all State and county standards. County QA will ensure that any systemic problems identified are addressed through implementation of System Improvement activities. Please refer to the section on System Improvement in this Manual for further information.

As part of the routine scheduled reviews, counties must also review a sample of denied cases to validate that the denial is consistent with regulations. Reviews of denied applications can account for up to 10 percent of the county's minimum required number of desk reviews.

County QA is required to report all desk reviews and home visits to CDSS as part of their quarterly SOC 824 report.

Scheduled Reviews vs. Targeted Case Reviews

During a routine scheduled review, QA performs a comprehensive review of the case. During a targeted review, QA only reviews a specific area of the case. While a case may have been included in a targeted review, it can only be counted as a scheduled review if a full review is completed. Please refer to the section on Targeted Case Reviews in this Manual for further information.

Desk Reviews

Desk reviews shall include a process to verify:

- Required forms are present, in the appropriate language, completed, and contain the appropriate signatures
- Any required forms which do not require a signature can be maintained in either electronic or paper format
- All required fields in CMIPS II are completed and are accurate
- There is a dated Notice of Action (paper or electronic) in the appropriate language for the current assessment period
- The need for authorized service hours is documented
- Unmet need for IHSS has been documented for recipients who have been assessed the maximum number of non-protective-supervision hours for IHSS

At a minimum, this review must:

- Comply with regulatory time per task guidelines (domestic, laundry, food shopping, and other shopping and errands) to ensure that sufficient exception language is provided when the total need for services exceeds regulatory guidelines
- Ensure exception language justifies any service authorization outside of hourly task guidelines
- Verify that appropriate documentation regarding the need for protective supervision is included, and validate protective supervision calculations
- Ensure that proration requirements contained in MPP Sections 30-763.3 and 30-763.4 are met
- Verify that the case files contain documentation of the name of the agency or individual providing any alternative resources with detailed information of services provided including frequency
- If the alternative resource service provided is compensable by IHSS, documentation should be completed and signed by the individual providing the service voluntarily - Voluntary Services Certification form (SOC 450)
- If paramedical services are authorized, verify the presence of the Request for Order and Consent Paramedical Services form (SOC 321), that the services are

paramedical in nature and that the certification period listed on the form, if any, has not expired
- Determine if the assessment or reassessment was conducted in the time period specified in regulations
- If the case is subject to variable reassessment criteria, check that all parameters have been met and documentation of variable reassessment criteria eligibility exists

County Specific Forms

If a county is using a substitute form for a required State form, the substitute form must also be reviewed and approved by CDSS for compliance.

Home Visits

The primary purpose of a home visit is to allow county QA to interact directly with the recipient and/or their authorized representative discussing the quality of care being provided. The home visit is also to ensure that the last assessment and/or reassessment was conducted in compliance with all State and county policies and procedures. Lastly, a home visit is an opportunity for county QA to get feedback on the services being provided to the recipient from both the provider and the county. To this end, neither caseworkers nor their supervisors should accompany county QA on a QA home visit. Also note, a QA home visit is distinct from either a reassessment conducted by a case worker or an unannounced home visit conducted by program integrity staff.

Prior to conducting home visits, county QA verifies that the number of hours claimed by the provider(s) match the service hours authorized. If county QA identifies a discrepancy they must follow all State and county policies and procedures.

In preparation, county QA reviews the case file focusing on the most recent face-to-face visit documentation.

Counties are required to notify the recipient prior to the QA home visit in a manner consistent with the method used by a case worker prior to a reassessment.

County QA must document that all the requirements as laid out in MPP Section 30-702.125(b) have been met.

During any face-to-face visit the following must be validated:

- The identity of the recipient
- It appears that the provider(s) is providing the authorized services, and working the hours being claimed on the timesheets

- The recipient's authorized services appear to have been assessed correctly based on his/her needs

In addition, the QA worker must confirm that the case worker has provided information to ensure that the recipient is aware of the following:

- His/her rights and responsibilities to self-direct
- How to report critical incidents
- How to access an advocate or one of the advocacy systems
- How to get in touch with his/her case worker
- How to access alternative community resources
- Who to contact if his/her provider is not available and an immediate replacement is necessary
- How to report fraud, abuse, or neglect

The county case worker and county QA will document: any referrals made, that the recipient has been given the required information, a list of the specific forms, and any additional resources and outside referrals (such as Meals on Wheels, Legal Aid etc.) provided to or discussed with the recipient.

If, based on the information provided or observed, county QA believes a change is needed in the case they must follow the corrective action process documented in their county policies and procedures; changes are not to be made to the case by QA. Please refer to the section on Corrective Action in this Manual for further information.

If there is a discrepancy in the time claimed on timesheets, the recipient should be reminded of his/her responsibility as an employer to sign timesheets that accurately reflect the hours worked. If fraud or overpayment is suspected, county QA must refer the case for follow-up. Please refer to the section on Detection of Fraud and Overpayment Recovery in this Manual for further information.

In a case where county QA believes there is an immediate threat to the recipient's wellbeing, they must take immediate action following all State and county policies and procedures. Please refer to the section on Critical Incidents in this Manual for further information.

NOTE: Authority: Sections 12305.7 and 12305.71, WIC; Sections 30-702.12 through 702.131, CDSS MPP; SPA Number 13-007 Effective Date July, 2013.

Targeted Case Reviews

For targeted case reviews, county QA reviews multiple cases based on specific criteria. Through this process, county QA engages in a more focused analysis to identify trends. If the results warrant, county QA will initiate system improvement activities. Please refer to the section on System Improvement in this Manual for further information. Counties must perform targeted case reviews on an on-going basis with a minimum of one per year.

Topics for targeted case reviews can be identified in several ways which include the following:

- Trends identified as a result of routine scheduled reviews
- Data derived from CMIPS II
- Input from supervisors and program staff
- Input from county QA/QI committees
- Input from stakeholders

Targeted case reviews differ from routine scheduled reviews as targeted case reviews are focused on specific criteria and routine scheduled reviews require a comprehensive review of the case. Please refer to the section on Scheduled Reviews in this Manual for further information.

County QA must submit brief outcome reports on all targeted reviews to CDSS as part of their quarterly SOC 824 report. To do so, county QA must be able to describe what targeted review was completed, how the topic was chosen, and describe the criteria and process used in conducting the targeted review. In addition, county QA must describe the results and what actions were taken as a result.

NOTE: Authority: Section 12305.71(d), WIC; SPA Number 13-007 Effective Date July, 2013.

Error Rate Studies

CDSS conducts error rate studies at least annually to estimate the extent of payment and service authorization errors and fraud in the provision of IHSS.

