



**Waiver Review Initiative Report
RICE COUNTY**

November 2010



Minnesota Department of **Human Services**

Prepared with the assistance of

the **ImproveGroup**[™]

Acknowledgements

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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 September 2010, the Minnesota Department of Human Services conducted a review of Rice County's Home and Community Based Services (HCBS) programs. Rice County is a rural county located in south central Minnesota. Its county seat is located in Faribault, Minnesota and the County has another six cities and 14 townships. In Fiscal Year 2009, Rice County's population was approximately 62,723 and it served 917 people through the HCBS programs. In 2006, Rice County had an elderly population of 11.4%, placing it 76th (out of the 87 counties in Minnesota) in the percentage of residents who are elderly. More than nine percent (9.2%) of Rice County's elderly population are poor, placing it 67th (out of the 87 counties in Minnesota) in the percentage of elderly residents who are poor. In Rice County, 18.57 out of every 1,000 persons had a 2006 federal disability determination,¹ placing it 74th (out of 87 counties) in the proportion of residents with a federal disability determination.

Public Health is the lead agency for the EW, AC, CAC, CADI and TBI programs and Social Services is the lead agency for the DD program. The County is working to move management and administration of the CAC, CADI and TBI (CCT) programs to Social Services. The County provides care coordination for the UCare and Blue Plus managed care organizations. Each waiver program is managed slightly differently. The DD-program conducts single-person screenings through social workers. There is one social worker in Public Health who takes intakes and completes all of the initial LTCC with CADI, TBI, EW and AC participants. The County does dual initial assessments with the social worker in Public Health and a public health nurse for potential CAC cases and for other participants with high medical needs. Participants with adult mental health targeted case management and waived services have two case managers. CADI participants who receive Rule 185 DD case management have two case managers.

Between 2003 and 2008, enrollment in the EW and AC waiver programs has increased 9% from 291 to 317 participants (an increase of 26 participants); while enrollment was down in the AC program by 78 participants during this timeframe, the number of EW participants rose by 104 participants. During the same time frame, the number of participants with higher acuity in the EW and AC programs (case mix "B" and above) grew by 74 participants. This indicates

¹ This includes persons using social security insurance (SSI), old age, survivors, and disability insurance (OASDI) and persons with dual federal determinations.

that much of the growth in Rice County's elderly population has come from an increase in enrollment of participants with high needs.

Between 2003 and 2008, enrollment in the CCT waiver programs has increased 71% from 92 to 157 participants (a gain of 65 participants). During this time frame, the number of participants with higher acuity in the CCT programs (case mix "B") grew by 46 participants. This indicates that much of the growth in Rice County's CCT population has come from an increase enrollment of participants with high needs.

Between 2003 and 2008, enrollment in the DD waiver program has declined 7% from 236 to 220 participants (a decline of 16 participants). During this time frame, the number of participants with higher acuity in the DD program (profile 1, 2 or 3) declined by 8 participants.

Introduction and Methods

The primary goal of the Waiver Review Initiative 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 and DD) and the Alternative Care program, are overseen by the Minnesota Department of Human Services. When developing the Waiver Review Initiative, DHS intends 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; (2) contracts held by Rice County for services; (3) policies developed by Rice County to guide it in administering the HCBS programs; (4) a survey instrument completed by County staff; (5) interviews with administrative and supervisory staff; (6) a focus group of staff working across the six HCBS programs; and (7) County operational indicators developed using state data. Seventy-seven (77) case files and eleven (11) provider contracts were examined during the Rice County visit. The systematic way the data was collected during this review will be used in other lead agency waiver reviews over the next several years. Much of the data was collected on-site through a three-day site visit process during which participant records and contracts were reviewed and staff participated in interviews and the focus group.

The HCBS quality framework developed by the Centers for Medicare & Medicaid Services² 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 Rice 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.

- Case management in Rice County is strong. The case managers build relationships with families and advocate for participants. Case managers are responsive to changing participant needs, and frequently consult each other on cases. Case managers are knowledgeable about resources and informal supports in the communities they serve, and access these and regional resources to serve their participants. They have good working relationships with participants and have good continuity over time. They spend a lot of time out in the community in contact with participants. Across programs 92% of participants in the programs for longer than a year were seen on at least a biannual basis, including at least 72% of elderly participants, of these 25% were seen at least quarterly. Frequent face-to-face visits help establish and maintain trusting relationships between the participant and case manager.
- Rice County has a strong practice for managing waiver budgets as a team. Case managers must request approval from the unit for any budget changes over \$500. For the DD waiver program, Rice County had a 3% balance at the end of calendar year 2009. Rice County's DD budget balance is smaller than both its cohort (9%) and the statewide average (9%). For the CAC, CADI and TBI programs, Rice County had a 5% balance at the end of fiscal year 2010.
- The individual service plan format template used in the DD waiver program is especially strong. Twenty-one out of 22 DD care plans exceed documentation

² http://www.cms.hhs.gov/HCBS/04_CMSCommunications.asp#TopOfPage

expectation of participant health and safety and participant needs and fourteen of 22 DD cases exceed documentation expectations of goals and outcomes. Though not required, all 22 DD care plans also included emergency contact information.

