

Waiver Review Project Report  
HENNEPIN COUNTY  
Executive Summary

MARCH 2007



Minnesota Department of **Human Services**

Prepared with the assistance of

the **ImproveGroup**<sup>™</sup>

## Acknowledgements

This report was prepared by the Minnesota Department of Human Services with assistance from the Improve Group. The findings presented in this report are based on a comprehensive review process made possible through the help and assistance of Hennepin County.



### ABOUT THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

The Minnesota Department of Human Services helps people meet their basic needs by providing or administering health care coverage, economic assistance and a variety of services for children, people with disabilities and older Minnesotans. The Minnesota Department of Human Services touches the lives of one in four Minnesotans with a variety of services intended to help people live as independently as possible. DHS is the state's largest agency, with an annual budget of approximately \$8 billion and 6,600 employees located throughout Minnesota.



### ABOUT THE IMPROVE GROUP

The Improve Group is an independent evaluation and planning firm with the mission to help organizations deliver effective services. The research design, data collection, analysis and reporting expertise of the Improve Group particularly emphasizes building the capacity of local organizations to make information meaningful and useful.

## Executive Summary

In January and February 2007, the Minnesota Department of Human Services conducted a review of Hennepin County's Home and Community Based Services (HCBS) programs. Hennepin County is an urban county located in east-central Minnesota. Its county seat is located in Minneapolis, Minnesota and the County has 45 cities and one township. Hennepin County's 2005 population estimate was 1,119,364 and it serves 7,746 people through the HCBS programs. The on-site review resulted in a number of identified best practices, recommendations for improvement and required corrective actions.

### Introduction and Methods

The primary goal of the Waiver Review Project is to support the assurances that the Minnesota Department of Human Services (DHS) makes to the Centers for Medicare & Medicaid Services (CMS) about Home and Community Based Services. The HCBS programs, including five waivers (EW, CAC, CADI, TBI, MRRC) and the Alternative Care program, are overseen by the Minnesota Department of Human Services. When developing the Waiver Review Project, DHS intended to both monitor compliance with state and federal regulations and identify successful practices that improve the quality of service to HCBS participants.

The Waiver Review Process employed seven methods for collecting data to substantiate the State's assurances: (1) participant case files (491 total); (2) contracts held by Hennepin County for services (21 total); (3) policies developed by Hennepin County to guide it in administering the HCBS programs; (4) a survey instrument completed by County staff (190 total); (5) interviews with administrative and supervisory staff (10 total); (6) focus groups of staff working across the six HCBS programs (3 total) and (7) County operational indicators developed using state data. Much of the data was collected on-site through a four-week site visit. This systematic review process will be applied to all counties and health plans over the next five years. We reviewed both electronic and paper case files; the findings below reflect our review of both versions.

The HCBS quality framework developed by the Centers for Medicare & Medicaid Services<sup>1</sup> was used as a guiding force for this review and includes the following seven framework areas: (1) Participant Access; (2) Person-Centered Planning and Delivery; (3) Provider Capacity and Capabilities; (4) Participant Safeguards; (5) Participant Rights and Responsibilities; (6) Participant Outcomes and Satisfaction and (7) System Performance.

## Waiver Review Findings- County Strengths and Promising Practices

The following findings around Hennepin County's promising practices and strengths are drawn from reports by County staff, reviews of participant case files and provider service contracts and observations made during the site visit.

- The county has become a principle-driven business, applying the principles of strong connections to consumers, consumer driven service markets, flexibility, simplicity, equity and consumer control. These principles have guided the county in making many policy and operational changes, allowed for creative and "out of the box" solutions, maintained a strong consumer focus in the agency and have broken down traditional barriers of working across programs, functions and disciplines.
- Care planning for the LTCC programs participants was strong and complete, especially for people with special needs. For all LTCC programs, the majority of care plans reviewed for the LTC programs (83%) met or exceeded documentation expectations of participant goals and outcomes in the care plan; of those, 6% exceeded documentation expectations for goals and outcomes. For the LTCC waiver programs with special care plan requirements (CAC and TBI), the special care plan requirements were met. All (100%) of CAC participants had the required CAC Application/Reassessment Support Plan, and most (97%) of TBI participants had the TBI Waiver Assessment and Eligibility Determination form.
- The MRRC care plan format includes excellent documentation health and safety concerns. 96% of MRRC care plans met or exceeded documentation expectations of health and safety concerns, 44% of which exceeded expectations. Although not

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<sup>1</sup> [http://www.cms.hhs.gov/HCBS/04\\_CMSScommunications.asp#TopOfPage](http://www.cms.hhs.gov/HCBS/04_CMSScommunications.asp#TopOfPage)

required, 73% of MRRC care plans included complete emergency contact information. In addition, MRRC care plans had high-quality content to allow service planning.