The purpose of an error rate study is to:

- Identify any duplicate Medi-Cal payments
- Examine any errors in the application of program regulations, and the authorization of services
- Prevent and detect misuse and/or abuse of program funds
- Maximize recovery of overpayments

Error rate studies will aid in identifying areas where the greatest risk for payment errors occurs. The error rate study findings shall be used to prioritize and direct State and county fraud detection and quality improvement efforts.

One method used to identify overpayments is a data match report. A data match consists of matching data elements maintained in separate locations/databases. An example of a data match is the Hospital Stay Error Rate Report which investigates payments made to a provider during the time a recipient was hospitalized. The Death Match data distributed to counties through CMIPS II is another example of an error rate study where data match is used.

County QA staff will be responsible for timely response as defined in the instructions provided by the State with each error rate study, and for resolution to requests from CDSS in examining errors and potential overpayments identified through error rate studies.

NOTE: Authority: Sections 12305.7 and 12305.71(c)(1), WIC.

REMEDIATION

Corrective Action

When county QA identifies deficiencies through the discovery process outlined in this Manual, a standardized resolution process must be followed.

County policies and procedures must include:

- A standardized process to be followed for every case QA reviewed
- Workflow steps that define the resolution process between QA, caseworkers and supervisors. The resolution process must include:
    - QA findings
    - QA recommendations
    - Opportunity to contest findings
    - Corrective actions taken
    - Resolution
- Each workflow step must define turnaround times in accordance with the following table:

Maximum timeframes for:	A finding of "**Immediate Action Required**"	A finding of "**Action Required**"
Contesting	3 days	10 days
Resolving	10 days	45 days

Note: Resolution timeframes are from the date of notification by QA, they are *not* in addition to contesting timeframes.

- A process for following up with supervisors when deadlines have not been met by the due date
- Documentation of the resolution
- Consistent communication of the results to management
- How problems which are systemic in nature are corrected and how the root cause is corrected to avoid repeating the issue.

County QA will be required to submit basic outcome data resulting from all case reviews and home visits to CDSS as part of their quarterly SOC 824 report.

When statewide systemic issues and trends are identified, CDSS QA will respond by:

- Updating regulations, as needed
- Conducting QA monitoring visits to counties
- Presenting at regional and/or statewide meetings
- Conducting workshops, training, or other technical assistance as appropriate
- Updating the program material in the IHSS Training Academy
- Issuing statewide policy directives that reflect systemic issues and system improvement

The goal for each activity is to promote remediation and system improvement statewide.

NOTE: Authority: Section 30-702.13, CDSS MPP; SPA Number 13-007 Effective Date July, 2013.

System Improvement

System Improvement is the term used in SPA 11-034 and SPA 13-007 to describe the activities called "Quality Improvement" in SB 1104. The terms are used interchangeably herein.

System improvement activities are identified through the analysis of: routine scheduled review data, targeted review data, CMIPS II reports, and feedback from program staff and other stakeholders. Activities include county-wide training, creation of job aides, and updating county policies and procedures. When requested and as appropriate, CDSS QA will work with county QA in addressing areas identified.

County QA staff must take action to resolve issues that are systemic in nature. County QA will submit outcome reports on all system improvement projects as part of their quarterly SOC 824 report. Outcome reports must describe what system improvement project was completed, how the topic was chosen, what steps or activities were completed and what the outcome/results of the project were.

NOTE: Authority: SPA Number 13-007 Effective Date July, 2013.

CRITICAL INCIDENTS

A Critical Incident is an incident which presents an immediate threat to the health and/or safety of a recipient and requires county intervention.

Critical Incidents may include but are not limited to: serious injuries caused by accident, medication error/reaction, abuse or neglect. In addition, this includes any potentially harmful natural or man-made event that threatens a recipient's life, health, or ability to remain safely in their own home. Examples of this type of critical incident include but are not limited to: fire, earthquakes, floods, extreme weather conditions, power outages and hazardous material spills.

When a critical incident occurs, counties must follow State and county policies and procedures. County policies and procedures must include how the county defines, identifies, investigates, and resolves critical incidents to ensure that appropriate and timely action is taken to enable the recipient to remain safely in their home if possible. The following must be included in the county policies and procedures:

- Follow-up procedures
- Specific turnaround times for each step of the procedures
- Documentation guidelines, in the event that a recipient requests, and the county provides, assistance with a necessary evacuation
- Up-to-date information regarding resources available on a county-wide basis such as 24-hour referral service and any other available agencies/organizations that they work with in the event of an emergency
- Clear instructions on all State and county mandated reporting requirements
- Required steps for resolution of the incident, which includes confirmation from recipient or authorized representative

In the case of a community-wide disaster or extreme weather, counties will consult the Disaster Preparedness information from CMIPS II and take appropriate action, in accordance with county policies and procedures, for recipients who will be affected by the particular event. For example, recipients who have no air conditioning may be at risk during a heat wave. Counties will follow State law as well as their county policies and procedures defining how to respond.

If during a routine scheduled review or targeted review county QA or CDSS QA identify a critical incident in the case file they shall ensure the following:

- State and county policies and procedures were followed,
- Appropriate steps were completed and documented,
- The case documentation identifies that the case was referred to the appropriate agency and
- Appropriate and timely action was taken.

If it is determined that the appropriate procedures were not followed, immediate action is required. County QA, program supervisors and staff must follow all State and county policies and procedures with regards to corrective action steps. Please refer to the Corrective Action section in this Manual for further information.

County QA will be required to submit data on critical incidents to CDSS as part of their quarterly SOC 824 report.

NOTE: Authority: SPA Number 13-007 Effective Date July, 2013.

DETECTION OF FRAUD AND OVERPAYMENT RECOVERY

A county may identify suspected fraud or possible overpayment. If this is the case, county QA must follow all State and county policies and procedures, as well as the Uniform Statewide Protocols for Program Integrity Activities.

Detection of Fraud

County IHSS staffs at all levels are responsible for reporting any incident of suspected or reported fraud and must initiate the Complaint of Suspected Fraud form (SOC 2248).

The county IHSS staff shall submit the SOC 2248 form and supporting documentation, referred to as the fraud complaint package, to the designated county staff for triage, in accordance with the IHSS Uniform Statewide Protocols for Program Integrity. County QA must also report all suspected fraud discovered as a result of QA activities to CDSS on the quarterly SOC 824 report.