- Outreach to elderly participants is considered a strength in Rice County. Case managers are well known throughout the community. County staff are connected with other agencies that serve participants, such as hospitals and nursing homes. Public Health staff present information about the LTC programs to elderly community groups, at county fairs, and at senior and health expos. Public Health prints a publication once a year about programs, and senior centers provide information and brochures to publicize programs.
- Rice County uses fewer nursing home services (2.79 per 1,000 residents) than the statewide average (3.69 per 1,000) and when compared to a cohort of similarly sized counties (3.97 per 1,000). Rice County ranks as the eleventh-lowest user of nursing homes out of all 87 counties in the State.
- Rice County has a strong provider capacity to serve participants in community settings. Rice County serves more CCT participants in community settings (as opposed to institutional settings) compared with most other counties in the state. Rice County ranked 10th out of 87 counties for the CCT program in the percentage of participants served in the community versus institutional settings. In 2008, 95% of persons with disabilities were served in the community in Rice County, which is a higher rate than in 2006 (92%), its cohort (92%) and the statewide rate (91%).

Waiver Review Findings- County Barriers and Areas for Improvement

The following findings around Rice 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.

- One DD case (out of 22 cases), one CAC case (out of 7 cases), two CADI cases (out of 12 cases) and one TBI case (out of 3 cases) reviewed did not include a current care plan developed by the case manager. The care plan is the only document that the participant signs that indicates the participant's needs, their service plan, health and safety information and their goals for the HCBS programs. It is required that all participants in HCBS programs have a current care plan that has been completed within the past year.

- In Rice County, two out of three TBI cases were missing documentation of a back-up plan and complete documentation of emergency contact information. Additionally, four out of twelve CADI cases and one out of three TBI cases reviewed included partially completed back-up plans that did not include documentation of back-up staffing. It is required that all participants in CCT programs have a back-up plan with emergency contact information as part of a participant's care plan.
- Eight out of 22 DD cases, two out of three TBI cases and two of twelve CADI cases did not have completed documentation of informed consent to share private health care information included in the case file. It is required that all HCBS participants have a completed documentation of informed consent included in their case file. In six cases with a DD participant under public guardianship, the case file did not include informed consent with a documented signature from the County representative acting as the guardian.
- Some care plans were not completed within ten days of assessment for the CCT programs. In Rice County, two out of twelve CADI cases and two out of three TBI cases were not completed within this timeframe.
- Some CADI, DD and EW care plans were missing required signatures. Three out of 25 EW care plans and two out of 12 CADI care plans were signed by the case manager, but not the participant, and therefore did not include documentation of participant choice. One out of 25 of EW care plans reviewed has a participant or legal representative signature but not a case manager signature. One out of 22 DD care plans were signed but not dated by the participant. One out of 25 EW care plans reviewed was missing both the case manager and participant or legal representative signatures and therefore did not include documentation of participant choice. Another CAC case and two more EW cases were missing documentation of participant choice because the choice questions on the care plans were left blank.
- Some DD cases did not include current ICF/MR level of care documentation. It is required that ICF/MR level of care criteria are reviewed annually for DD participants and that the findings are documented in the case file. Two of the 22 DD cases did not have ICF/MR level of care documentation in the case file and another two DD cases had documentation that was not current.

- None of the three TBI cases included a TBI Waiver Assessment and Eligibility Determination Form.³ It is required that this form is completed annually and that the findings are documented in the case file.

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 Rice County work toward reaching their goals around HCBS program administration.

Corrective action requirements are areas where Rice County was found to be inconsistent in meeting state and federal requirements and will require a response by Rice County.

Correction actions are cited when it is determined that a pattern of noncompliance is discovered. There may be needed follow-up with individual participants when the noncompliance is more incidental in nature.

Recommendations

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

- Provide more oversight for case managers through supervision and periodic supervisory audits of case files. Developing a formal process for auditing documentation in case files, such as a supervisory checklist or peer review system, can ensure that all case managers understand expectations for documentation and are held accountable for maintaining their case files. Some variation in the quality of case file documentation was noted.
- Consider using paid contracted case management services to serve participants that live out of the County and to serve culturally specific populations in the waiver programs. Counties have found that contracted case management in these types of situations improves care oversight and the effective use of case management time, as well as to increase capacity in serving culturally diverse participants. In such cases, the County still needs to maintain administrative case management functions

³ The TBI Waiver Assessment and Eligibility Determination Form (DHS-3471) can be accessed at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_000688

within Rice County, including a case file with current documentation of all required paperwork.