- Hennepin County attempts to address challenges with creative solutions. For example, when the County had difficulty completing screenings on time, it carried out a business redesign of the intake and assessment process to meet the increasing demand. The County developed similar innovations where it was seeing backlogs in MRRC screenings and children's transitions. When a practice is found to be successful, the County makes an effort to adopt them County-wide.
- Hennepin County recognized an internal need to manage the quantity of information available about policies, service providers and best practices around a variety of topics such as PCA and Behavioral Health. To manage the quantity of information, the County assigned responsibility for different topical issues to staff. Each staff person responsible for a given area (ex: some staff are assigned to monitor PCA issues) tracks changes in the field and is in charge of fielding questions from their coworkers about the topic.
- Currently, Hennepin County has many agencies available to their participants, with one provider for every 6.2 participants. Staff reports that there is strong culturally-appropriate provider capacity in the County, and they are able to connect participants with the services they need including non-English speakers and people with mental health needs. The County is taking steps to solicit and help develop specialized providers to meet local needs and is working with other metro counties to reshape existing services through new provider solicitations. Its work on employment and alternative services exemplify this practice.
- Hennepin County uses a person-centered approach to service delivery. They offer community training to participants about programs and providers and participate in fairs where participants can meet providers. They also work to ensure participant choice, with documentation of participant choice in 87% of LTCC cases reviewed (although only 72% in MRRC). The County makes use of Consumer Directed Community Supports (CDCS), with 498 participants using CDCS options in 2005; there was a large increase in CDCS use in the county between 1999 and 2001, but a decline between 2004 and 2006 due to reductions in State-set budget limits.

- Hennepin County has focused their efforts to reduce the number of residents under 65 years of age and residing in nursing homes. Over the last two years, the County has reduced the number of people under 65 residing in nursing homes by 114 or 10.6%. Not only has this initiative provided home and community based options and opportunities for these people, but has also saved the County about an estimated \$500,000 per year.
- Hennepin County has excellent policies, procedures and business practices for executing, monitoring and enforcing contracts. All (100%) contracts were current for services provided and signed within 30 days of the date the contract was executed. Additionally, all contracts reviewed (100%) incorporate basic participant outcomes and include procedures for monitoring whether these outcomes are achieved and if contract services are provided as expected. The County has strong resources for executing and maintaining contracts and has developed contract protocols which easily allow for the customization of contracts across waiver programs.
- Hennepin County also has well-established quality assurance efforts. They conduct participant surveys and quality reviews of providers on-site. All contracts provided documentation that quality service measures are in place; for example, there are performance measures and basic outcomes incorporated into each provider contract. The County has processes to monitor these contracts through site visits of providers at least once every two years.

## Waiver Review Findings- County Barriers and Areas for Improvement

The following findings around Hennepin County's barriers and areas for improvement are drawn from reports by the County's staff, reviews of participant case files and provider service contracts and observations made during the site visit.

- Overall, there is frequent turnover of staff and reassignment of cases, and a rapid pace of change which effects staff morale and service quality. There was significant variation in the quality of care plans, frequency of visits and contact and follow-through on provider issues from case manager to case manager.
- In this review, 68 out of 149 MRRC cases were missing information in the electronic systems; several documents were later found in hard copies. Although Hennepin County is moving to greater use of technology, case managers overwhelmingly

reported that the current systems hinder rather than support their daily work. Additionally, while the Diamond system used by the MRRC program has many attributes, currently documents are not scanned in a timely manner and many are mislabeled.

- Sixty percent (64%) of all LTC cases did not have a completed OBRA Level One form in the case file. In addition, very few MRRC case files (1%) included documentation that the ICF/MR Level of Care was reassessed annually. It is required that LTC case files have an OBRA Level One form and that MRRC case files have an updated ICF/MR Level of Care assessment that is updated annually.
- Overall 69% of CCT cases did not include emergency contact information and 83% of CCT cases did not include a complete back-up plan in the care plan. A back-up plan and emergency contact information are required in care plans for participants receiving services through the CAC, CADI and TBI waivers to ensure health and safety needs are being met in the community.
- The care plan forms used by Hennepin County do not meet all requirements and are used inconsistently. In LTC care plans, provider names and the frequency and duration of services are not always included. In addition, participant needs were rarely documented in either LTC or MRRC care plans. In LTC case files, participant needs were not reported in 66% of the care plan documents, including 50% of TBI cases, 63% of AC cases, 66% of EW cases and 69% of CADI cases. In the MRRC case files, there were multiple cases where a change in needs was apparent from case notes but no updated screening was completed.
- Required signatures were frequently missing in MRRC case files, with screening documents not existing or when they did exist were not signed and dated. 14% of MRRC care plans were missing the required signatures, and another 21% were missing a portion of the signature such as the date; only 65% of MRRC care plans were signed completely. In cases where there is a public guardian, either only one case manager signed the MRRC screening form and care plan or there was no signature at all. In other cases there were notes in the case files that care plans had been sent out for signatures and not returned.