Overpayment Recovery

An overpayment is any amount paid to a provider or recipient for the provision of IHSS which is:

- In excess of the amount for services authorized
- In excess of the amount for services actually provided
- Due to the recipient's failure to use total direct advance payment for the purchase of authorized hours
- Due to incorrect or nonpayment of share of cost in the IHSS-R program

In MPP Section 30-768, “overpayment” is used in relation to recipient overpayment. In MPP Section 30-769.9, “excessive compensation” is used in relation to provider overpayment. In this manual, the term overpayment refers both to the recipient and the provider, and is recoverable in most cases.

If an overpayment is determined, the county is obligated to initiate recovery action. The county must follow all State and county policies and procedures as pertains to the recovery of an overpayment. If it is also determined that the overpayment is a result of suspected fraud, the county must follow their fraud referral procedures.

County IHSS staff shall submit overpayment recovery data to CDSS as part of their quarterly Fraud Data Report (SOC 2245). County QA must also report all overpayments discovered as a result of QA activities to CDSS on the quarterly SOC 824 report.

NOTE: Authority: Sections 12305.71 and 12305.83, WIC; Sections 30-702.15 and .16, 30-768 and 30-769.9, CDSS MPP; Uniform Statewide Protocols for Program Integrity Activities.

THIRD-PARTY LIABILITY

Third-party liability refers to the legal obligation of other parties (e.g. certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for assistance furnished under a state plan. By law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. Counties are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

The existence of any of the third-party liability sources listed in MPP Section 30-702.17 may indicate one of the following:

- There are other funds available to cover the costs of services
- Lump sum payments may have been made or will be made in the future that may result in ineligibility for Medi-Cal due to excess resources
- Resources that would be counted as income may be available and may result in a share of cost for recipients who do not currently have a share of cost or in an increased share of cost for other recipients

All cases of potential third-party liability will be referred to the appropriate staff for action. If an overpayment is determined, the county is obligated to recover the overpayments. The County must follow all State and county policies and procedures with regards to overpayment recovery and/or suspected fraud. Please refer to the section on Detection of Fraud and Overpayment Recovery in this Manual for further information.

Staff who has questions about reporting third party liability may also contact DHCS Third-Party Liability and Recovery Division.

NOTE: Authority: Section 12305.71, WIC; Section 30-702.17, CDSS MPP.

QA PROGRAM VS. PROGRAM INTEGRITY/FRAUD PREVENTION PROGRAM

As is established in ACL 10-39, there are specific differences between the roles and responsibilities of QA and Program Integrity staff.

> [ACL 10-39] clarifies the responsibilities of, and distribution methodology for, the 78 county positions established to conduct program integrity and anti-fraud activities in IHSS. These activities differ from both QA responsibilities and the responsibilities associated with county anti-fraud plans.
>
> In October 2009, counties received an allocation as set forth in County Fiscal Letter (CFL) 09/10-33 for program integrity/anti-fraud positions. These positions carry responsibilities specific to the anti-fraud initiative, enacted pursuant to Assembly Bill (ABX) 4 19 (Chapter 17, Statutes of 2009) of the Fourth Extraordinary Session. These positions and their scope of responsibilities differ from those held by QA staff and from positions associated with the State-approved county anti-fraud plans. Each has a role in ensuring program integrity, including fraud prevention, detection, mitigation, and reporting within the IHSS program, yet they differ in responsibilities as shown below.
>
> <u>QA Staff</u>
>
> The IHSS QA program was established through Senate Bill 1104 (Chapter 229, Statutes of 2004), which outlined a number of enhanced responsibilities for CDSS and counties, including: routine scheduled desk reviews, home visits, targeted reviews, general verification of receipt of services, third-party liability, and cooperation with data match and error rate studies. Most counties have been performing these activities since the program's implementation in 2004. QA activities must not be duplicated in other anti-fraud components. Further clarification can be found in ACL 06-35.
>
> <u>78 County Staff for Program Integrity</u>
>
> The responsibilities associated with these positions are distinct from other fraud responsibilities, as they stem from the anti-fraud initiative. The duties of these staff are determined by each county based on need, and may include: conducting unannounced home visits, reviewing the results of criminal background checks, assisting as needed with the facilitation of provider orientations, reviewing a sample of provider timesheets, compiling and reporting fraud-related data, meeting with State and other designated staff regarding anti-fraud issues, and referring cases of suspected fraud in the IHSS program to the appropriate investigative agencies. These responsibilities supplement other anti-fraud and program integrity activities; however, the activities must not duplicate other anti-fraud activities. Claiming instructions can be found in CFL 09/10-37.

The allocation and claiming codes are different for each program. Staff time assigned to one program code cannot also be assigned to another program code.

NOTE: Authority: SPA Number 13-007 Effective Date July, 2013. Section 12305.71, WIC

JOINT CASE REVIEWS AND CDSS MONITORING

Overview

CDSS QA visits counties for the purpose of conducting case file reviews, including county-QA-reviewed files, denied applications, observes county QA conducting home visits, and reviews any existing QIAPs.

Prior to a site visit, CDSS QA reviews the county's policies and procedures, quarterly reports, annual QA/QI plans and QIAPs. CDSS also pulls data and analyzes performance. The county data is compared to the statewide averages as well as data from counties with comparable caseloads. County performance is reviewed in areas including but not limited to:

- Timely reassessment compliance rate
- Proportion of severely impaired recipients to total caseload
- Average hours assessed per case
- Average cost per case
- IHSS staff participation in State-sponsored Social Worker Training Academy
- Participation in recent data match and other error rate study activities

While CDSS may initiate a QIAP request based on some of these criteria, it is not the purpose of this analysis. This is compiled for the county's benefit and it is left with the county for their use as they see fit.

Entrance Interview

All State monitoring visits begin with an entrance interview, which includes an introduction, discussion of the county's policies and procedures and annual QA/QI plan, the comparison data, and an opportunity for the county to discuss any issues that may impact the visit or the result of the review.

Case Reviews

The CDSS QA then reviews:

- A predetermined sample of case files for correct application of State regulations and requirements, proper use of required documents, appropriate and well documented justification for services, appropriate and clearly documented reasons for exceptions to hourly task guidelines, and verification that an individualized back-up plan is in place
- If a county is using a substitute for a required form, CDSS QA must validate that the county has received permission from CDSS to do so. If the form being substituted was released after 2003, CDSS QA must validate that when the form was released the GEN 127 indicates *Substitute Permitted with Prior CDSS*

Approval

- The case narratives to identify possible issues such as provider problems, timesheet issues or questions related to the recipient's assessment and/or reassessment needs
- A sample of denied applications and case files previously reviewed by county QA
- Procedures for identification, remediation, and prevention of abuse
- Provider enrollment forms and qualifications, if available

Based on the reviews, CDSS QA staff can immediately bring the issues to the attention of county QA staff. Alternatively, CDSS QA staff may make comments and/or recommendations to the county at the conclusion of the county review. It is the responsibility of county QA staff to then follow all State and county policies and procedures with regards to corrective action steps. Please refer to the section on Corrective Action in this Manual for further information.

