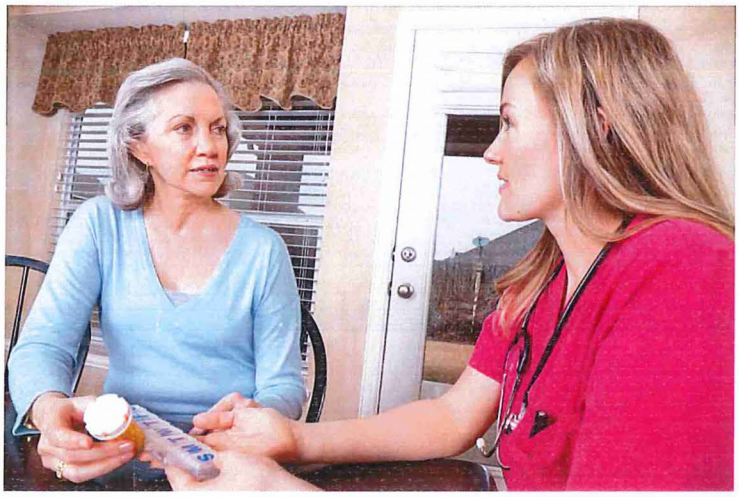
Home and Community-Based Services



Findings and reflections from reviews in each of Minnesota's 87 counties

March 26, 2012

Since 2006, the State has conducted a thorough review of the programs that help Minnesotans stay in their homes as they age and regardless of ability. Findings from the study show that most participants receive services under care plans that address their health and safety needs and have individualized goals. Many requirements, such as informing people of their rights, are being completed and documented. The frequency of visits seems to be in decline, with more people being seen on an annual, rather than on a biannual, quarterly or monthly basis.

The Improve Group

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Findings and reflections from reviews in each of Minnesota's 87 counties

As of March, 2012, DHS has completed reviews of the Home and Community Based Waiver programs in each of Minnesota's counties. While a few waiver review tasks remain (reviews in two tribal communities; continued follow-up reviews), the results are comprehensive enough to reflect on the data findings and lessons learned throughout the years.

Since the review started in 2006, many requirements have reached a notably higher level compliance. For example, more participants have completed back up plans, are informed of their rights, and have current care plans. While compliance overall is better than 6 years ago, we found that counties reviewed in 2011 had slightly worse compliance than in the previous year.

Three major lessons can inform the State's efforts moving forward. First, counties look to the State for assistance and guidance more than expected. In particular, counties are interested in receiving assistance and supporting tools to help them assure quality in their services and increase access to services.

Second, while most counties were very open to the review process, and reported they found the feedback and ideas helpful, few made preemptive improvements as a result of findings in other counties. They seemed to look at the review process as an opportunity more for individual technical assistance than an opportunity to learn about promising practices. In the future, a more comprehensive communication plan, focused on improvements across counties, rather than just within counties, may be beneficial.

Third, broader community change impacts how waivers are administered in counties. As new options, such as consumer-directed community supports, become more familiar, they are more likely to be requested by participants or recommended by case managers. Several of the trends over the 6-year period are likely related to these types of broader community changes.

Accomplishments

The Waiver Review Initiative began over six years ago as the Centers for Medicare & Medicaid began requiring states to provide evidence of compliance with HCBS program requirements. The Minnesota Department of Human Services and the Improve Group developed and began implementing an on-site review of all the HCBS programs in 2006. So far we have:

- Reviewed HCBS waivers in all 87 counties
- Surveyed over 1,400 staff.
- Interviewed approximately 325 directors, managers and supervisors
- Conducted over 90 focus groups
- Reviewed over 5,600 case files
- Examined over 1,000 contracts.

All of this activity provides an excellent opportunity for reflection. As a team, we think the review process itself is having an impact on some aspects of the waiver programs. In addition, other aspects are changing as the broader community changes and as counties continue to learn from each other and from DHS. Some things have not changed—both positive and negative aspects.

Quality and strengths of Minnesota's systems

Many strengths of Minnesota's home and community based services have remained consistent throughout the six years of the review. Notably:

- Close collaboration across units and agencies is evident in nearly every county we reviewed. **Case managers collaborate** with other case managers who have expertise in particular issues, such as mental health, or with financial staff, or with community agencies in order to ensure that participants receive timely and individualized attention.
- County staff is **well connected within the local community**. The relationships staff members have with providers, schools, hospitals and other agencies in their area represents one of the biggest strengths of the county-based systems. Because of these relationships, case managers can navigate systems, advocate for participants and find the best service options available. Formal communication practices have become more common place; counties have deliberately created the bridges needed to work with the providers in their communities. Staff from multiple counties serves on local committees that address participant concerns and convene stakeholder groups to assess participant needs.
- Another strength of case managers is the **resourcefulness, continuity and focus they bring to their case management**. They find creative ways to help participants—regardless of the region or the size or diversity of their communities. Case managers are in frequent contact with participants and their family members. They help participants get rides to appointments, complete MA paper work, find and change providers, and help resolve other issues as they arise. Most counties have established practices that allow case managers to maintain relationships with participants over a long period of time.
- The **developmental disabilities care planning process leads to a very detailed, person-centered individual care plan**. Most of the time, the DD individual service plan relies on the input of multiple individuals, such as providers, caregivers and individuals, to provide a rich narrative that

links individual needs and desires with specific goals and supporting services. This input leads to a service plan that includes a comprehensive assessment of the participant's current needs, resources available to them and a plan to provide services to address the participant's needs.