- Evidence of informed consent or participants being informed of their rights was not found, particularly in MRRC cases. Of the reviewed MRRC case files, only 49% showed documentation of informed consent and 78% that participants were informed of their rights.
- While some participants received more frequent visits, case managers do not conduct face to face visits with participants as specified in statute for significant portion of the cases reviewed. In particular, there were some CDCS participants who were seen on a less-than-annual basis. Participants in the MRRC and AC programs receive the fewest visits, with 46% and 43% respectively seeing case managers just once per year. The frequency of visits was indeterminate from case file review for 17% of participants across all waiver programs.
- There were contradictions between the needs and services indicated in the screening, assessment and care plan documents and a lack of continuity was noted by reviewers in 33% of cases overall. In particular, assessment data did not always support that reported in the screening document and the assessment narrative did not always document any ADL or IADL needs of the participants. Thirty-eight percent of CADI (57 out of 150 cases), 36% of MRRC (54 out of 149 cases), 32% of EW (37 out of 115 cases), 30% of CAC (3 out of 10 cases), 22% of TBI (7 out of 32 cases) and 17% of AC (6 out of 35 cases) cases were considered to have a lack of continuity across these documents.
- Initial assessments are not completed within the required time limit. In 2005, 25% of participants in the elderly programs and 25% of participants in the CCT programs had assessments completed within 10 working days of referral.
- Overall, there was no difference in quality of documentation or frequency of visits between contracted and staff case managers; the limitations seen were evident regardless of who managed the case.

## Recommendations and Corrective Action Requirements

The following are recommendations and required corrective actions developed by the Waiver Review Team. The recommendations are intended to be ideas and suggestions that could help Hennepin County work toward reaching their goals around HCBS program administration. Corrective action requirements are areas where Hennepin County was found to be not in

compliance with state and federal requirements and will require a response by Hennepin County.

## Recommendations

The following recommendations would benefit Hennepin County and its HCBS participants.

- Continue and expand County efforts to outreach and connect with consumers earlier in the process at hospitals and nursing homes so consumers can be presented information about program options before they make placement decisions. This recommendation is based on the information that even though Hennepin has very strong home and community based capacities that can serve persons with high needs, there are still many persons that go directly into nursing homes.
- Ensure relationships with participants are maintained through more frequent visits, smoother transitions when new case managers are assigned and better documentation in files of participant needs. Building a strong relationship is one of the best ways to assure service quality and responsiveness for participants.
- Address systems issues that impact the ability of case managers to ensure person-centered planning and delivery. These include creating protocols and procedures that address the lack of documentation available in files and the difficulty of finding information in the Diamond system. In addition, create or adapt forms that include all of the required assessment and care plan elements and ensure consistent implementation.
- To maximize CCT waiver allocations, revise encumbrance practices to better align authorized levels of services with the actual use of those services. Consider service areas such as case management, adult day care, independent living skills and extended transportation where typically only 60% or less of the authorized amounts are used. These monies could then be used to continue the County's efforts on relocating persons from nursing homes, expanding vocational opportunities, or meeting other needs for waiver recipients in these programs.
- Secure the signed signature pages on host county contracts. Continue efforts to assure provider quality by more fully implementing quality assurance measures and

participant satisfaction surveys and link results back to provider contract performance.

- Continue to develop a case file check list. The use of this checklist is a good way to assure compliance with program requirements and ensure that participants make informed decisions and that their rights have been protected. Additionally, the practice of using a checklist assures consistency in program administration during times of turnover. Continue and expand efforts to have supervisors audit case files and participant information to increase oversight.
- Develop protocols and training to ensure that contracted case managers are meeting all requirements such as case file documentation and required visits. Because these items are required both by law and by Hennepin County's contracts, improved monitoring systems can ensure performance.

### Corrective Action Requirements

The following are areas in which Hennepin County will be required to take corrective action. All of these requirements are applicable to both County staff and contracted case managers.