Home Visits

CDSS QA accompanies county QA in conducting a home visit to ensure all State and county policies and procedures are being followed. When CDSS QA accompanies county QA during a home visit, it will be as an observer only and State QA will not conduct the home visit.

Exit Interview

County QA's annual monitoring visit concludes with an exit interview. The topics covered are best practices, how State requirements were met, and positive findings and/or needed improvements. CDSS QA uses this meeting with the county as the initial opportunity to share information with county staff regarding issues that appear to be systemic.

The county is advised that CDSS QA is available to work with the county QA to remediate the issue(s), as well as to provide technical assistance with developing the annual QA plan and county policies and procedures.

Follow-Up

A site visit is followed up with a letter from CDSS QA to the director of the county department responsible for administering IHSS. Copies are sent to the county QA, the IHSS program manager and other appropriate staff, and DHCS. The letter details the site visit findings and the exit interview. Feedback is also provided in the form of a monitoring summary. Both the findings letter and the monitoring summary may contain positive feedback and areas for improvement. Counties may discuss and successfully dispute the findings to CDSS satisfaction, or correct the

discrepancies noted in the letter. In some cases, given sufficient discrepancies or discrepancies deemed very serious in nature, a QIAP request may be issued.

Based on the findings from these reviews, CDSS QA will assist counties by:

- Collaborating on the creation of county QIAP (if needed)
- Providing technical assistance

At any point during the exit interview or the follow-up process, the county has the option to correct any issues identified in the CDSS QA findings, or dispute the findings in writing. If the county disputes the findings, it must either defend its dispute to CDSS' satisfaction, or correct the issue to meet compliance standards.

Subsequent County Monitoring Visits

In preparation for subsequent county monitoring visits, CDSS QA staff review any existing monitoring documentation and existing QIAPs to ensure the county has corrected issues identified during previous visits.

NOTE: Authority: Section 12305.7, WIC; SPA Number 13-007 Effective Date July, 2013.

ANNUAL COUNTY QA/QI PLAN

Counties are required to submit an annual QA/QI Plan to CDSS no later than June 1st of each year.

The required elements of the plan are:

- A QA Annual Budget Plan for the upcoming fiscal year
- A statement from the IHSS Program Manager attesting that the county IHSS QA policies and procedures are current
- A summary explaining any noteworthy changes to the county's IHSS QA policies and procedures since the previous annual QA/QI Plan
- A brief explanation of how the county is using the information gathered through QA activities to improve the quality of the IHSS Program at the local level

Please see APPENDIX C. The Annual Budget form and instructions can be found on the CDSS – IHSS QA Forms website

NOTE: Authority: Section MPP 30-702.2, CDSS MPP; SPA Number 13-007 Effective Date July, 2013.

COUNTY QA POLICY AND PROCEDURES MANUAL

Each county is required to establish and maintain a QA Policy and Procedures Manual. The purpose of a county QA Policy and Procedures Manual is to ensure that counties are in compliance with federal and State requirements, and to promote consistency of county QA activities.

County IHSS QA policies originate from WIC and MPP, State issued releases of ACLs/ACINs/CFLs, and existing county policies. County QA policies and procedures must address all sections previously required in the annual QA/QI Plan as outlined in ACIN No. I-64-05 (Discovery, including fraud detection and third party liability, Remediation, including overpayment recovery, Critical Incidents, and Person-Centered Planning) and, at a minimum:

- Document standardized processes
- Establish specific workflow steps including:
    - turnaround times
    - staff/supervisor functions/responsibilities
    - internal approval/sign-off processes
    - reporting, documentation and follow-up requirements
- Include QA forms developed and used by the county
- Contain document control information that will identify all changes from one version of the policies and procedures to another

CDSS will:

- Provide technical assistance
- Verify that each county's QA policies and procedures includes all State and county policies and includes detailed step-by-step procedures for each
- Require counties to verify their QA policies and procedures are up-to-date annually and provide a summary explaining any changes of note since the previous annual QA/QI Plan

NOTE: Authority: ACIN Number I-64-05; SPA 13-007 Effective Date July, 2013.

UPDATES TO THE CDSS IHSS QA/QI POLICY MANUAL

As additional information and guidance are released pertaining to the IHSS program and/or QA/QI requirements, CDSS will make updates to this manual. In doing this CDSS is committing to the counties that there will be a single source for information as it relates to the IHSS QA/QI policies. Counties will be notified of changes through the established county letter system. Counties will be responsible for updating their county specific policies and procedures with the new or updated guidance. Counties will confirm the updates have been completed through the County QA/QI Annual Plan submission. Please refer to the section on County QA/QI Annual Plan in this Manual for further information.

APPENDIX A

Sample Size Determination Methodology

In order for desk reviews to have any statistical significance, the number of desk reviews conducted in each county must constitute a sample that could reasonably be expected to represent the entire IHSS caseload of that county. CDSS will notify counties of their minimum required number of desk reviews for the next fiscal year each April 15th. For information purposes only, CDSS uses the following commonly accepted method for determining representative sample size:

$$n = \frac{k^2 * N * 0.25}{e^2 * (N - 1) + (k^2 * .25)}$$

Where:	
n = Sample size	*N* = Population
k = Critical value	*e* = Margin of error

"*n,*" Sample size, is the number of desk reviews required to represent the county IHSS caseload with a degree of accuracy; this is the number that CDSS will provide to counties each April.

"*N,*" Population is the county's total IHSS caseload. For the purpose of this formula, CDSS will use the caseload as of the end of March to determine desk review requirements for the next fiscal year.

"*k,*" Critical value, based on the desired confidence level (CL), represents the level of certainty that the randomly drawn sample is representative of the county's total IHSS caseload. Based on a county's allocated number of QA full time equivalents (FTEs), CDSS will use confidence levels of 90%, 95%, or 97%, as shown below. The critical value (also called a "*Z* score") for a 90% confidence level is **1.645**; the critical value for a 95% confidence level is **1.96**, and the critical value for a 97% confidence level is **2.17**.

"*e,*" Margin of error is a +/- number range representing how closely the sample size represents the total population. Based on a county's allocated number of QA FTEs, CDSS will use a margin of error ranging from +/-3% to +/-6%.