- Use a Request for Assistance (RFA) process or work with existing provider networks to develop person-centered homecare packages to support participants in their homes, even those with more challenging needs. Person-centered service packages that include assistive technology, home modifications, ILS services, transportation, and homecare services will help support participants in their homes. When developing these services, work across programs to ensure they can be accessed by all participants regardless of their waiver.
- Provide more guidance, oversight and support for LTC case managers in developing care plans that identify and document all participant needs. Train staff on how to more completely use current care plan formats; this will provide for thoroughness and consistency across cases. Out of the 55 LTC cases reviewed, one had no participant needs identified and eleven had documentation of needs significantly below those identified on the screening and assessment forms. Consider adopting a care plan that includes caregiver needs. Out of the 77 cases reviewed, only 26% of case provided documentation where a caregiver was identified and addressed caregiver needs in the care plan.
- Consider using a shared network drive to access documents across agencies. Other Counties have found a shared network drive to be useful for accessing required forms and case file documents. Work to devise a system to effectively update the shared network drive to ensure that all required forms are easy-to-access and up-to-date.
- Rice County is moving the management of the CCT programs from Public Health to Social Services. During this process be careful to ensure that the workload distribution does not become overwhelming for case managers. Monitor workloads closely and make necessary adjustments when appropriate, especially as participants are added to case managers' caseloads. The CCT programs have the potential to grow rapidly in Rice County. Between 2003 and 2008, the CCT programs increased by 65 participants.
- Consider training adult mental health and DD case managers about CADI program requirements to provide more streamlined services for participants. Currently, participants with mental health needs or who receive Rule 185 DD case management may have two case managers; one for the CADI waiver case management and one for

the mental health case management or Rule 185 case management. Cross-training could also help integrate mental health services across the waivers and reduce the number of case managers assigned to a single participant.

- As you move the CCT programs to Social Services, consider developing or adopting a single, integrated care plan that meets all requirements for waiver participants that receive mental health case management. This would help streamline services for participants across multiple programs, as participants could reference one care plan document for all of their program needs.
- Require LTC residential and day providers, including assisted (customized) living and homecare providers, to submit quarterly reports on participant's progress to case managers. Consider adding provider reporting requirements in contract attachments. This is an additional way Rice County can monitor provider performance.

Corrective Action Requirements

The following are areas in which Le Sueur County will be required to take corrective action.

- Beginning immediately, ensure that case managers develop a current care plan for all participants that do not have one. One DD case (out of 22 cases), 1 CAC case (out of 7 cases), 2 CADI cases (out of 12 cases) and 1 TBI case (out of 3 cases) reviewed did not include a current care plan developed by the case manager.
- Include a back-up plan and emergency contact information in the care plan of all CADI and TBI participants.⁴ All care plans must be updated with this information within six months. This is required for all CCT programs to ensure health and safety needs are being met in the community. In Rice County, two out of three TBI cases were missing documentation of a back-up plan and complete documentation of emergency contact information. Additionally, four out of twelve CADI cases and one out of three TBI cases reviewed included partially completed back-up plans that did not include documentation of back-up staffing.
- Beginning immediately, ensure that each participant case file includes signed documentation of informed consent. Eight out of 22 DD cases, two out of three TBI

⁴ A sample back-up plan with emergency contact information can be accessed at:
http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs_id_048151.pdf

cases and two of twelve CADI cases did not have completed documentation of informed consent to share private health care information included in the case file. In six cases with a DD participant under public guardianship, the case file did not include informed consent with a documented signature from the County representative acting as the guardian.

- Beginning immediately, ensure that the completion of care plans for CCT cases occurs within 10 days of the assessment. MN statute 256b.49 subd 13.(2) requires that care plans be completed within 14 days (10 business days) of the completion of the assessment. Currently, two out of twelve CADI cases and two out of three TBI cases were not completed within this timeframe.
- Beginning immediately, ensure that all care plans have the two required signatures and include documentation of participant choice. It is required that the care plan is signed and dated by the case manager and either a participant with their own guardianship or a participant's legal representative. Three out of 25 EW care plans and two out of twelve CADI care plans were not signed by participant but were signed by case manager and therefore did not include documentation of participant choice. One out of 25 of EW care plans reviewed has a participant or legal representative signature but not a case manager signature. One out of 22 DD care plans were signed but not dated by the participant. One out of 25 EW care plans reviewed was missing both the case manager and participant or legal representative signatures and therefore did not include documentation of participant choice. Another CAC case and two more EW cases were missing documentation of participant choice because the choice questions on the care plans were left blank.
- Complete ICF/MR level of care documentation for all participants in the DD program that do not have this documentation in the next 30 days. Maintain a copy of the findings in the participant's case file. It is required that ICF/MR level of care criteria are reviewed annually for DD participants and that the findings are documented in the case file. Two of the 22 DD cases did not have ICF/MR level of care documentation in the case file and another two DD cases had documentation that was not current.
- Complete a TBI Waiver Assessment and Eligibility Determination Form for all participants in the TBI program that do not have this form within the next 30 days.

Maintain this form in the case file and update it annually. None of the three TBI cases included a TBI Waiver Assessment and Eligibility Determination Form.⁵

⁵ The TBI Waiver Assessment and Eligibility Determination Form (DHS-3471) can be accessed at:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_000688