

HCBS MI

1995 program began
 2002 CMS Audit 1500 clients
 2007 CMS Audit 1807 clients

Found in 2002

Found in 2002 by CMS	Found in 2007 by CMS	HCPF had promised following 2002
<p>We did not have a way to report, track and deal with client abuse, neglect, exploitation. Case managers and others did not know where to go to report such events.</p>	<p>Not fixed and problem and it has caused at least one client death by suicide when MHC staff did not accept crisis call from CM IDENTIFIED AGAIN AS A PROBLEM-PLAN TO WORK WITH EXTERNAL STAKEHOLDERS SUPPOSED TO BE IN PLACE BY MAY 31, 2007</p>	
<p>Assisted living (or Alternative Care Facilities) care is inadequate. Clients denied freedom of choice about basic issues like when to eat and go to sleep, also they are not providing activities and structure for clients during the day (which leads to increase in mental illness symptoms), also incorrect medication administration</p> <hr/> <p>CMS requested that staff at least in ACF working with these clients be trained on mental illness</p>	<p>Found that too many clients are dumped in ACF and that there are serious quality problems. Clients are not integrated in community and are not being given any activities to do. This exacerbates mental illness symptoms Still found problems of clients not having a choice about basic issues like when and what they eat. Found ACF with 68 clients in C. Springs to be like an institution with clients fearful to speak out</p>	<p>HCPF response in 2002 was that training ACF or other staff in how to work with mentally ill clients was not required by waiver and that they were not going to do it. This population has increased in ACF's as has abuse of this population.</p> <p>HCPF response re activities is that they would require posting of a schedule.</p> <p>HCPF said they would have state ombudsman do client rights training</p>
<p>Lack of guidelines for providers in dealing with drug addiction or alcoholism (active use of substances by</p>	<p>Not addressed in 2007 waiver-However 2007 waiver said clients are often not in any sort of mental health</p>	<p>Department response was punitive towards clients, considering requiring clients to be in</p>

clients in facilities)	treatment	treatment and denying services when client not in treatment. Does not acknowledge the difficulty in getting treatment.
Plan of care does not reflect client long or short term goals	Not addressed	Department response was to “add a goal section to the form” even though concern was about lack of individualized planning
case manager case load too high, not doing quarterly evaluations as required	Quarterly visits are being done although case loads are still a problem. CMS found that case loads prevent CM from being able to assure health and safety of clients	Turn over found to be serious problem –state will hold one break out session in annual conference on state plan services
Waiver did not reflect how state would monitor plans of care		Renewal waiver was supposed to address how POC would be monitored by HCPF- HCPF promised to increase case manager training and coordination with MHC staff
Communication between case managers and mental health staff lacking	Still a problem-see first item	
Clients being allowed to stay on waiver even if not using services	No longer a problem	Department passed rule clarifying that clients must use service each month.
No way to reconcile services authorized (PAR) with plan of care with what is billed	Still a problem in all waivers	Department promised to change this in both 2002 and 2007
Lack of assuring if clients are actually getting services on plan of care (clients forced to sign blank time sheets)	Found clients are not getting services on care plan—still same problems as before. Still found CM did not know how to get state plan benefits.	Department promised to fix this in both 2002 and 2007
	State has good LOC tool but should monitor to see where	State agreed to do so at annual training

	areas of additional training are needed	conference
	<p>CM knowledge about state plan services varies greatly. Recommended a QMS to monitor for ongoing consumer assessed needs and goals and what state will do when they find plan development and implementation inadequate HCPF said that they have a QMS and that service plan is going to be online July 01, 2007. They claimed to administer client satisfaction surveys in spring of 2006 and results will be discussed at meeting and process for further analysis will be presented. DID THIS EVER HAPPEN?</p>	

Other changes:

HCPF had abdicated waiver responsibility to DHS and had to take control back. However many of the best practices were done by DHS staff at the time and those functions were not transferred to HCPF. For example:

-DHS staff would meet with case managers quarterly. There are no current meetings for MI case managers at all and the only interactions are annual training for all case managers but not all case managers are able to attend. CM indicated in 2002 that they needed more training, not less and that they needed training to be in their local community.

-HCPF was going to require that survey information on providers be sent to DHS. That never translated to getting the surveys to SEP agencies when they took over.

Questions on 2007 responses:

-In 2007 audit HCPF said it was meeting with internal and external stakeholders about the problems—has this happened? Who has been involved? There is one ongoing group dealing with ACF issues but very little is being done in this regard and staff are needing to be persuaded that the problems are real. (CHECK WITH KELLY).

-HCPF is to design a component on ACF training on hwo to work with people with SMI. Who is designing and implementing this training?

HCPF promised to work with external stakeholders on how to track problems in the system by 5/31/07. (ASK NAMI, ED KNIGHT, AMY, CAROL, OTHERS IF THIS

HAPPENED). There is also supposed to be an action plan from ACF's about how they are going to change to become less like an institution. THIS WAS DUE AUGUST 01, 2007.

-HCPF is supposed to work with DPHE on making ACF more home like so hopefully this will become an issue on surveys. What specific areas will change?

-The MHC that did not cooperate and resulted in a suicide in Western CO—CCDC submitted a report in (check date) about the problems in this area specifically related to LTC services for people with mental illness. There was never any response.

-CCDC in this report also identified that clients were not getting services identified on the care plan.

Relevant to both audits:

SEP agencies have been repeatedly told by HCPF that they are NOT to arrange or deal with state plan benefits. They are told they are only to deal with HCBS benefits. They do not get training from the state on state plan benefits, some have sought voluntary training from CCDC.

2004-CMS Audit of Community Mental Health-