The required confidence level (and therefore critical value) is determined for each county based on the allocated number of QA FTEs as follows:

5 or more QA FTE		4 QA FTE		3 QA FTE		2 QA FTE		.5 – 1.5 QA FTE	
e	*CL*	***e***	*CL*	***e***	*CL*	***e***	*CL*	***e***	*CL*
+/-3.0%	97%	+/-3.5%	95%	+/-4.0%	95%	+/-4.5%	90%	+/-6.0%	90%
k=	2.17	***k=***	1.96	***k=***	1.96	***k=***	1.645	***k=***	1.645

CDSS uses the following Excel tool to calculate the minimum annual number of desk reviews for each county:

A	B	C
3	*Caseload=*	
4	*k=*	
5	*e=*	
6	*n=*	

The formula for *n* in cell C6 is:

=((C4*C4)*C3*0.25)/((C5*C5)*(C3-1)+((C4*C4)*0.25))

For example, given a county with a caseload of 6,000 recipients and 3 allocated QA FTEs, the CL to be used is 95% which is a *k* of 1.96; the appropriate margin of error is +/- 4%.

Caseload = 6,000 (cell C3);
K= 1.96 (cell C4),
E = .04 (cell C5)

The minimum number of required annual desk reviews, which would appear in cell C6, is 546. Those 546 desk reviews would be 95% certain to represent the characteristics of that county's total IHSS caseload within +/- 4%. The minimum number of required home visits would be 20% of that for an annual total of 109.

IMPACT OF IMPLEMENTING NEW CASE REVIEW MINIMUMS

vs. Old Case Review Requirements (250/50)

County Size	Caseload	QA FTEs	New Desk Review Reqmt	Old Desk Review Reqmt	New Home Visit Reqmt	Old Home Visit Reqmt
V/L County (50,000+):	200,000	7	**1,300**	1,750	**260**	350
Large County (high):	49,999	3	**593**	750	**119**	150
Alameda*	20,919	3	**584**	750	**119**	150
(low):	10,000	3	**566**	750	**113**	150
Med County (high):	9,999	2	**323**	500	**65**	100
Solano*	3,961	2	**308**	500	**62**	100
(low):	1,000	2	**251**	500	**50**	100
Small County (high):	999	1	**158**	250	**32**	50
Del Norte*	318	1	**118**	250	**24**	50
(low):	26	1	**23**	250	**5**	50
V/S County (25 or fewer):	25	0.5	**22**	125	**4**	25

* Median caseload in each county size group. Data from September 2013 CMIPS II Caseload Summary Report run 9/11/2013

APPENDIX B

IHSS Quality Assurance/Quality Improvement Quarterly Activities Report and Instructions

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
ADULT PROGRAMS DIVISION
QUALITY ASSURANCE BUREAU

IN-HOME SUPPORTIVE SERVICES (IHSS) QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) QUARTERLY ACTIVITIES REPORT - SOC 824

County:	
Date Completed:	
Fiscal Year:	
Quarter:	
Name of Person Completing Report:	
Title of Person Completing Report:	
Telephone Number:	
Number of QA Staff (FTEs):	
Number of IHSS Caseworkers (FTEs):	
Number of Desk Reviews Conducted by QA:	
Number of Home Visits Conducted by QA:	
Reviewed Cases with Completed SOC 864:	
Reviewed Cases with Timely Reassessments:	

All Fields are Mandatory

1	**IHSS QA Case Reviews**				
A.	**Number of Denied Applications Reviewed**				
		CFCO	PCSP	IPO	IHSS-R
B.	**Number of Desk Reviews Completed with No Action Required**				
C.	**Number of Desk Reviews Completed Requiring Action (Indicate Results Below - Multiple Actions Can Be Reported)**				
C.1	Missing, Incorrect, or Incomplete State Form(s)				
C.2	Missing, Incorrect, or Incomplete County-Specific Form(s)				
C.3	Insufficient or inaccurate case documentation				
C.4	Increase in Service Authorizations				
C.5	Decrease in Service Authorizations				
C.6	Cases Terminated				
C.7	Fraud Referral(s)				
C.8	Suspected Overpayment				
D.	**Number of Home Visits Completed with No Action Required**				

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E.	**Number of Home Visits Completed Requiring Action (Indicate Results Below - Multiple Actions Can Be Taken)**				
E.1	Insufficient or inaccurate case documentation				
E.2	Increase in Service Authorizations				
E.3	Decrease in Service Authorizations				
E.4	Cases Terminated				
E.5	Fraud Referral(s)				
E.6	Suspected Overpayment				
2	**Critical Incidents (Identified by or reported to QA)**	CFCO	PCSP	IPO	IHSS-R
A.1	Number of cases reviewed by QA with a documented critical incident which occurred in the last 12 months				
A.2	Number of cases in which QA identified a critical incident during a home visit, or received a report involving a critical incident				
B.	**Number of Referrals Resulting From Critical Incidents**				
3	**Overpayments (Identified by or reported to QA)**	# of Cases	Amount ($)		
A.	**Overpayments Confirmed**				
B.	**Overpayment Recovery Actions Initiated**				
4	**QA Targeted Reviews**				
A.	Targeted Review Topics Completed this Quarter? (Yes/No)				
B.	Attach Targeted Review Outcome Report(s)				
5	**Quality Improvement Efforts**				
A.	Quality Improvement Efforts Completed this Quarter? (Yes/No)				
B.	Attach Quality Improvement Efforts Outcome Report(s)				

INSTRUCTIONS FOR COMPLETING IN-HOME SUPPORTIVE SERVICES (IHSS) QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) QUARTERLY ACTIVITIES REPORT – SOC 824

County – Select county name from the drop-down list.

Date Completed – Enter the date the report was completed.

Fiscal Year – Select the state fiscal year from the drop-down list.

Quarter – Select the quarter being reported from the drop-down list.

Name of Person Completing Report – Enter the name of person completing report.

Title of Person Completing Report – Enter the title of person completing report.

Telephone Number – Enter the telephone number of person completing report.

Number of QA Staff (Full Time Equivalent - FTEs) – Enter the number of QA staff positions in your county (Example: 1 full time and 1 half-time = 1.50.)

Number of IHSS Caseworkers (FTEs) – Enter the number of IHSS caseworker positions in your county.

Number of Desk Reviews Conducted by QA – Enter the number of case reviews conducted by QA this quarter regardless if an outcome has been determined.

Number of Home Visits Conducted by QA – Enter the number of Home Visits conducted by QA this quarter regardless if an outcome has been determined.