- Beginning immediately, all future care plan development must be completed and signed by all relevant parties within ten (10) days of the assessment or reassessment date for all waiver programs serving persons with disabilities (CAC, CADI, TBI). This is required for all CCT programs. Overall, only 80% of waiver programs serving persons with disabilities administered by Hennepin County met this standard, and only 79% of CADI and 78% of TBI participant cases met the requirement for completion of care plans within 10 days of assessment. A compliant practice would produce on-time care plans at least 90% of the time.
- Beginning immediately, for all HCBS participants with public guardianship, designate separate case management and guardianship roles so each participants has different people serving this function. For HCBS participants with public guardianship, it is required that one staff maintains the role of case manager and a separate person maintains the role of guardian. This must be documented by separate signatures on all

full-team screenings, service plans, releases and other forms requiring consumer signature.

- Complete an OBRA Level One form for all participants of LTC programs (EW, AC, CADI, CAC and TBI) that do not have one, in the next 30 days.<sup>2</sup> Maintain a copy of this completed form in the participant's case file. Only 35% of LTC cases had this documentation in the case file. It is a requirement that this form be in the case file and it is considered a promising practice to update this form yearly.
- Complete ICF/MR level of care documentation for participants in the MRRC program that do not have one in the next 30 days.<sup>3</sup> Maintain a copy of this completed documentation in the participant's case file. It is a requirement to update this form with case manager signature annually. 1% of MRRC cases had the required documentation.
- Beginning immediately, ensure that all MRRC screening documents and care plans have signatures. All care plans must be updated at the next ISP update so that within 12 months all required signatures and dates are included on the screening document and care plan.
- Ensure and document that participants are informed of their rights and have agreed to release information. An informed consent form can be used to document that participants are informed of their rights.
- Ensure that assessments and care plans include all required documentation for all participants, including participant needs, emergency contract information for all LTC waivers and back-up plans for the CAC, CADI and TBI waivers. All care plans must be updated within 6 months.

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<sup>2</sup> The OBRA Level One form can be accessed at:  
[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id\\_000688](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_000688)

<sup>3</sup> The ICF/MR Level of Care form can satisfy this documentation requirement. The form can be accessed at:  
[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id\\_000688](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_000688)

- Beginning immediately, improve timeliness of assessments so that at least 80% occur within 10 days of referral. State law requires that LTC screenings should be conducted within 10 days of a request for screening. Currently, 25% of LTC screenings for AC and EW participants and 25% of LTC screenings for CCT participants occur within this time frame. If a screening cannot take place in required time period, document the reason for the delay in the client record.
- Beginning immediately, case managers must conduct face to face visits with participants as specified in statute. Findings from the case file review indicate that 46% of MRRC participants did not have semi-annual case manager visits, 21% of EW and 14% of AC participants did not receive a case manager visit in the last year and that 37% of CADI participants did not receive two case manager visits in the last year. Review and update all cases to ensure visits are completed according to requirements.
- Complete new screening documents for all participants when significant changes occur in the areas of needs or services and input the data from screening documents into MMIS at each assessment and reassessment. Significant changes are those that result in changes or additions to needs, services or service limits.

## Appendix F: Glossary of Terms

*AC* is the Alternative Care program

*CDCS* refers to Consumer-Directed Community Services

*CAC* is the Community Alternative Care Waiver

*CADI* is Community Alternatives for Disabled Individuals Waiver

*CCT* refers to the CAC, CADI and TBI programs, which serve people with disabilities

*CMS* is the federal Centers for Medicare & Medicaid Services

*Disability waiver programs* refers to the CAC, CADI and TBI Waiver programs

*EW* is the Elderly Waiver

*DHS* is the Minnesota Department of Human Services

*HCBS* are home and community-based services for persons with disabilities and the elderly: For the purpose of this report, HCBS include the Alternative Care program, CAC, CADI, Elderly, MRRC and TBI Waivers

*Home care services* refers to extended home care services, including personal care attendant services

*Individual Plan of Care* is the service plan developed by the HCBS participant's case manager (also referred to as Community Support Plan, Individual Support Plan and Individual Service Plan)

*MRRC* is Mental Retardation and Related Conditions and refers to the program serving persons with developmental disabilities

*Local Lead Agency (LLA)* is the local organization that administers the HCBS programs: LLA may be a county department, health plan or tribal community

Participant *case files* were examined for much of the evidence cited in this report. They included the written participant records and information of case management activity from electronic tracking systems

*Operational process*- refers the actual methods and activities used by a LLA to accomplish business objectives

*Promising practice*: An operational process used by the LLA that consistently produces a desired result beyond minimum expectations

*Participants* are individuals enrolled and receiving services in a HCBS program

*Policies* are written procedures used by LLA's to guide their operations

*Provider contracts* are agreements for goods and services for HCBS participants, executed by the LLA with local vendors

*Site visits* were conducted to collect most of the data used in this report

*TBI* is the Traumatic Brain Injury Waiver