Reviewed Cases with Completed SOC 864 – Enter the number of cases reviewed by QA which included a completed SOC 864 (IHSS Program Individualized Back-up Plan and Risk Management.)

Reviewed Cases with Timely Reassessments – Enter the number of cases reviewed by QA where the case was in compliance with timely reassessment criteria. Per the definitions, compliance means that the case file had evidence of a face-to-face reassessment within the previous 12 months, OR had evidence of a face-to-face reassessment within the previous 18 months, and included clear documentation of meeting the Variable Reassessment Criteria.

Note: All fields are mandatory - If the response is zero indicate by entering the number "0". Blank fields are considered unanswered.

SECTION 1 – IHSS QA Case Reviews *Completed* During the Reporting Quarter – The required number of case reviews is 250 desk reviews, of which 50 resulted in home visits, per QA FTE staff per fiscal year. Example: If one half-time position is dedicated to QA activities, the formula would be .5 QA FTE x 250 = 125 required desk reviews, and .5 QA FTE x 50 = 25 home visits. (See ACL 06-35 (September 1, 2006) – Attachment C.)

1A. Number of Denied Applications Reviewed - Enter the number of denied applications reviewed by QA.

1B. Number of Desk Reviews Completed with No Action Required (CFCO, PCSP, IPO, IHSS-R) – Enter the number of cases reviewed by county QA staff that were found to be in compliance with State and county requirements. Cases where a case worker has successfully contested the QA findings and no changes and/or adjustments were required are to be counted under No Action Required.

1C. Number of Desk Reviews Completed Requiring Action (CFCO, PCSP, IPO, IHSS-R) – Enter the number of desk reviews conducted by QA that were found to be out of compliance with State and/or county requirements. A completed case review is one which the responsible case worker has reviewed the QA desk review recommendations and made the necessary changes and/or adjustments.

If a case required multiple corrections, report all that apply. The sum of 1C.1 through 1C.8 may be greater than the number reported in 1C.

Report the number of cases involving the following:

- 1C.1 Missing, Incorrect or Incomplete State Form(s) – Number of cases missing mandatory forms, with the wrong form(s) or forms not completed as required
- 1C.2 Missing, Incorrect or Incomplete County-Specific Form(s) – Number of cases missing forms, with the wrong form(s), or forms not completed as required by the county
- 1C.3 Insufficient or inaccurate case documentation – including justification for exceptions to HTGs
- 1C.4 Increase in Service Authorizations - An increase in the number of service hours authorized
- 1C.5 Decrease in Service Authorizations - A decrease in the number of service hours authorized
- 1C.6 Cases Terminated - The termination of a case
- 1C.7 Fraud Referral- A referral to a fraud investigation unit or agency
- 1C.8 Suspected Overpayment

1D. Number of Home Visits Completed with No Action Required (CFCO, PCSP, IPO, IHSS-R) – Enter the number of home visits completed by county QA staff where the home environment appeared to support the assessment and authorization paperwork and it appeared that the recipient was receiving adequate care. Cases where a case worker has successfully contested the QA findings and no changes and/or adjustments are required are to be counted under "No Action Required."

1E. Number of Home Visits Completed Requiring Action (CFCO, PCSP, IPO, IHSS-R) – Enter the number of home visits completed by county QA staff where the home environment did not support the assessment or authorization paperwork, or it appeared that the recipient was not receiving adequate care. A completed home visit is one which the responsible case worker has reviewed the QA home visit recommendations and made the necessary changes and/or adjustments.

If a case required multiple actions as a result of a home visit, report all that apply. The sum of 1E.1 through 1E.6 may be greater than or equal to 1E.

Report the number of cases involving the following:

- 1E.1 Insufficient or inaccurate case documentation - Based on observations the case has insufficient or inaccurate case documentation
- 1E.2 Increase in Service Authorizations - An increase in the number of service hours authorized
- 1E.3 Decrease in Service Authorizations - A decrease in the number of service hours authorized
- 1E.4 Cases Terminated - The termination of a case
- 1E.5 Fraud Referral(s) - A referral to a fraud investigation unit or agency
- 1E.6 Suspected Overpayment

SECTION 2 – Critical Incidents Critical incidents identified through QA Case Reviews or Targeted Reviews, or that were reported to QA.

A Critical Incident is defined as one in which there is an immediate threat to the health and/or safety of a participant. Critical Incidents include, but are not limited to: serious injuries caused by accident, medication error/reaction; physical, emotional or financial abuse or neglect.

2A. Critical Incidents Identified, Reported by Program (CFCO, PCSP, IPO, IHSS-R)

- 2A.1. Number of cases reviewed by QA where a critical incident had been identified, documented, and addressed by a case worker during the previous 12 months. Do not include instances which have previously been reported on a SOC 824 quarterly report.
- 2A.2. Number of cases in which QA identified a critical incident during a home visit, or received a report involving a critical incident.

2B. Number of Referrals Resulting from Critical Incidents (CFCO, PCSP, IPO, IHSS-R) – Enter the number of referrals initiated as the result of critical incidents. Examples: A referral to an agency or authority, such as Adult Protective Services, Child Protective Services, 911 or other law enforcement. Not all incidents result in a referral; conversely, a single incident can result in more than one referral.

SECTION 3 – Overpayments – Confirmed Overpayments identified through QA Case Reviews or Targeted Reviews, or reported to QA.

3A. Overpayments Confirmed – Enter the number of cases that were identified in the reporting quarter with confirmed overpayments and the total dollar amount of the overpayments. Enter only the cases identified through or reported to QA. Enter the number of cases, *not* the number of warrants involved.

3B. Overpayment Recovery Actions Initiated – Enter the number of cases identified by or reported to QA with overpayment recovery actions initiated in the reporting quarter, and the total dollar amount of the recovery actions. Initiation of overpayment recovery action means:

1. Submission of the completed SOC 312 (IHSS Special Pre-Authorized Transactions form) to Hewlett Packard with accompanying check,
2. Submission of the completed SOC 330 (Overpayment Collection Transaction form) to Hewlett Packard,
3. A negotiated repayment agreement has been reached with the overpaid party, or
4. Civil action has been filed.

SECTION 4 – QA Targeted Reviews

4A. Targeted Reviews Completed this Quarter – If you completed one or more Targeted Review this quarter, select "*YES*" from the drop down-list. If none were completed please select "*NO*."

4B. Attach Targeted Review Outcome Report(s) – See ATTACHMENT A

SECTION 5 – Quality Improvement Efforts

5A. Quality Improvement Efforts Completed this Quarter – If you completed one or more QI Efforts this quarter, select "*YES*" from the drop down-list. If none were completed please select "*NO*."

5B. Attach Quality Improvement Efforts Outcome Report(s) – See ATTACHMENT B

ATTACHMENT A

4B. Instructions for the Targeted Review Outcome Report(s)

The Outcome Report contains four sections:

Background
1. Describe the topic you chose for your Targeted Review and why

Methodology
1. Describe the criteria you used to select cases and the number of cases reviewed?
2. Describe your process for conducting this review

Outcomes
1. Describe the results.
2. Describe the lessons learned.
3. Describe the actions planned or implemented as a result of the Targeted Review. If a corrective action was implemented in this quarter, report in Section 5 - Quality Improvement Efforts.

Additional Information Required
- Provide the following information:
  - Name of person completing the Outcome Report
  - Title
  - Phone Number
- Provide any additional information that you feel is important

Please see Sample Report on next page.

SAMPLE OUTCOME REPORT – TARGETED REVIEWS (SOC 824)

Protective Supervision Targeted Review
XYZ County
April 2013

Background

1. **Describe the topic you chose for your Targeted Review and why**
   Example: Detected an increase in Protective Supervision cases. We want to ensure Protective Supervision is being assessed properly and validate that case files are accurate and complete.

Methodology

1. **Describe the criteria you used to select cases and the number reviewed**
   Example: There are 500 Protective Supervision cases county-wide, 400 are recipients 18 and over, we reviewed ten percent or forty of those cases.
2. **Describe your process for conducting this review**
   Example: The QA worker ran a CMIPS II report and identified 40 cases of Protective Supervision cases where the recipient was over 18. Using a check list all 40 cases were reviewed to check for documentation errors and incorrect authorization.

Outcomes

1. **Describe the results**.
   Example: Of the 40 Protective Supervision cases reviewed, 5 were missing required forms, 10 had errors on required forms, 15 cases were incorrectly authorized and the rest were in compliance with state and county requirements.
2. **Describe the lessons learned.**
   Example: Consistently case workers are making similar mistakes in incorrectly filling out required forms. Additionally, we identified that there was a misunderstanding on authorization of Protective Supervision by case workers hired in the last 9 months.
3. **Describe the actions planned or implemented as a result of this Targeted Review.**
   Example: Initiated a corrective-action plan to train all caseworkers on the documentation errors and authorization guidelines. (If a corrective action was implemented in this quarter, report in Section 5 of the SOC 824: Quality Improvement Efforts.)

Additional Information Required

- Name of person completing this Outcome Report: *Jen Thomas*
- Title: *QA Manager*
- Phone Number: *555-123-4567*
- *We have attached our quarterly QA Case Reviews Report broken out by caseworker and then grouped by supervisor.*

ATTACHMENT B

5B. Quality Improvement Efforts Outcome Report(s)

The Quality Improvement Efforts Outcomes Report is comprised of five questions (Please submit a Quality Improvement Outcomes Report for each QI Effort):

1. Describe the quality improvement effort you implemented and why
2. Identify who initiated the improvement effort
3. Describe what was done to prepare for and complete this Quality Improvement effort.
4. What was the outcome?

5. Additional Information Required
   - Provide the following information:
     - Name of person completing this Outcome Report
     - Title
     - Phone Number
   - Provide any additional information that you feel is important

Please see Sample Report on next page.

SAMPLE OUTCOME REPORT – QUALITY IMPROVEMENT EFFORTS (SOC 824)

Authorization of Protective Supervision - Quality Improvement Efforts
XYZ County
April 2013

1. **What quality improvement effort did you implement and why?**
   Example: As a result of a Targeted Review the QA team recognized the need to improve the manner in which caseworkers were authorizing Protective Supervision cases. This led to the development of a new training and a one page training aid on authorizing Protective Supervision.

2. **Who initiated the improvement activity?**
   Example One: The QA staff initiated training based on observations from a Targeted Review.
   Example Two: After having completed a number of case reviews the caseworkers worker supervisors asked the QA team to work with them in finding ways to improve authorization of Protective Supervision cases.

3. **Describe what was done to prepare for and complete this QI effort.**
   Example: The QA staff reviewed regulations on Protective Supervision in MPP Section 30-757.17 thru 757.17.174 as well as consulted with the QA Bureau at the State. The next step was to create a one page resource "cheat-sheet" and prepared a short training for case workers to be given at a staff meeting. QA staff also created a pre and post-test which was administered to the case workers prior to and just after the training.

4. **What was the outcome?**
   Example: Four weeks later QA checked a sample of Protective Supervision cases which had recently been assessed and found improvement in the authorization of Protective Supervision.

<u>Additional Information Required</u>

- Name of person completing this Outcome Report: *Max Richards*
- Title: *Quality Improvement Specialist*
- Phone Number: *555-222-1234*
- *We have attached a copy of the resource page created for this training as well as a copy of the pre and post-test.*

ATTACHMENT C - DEFINITIONS for SOC 824

1. **QA Desk Reviews** - Case file reviews conducted by QA staff to confirm that all required forms are present and correctly completed, to determine if participant needs appear to be correctly and uniformly assessed, to ensure that service hours are appropriately authorized, proper justification to any Hourly Task being out of the pre-defined range be provided, and case file documentation pertaining to death match reports, error rate studies, or critical incidents are documented.

2. **QA Home Visits** – A sub-sample of desk reviewed cases are selected for Home Visits. The purpose of a QA Home Visit is to observe the recipient at home to determine that the recipient's home environment supports the documentation in the case file. The QA worker will use the opportunity to help determine whether or not it appears that the recipient is getting the services authorized them, and whether hours are authorized appropriately.

3. **QA Targeted Reviews** – Based on the results of other QA activities such as Desk Reviews, Home Visits, and CMIPS/CMIPS II Reports, counties will identify criteria for Targeted Reviews. Targeted Reviews focus on a single subject and may involve case file reviews, or the review of data from other sources, such as CMIPS/CMIPS II.

4. **Quality Improvement Efforts** – Also referred to as "System Improvements", are intended to eliminate systemic problems. These may include written directives, modified procedures, new forms or tracking tools, staff training or other similar efforts. Areas of focus are determined through feedback from social workers, supervisors, QA staff or QA committees. The goal is to improve the administration of the IHSS Program or IHSS QA.

5. **Cases with Identified Critical Incidents** – A Critical Incident is defined as an incident which presents an immediate threat to the health and/or safety of a participant. Critical Incidents may include, but are not limited to: serious injuries caused by accident, medication error/reaction; physical, emotional or financial abuse or neglect, or disasters which require county intervention to protect the health and/or safety of IHSS recipients.

6. **Cases in Compliance with Timely Reassessment Criteria** – Of the Desk Reviewed cases, the number that either:
   -had evidence of a face-to-face reassessment within the previous 12 months, or
   -had evidence of a face-to-face reassessment within the previous 18 months, and included clear documentation of meeting the Variable Reassessment Criteria.

7. **Overpayment** – Any amount paid to a provider or recipient for the provision of IHSS which is:
   -in excess of the amount for services authorized or
   -in excess of the amount for services actually provided, or,
   -in Advance Pay cases, in excess of the amount paid to provider(s) by the recipient for the provision of IHSS.

APPENDIX C

Annual QA/QI Budget and Instructions

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | IHSS QA ANNUAL BUDGET PLAN | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Part 1. Quality Assurance Annual Budget Planning

A.	Personnel costs	$ -
B.	Operating expenses	$ -
C.	Travel / Training	$ -
D.	Subcontracts	$ -
E.	Equipment expenses	$ -
F.	Other expenses	$ -
	Total Expenses	**$ -**

FOR STATE USE ONLY	
Estimated Total QA Allocations	$ -
% utilization planned	
Actual Total QA Allocations	$ -
% utilization actual	

County:	
Fiscal Year:	
Date completed:	
Name of person completing QA Annual Budget Plan:	
Title of person completing QA Annual Budget Plan:	
Telephone number:	

	Item(s)	FTE / Description / Duties	Annual cost per item ($)	Total annual cost ($) A.
A. Personnel costs	PersonnelCosts			$ -

	Item(s)	Description	Annual cost per item ($)	Total annual cost ($) B.
B. Operating expenses	OperatingCosts			$ -

	Item(s)	Description	Annual cost per item ($)	Total annual cost ($) C.
C. Travel / Training	TravelCosts			$ -

	Item(s)	Description	Annual cost per item ($)	Total annual cost ($) D.
D. Subcontracts	SubCosts			$ -

	Item(s)	Description	Annual cost per item ($)	Total annual cost ($) E.
E. Equipment expenses	EquipCosts			$ -

	Item(s)	Description	Annual cost per item ($)	Total annual cost ($) F.
F. Other expenses	OtherCosts			$ -

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Part 2. Quality Assurance Annual Budget Justification

	Justification
A. Personnel costs	
	Justification
B. Operating expenses	
	Justification
C. Travel / Training	
	Justification
D. Subcontracts	
	Justification
E. Equipment expenses	
	Justification
F. Other expenses	

IHSS QA Annual Budget Plan Instructions

Part 1. Quality Assurance Annual Budget Planning

County:	Select the county that is reporting
Fiscal Year:	Select the fiscal year being reported
Date completed:	Enter the date the QA Annual Budget was completed
Name of person completing QA Annual Budget:	Enter the name
Title of person completing QA Annual Budget:	Enter the title
Telephone number:	Enter the telephone number of the contact person

A. Personnel costs

Item(s):	Enter each position/title assigned to QA.
Description / Duties:	For each line item, enter the number of staff, specify what percentage of an FTE, and include a very brief description of the assigned duties.
Annual cost per item ($):	Enter the total annual cost for each line item. If one line item includes three FTEs at an annual cost (including benefits) of $125,000 each, enter $375,000.

B. Operating expenses

Item(s):	Enter all ongoing expenses associated with QA activities.
Description:	Briefly describe each expense.
Annual cost per item ($):	Enter the total annual cost for each line item.

C. Travel / Training

Item(s):	Enter all travel/trainings for professional purposes planned for QA staff in the coming fiscal year. Include all reimbursable costs associated with travel and training.
Description:	Briefly describe each expense.
Annual cost per item ($):	Enter the total annual cost for each line item.

D. Subcontracts

Item(s):	Enter all subcontracts required for QA.
Description:	Briefly describe each subcontract.
Annual cost per item ($):	Enter the total annual cost for each line item.

E. Equipment expenses

Item(s):	Enter all equipment purchases planned for the coming fiscal year.
Description:	Briefly describe each piece of equipment, including its intended purpose.
Annual cost per item ($):	Enter the total annual cost for each line item.

F. Other expenses

Item(s):	Enter any QA expenses that are not appropriate in any of the above categories.
Description:	Briefly describe each expense.
Annual cost per item ($):	Enter the total annual cost for each line item.

Part 2. Quality Assurance Annual Budget Justification

Enter a concise but detailed justification for each category of expenses that apply from A through F.

A. Personnel costs	Enter a justification for the number of staff required for running the QA Function i.e. based on QA activities, workload, abilities required, etc.
B. Operating expenses	Enter a justification for operating expenses associated with running the QA Function i.e. monthly payments for specific expenses, average expenses on gasoline per month, etc.
C. Travel / Training	Enter a justification for all travels/trainings for professional purposes planned for QA staff i.e. number of people attaining, who will be attaining, benefits, etc.
D. Subcontracts	Enter a justification for all subcontracts to be required for QA.
E. Equipment expenses	Enter a justification for all equipment purchases planned for QA in the coming year.
F. Other expenses	Enter a justification for all expenses claimed under "Other" in Part 1.

Examples

	Item(s)	FTE / Description / Duties	Annual cost per item ($)
A. Personnel costs	QA Social Worker I	0.5 FTE QA SW I / Case reviews / Home Visits	$ 42,000
	QA Social Workers II	3 FTE QA SWs II / QA Case reviews, Home Visits, Death Match, QI	$ 375,000
	QA Supervisor	Supervises QA staff and manages QA activities in the county	$ 124,000
	Item(s)	Description	Annual cost per item(s) ($)
B. Operating expenses	Office Supplies	Paper, toner, others	$ 30,000
	Rent	Office rental in downtown	$ 90,000
	Utilities	Electricity	$ 8,000
	Official vehicles maintenance	Maintenance and gasoline for Home Visits and special assignments	$ 2,500
	Item(s)	Description	Annual cost per item(s) ($)
C. Travel / Training	IHSS Special areas	2 days training course in Sacramento for 3 QA Social Workers	$ 8,000
	Hotel	3 SWs staying 2 nights in Sacramento	$ 2,000
	Flights	3 round trip flights SD-SMF-SD for training in Sacramento	$ 1,800

	Justification
A. Personnel costs	In FY 11-12 ***"A"*** County increased its caseload from ***X*** to ***Y*** recipients and the QA Case Reviews increased from ***C*** to ***D***. In order to successfully review this number of cases we require 3.5 Social Workers and 1 QA Supervisor. We are also reviewing internal processes to improve performance indicators such as: ***a, b, c.***