- **Counties continue to manage their allocations well**; staff members take a close look at participant needs, availability of services and need to manage risk as they make funding decisions. Some counties have instituted a case review process that helps empower case managers to set budgets for their participants based on their needs; others review participants on waiting lists periodically and use a prioritization system to add participants to the waiver when funds are available. In the most recent year of reviews, these trends were even more noticeable, with counties maintaining a very small waiver balance and reporting that they are more conservative when adding new participants to services.
- **Counties support the work of case managers to encourage efficiency and standardization** by developing tools such as health/safety checklists, provider monitoring tools, homemaker reports and visit sheets. We have gathered many tools and posted them to a Yahoo Group to encourage counties to learn from each other's practices.

Changes in waivers since the review process began

Some of the patterns we've seen in recent reviews differ from those in earlier years. Many represent increased access to services, individualized approaches and system improvements; notably:

- **Technology is being used increasingly** to support case management and other services. For example, some counties have moved to electronic case files, using laptops during participant visits and even delivering

services electronically such as remote monitoring, Skype-based case management visits with participants and use of telemedicine.

- **CDCS services have been used in greater numbers** in rural, suburban and urban communities alike; each community seems to have different reasons for its use of CDCS. In rural communities, CDCS is a way to get services to individuals when no providers are available; in urban communities; CDCS is frequently used to ensure services respond to unique or culturally-specific needs. In 2006, 224 CCB participants and 1,401 DD participants statewide used CDCS. By 2011 the number of participants increased to 1,347 CCB participants and 1,675 DD participants statewide used CDCS.
- The majority of **participants are being served in the community** as opposed to institutions, and the percentage is increasing. In 2005, 50% of EW/AC participants, 87% of CCB participants, and 88% of DD participants were served in the community. By 2011 the percentages had increased to 63% of AC/EW participants and 92% of CCB and DD participants served in the community.
- **Compliance with technical requirements is improving.** For example, in 2006, 30% of DD participants had a complete, current ICF/DD level of care documentation, while 69% of the DD participants we reviewed in this past year had this documentation.[1] Similarly, in 2006, 67% of non-DD participants had a completed OBRA level one. In the past year, 93% of non-DD participants had a completed OBRA level one. Large improvements occurred with BI form documentation (44% to 79% between 2006 and the past year) (see Charts D and F in the appendix).

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[1] Throughout this report, we use the term" in the past year" to include the 14 counties reviewed in 2011, including Dakota County (reviewed in January 2011).

- **Contracting practices are improving**; the majority of counties moved to the statewide contract over the last 18 months, and now contracts meet all requirements and in general are in place for all services, with a few incidental exceptions (see Charts O and P in the appendix).
- The proportion of **participants earning income is increasing**. In the DD program, 69% of working-age participants earned income in 2005, compared to 71% earned income in 2010. There has been a smaller increase in CCB, where 23% of working-age participants earned income in 2005, while 24% earned income in 2010.
- More of the counties reviewed in the past year are **making use of case consultation and dual assessments to ensure that all participants' needs are understood and met**, when compared to the counties reviewed in previous years. Data collected during interviews with county staff members indicate that 9 of the 14 counties visited in the past year were using dual assessments and/or case consultation on at least a portion of their cases. Most of these counties specifically used dual assessments for initial assessments of new CCB participants.
- **Care plan documentation of participant health and safety and participant goals is improving**. In 2006, 79% of the care plans we reviewed had expected documentation of health and safety, while 94% of care plans did this year. In 2006, 74% of the care plans we reviewed had expected documentation of participant goals, while 97% of care plans did this year (see Chart A in the appendix). Generally, county staff is doing a more thorough documentation of health and safety in the care plan forms they use. In addition, counties have significantly improved effective documentation of participant services to be provided on care plans; in 2006, 83% of the care plans documented participant services to be provided, while 95% did so in the past year (see Chart B in the appendix).

- **Timeliness of care plan development is significantly improving.** The percentage of care plans developed within the required 10-day timeframe has increased. In the past 6 years, the percentage of care plans that were developed within 10 days of the assessment increased from 60% to 83% for CCB programs and 66% to 80% for elderly programs (see Chart H in the appendix).
- Overall, **counties are serving a population with higher needs.** In CCB, the percentage of participants with high needs increased from 77% in 2005 to 79% in 2011. In the elderly programs, the percentage of participants with high needs increased from 48% to 54% in the same period. In DD, the percentage with high needs increased from 81% in 2005 to 84% in 2011.
- A growing **proportion of LTC funds are being spent on participants that are being served in the community.** In all the waiver programs, the percentage of LTC funds, spent in the community as opposed to nursing facilities has increased. For example, funds spent in the community increased from 21% to 35% for elderly programs between 2005 and 2011. In that same period, funds spent in the community increased from 76% to 88% for CCB programs. For DD programs, fund spent in the community increase from 84% to 87% between 2005 and 2011.
- Counties have had an **increased focus on caregivers** when a participant is being cared for by a family member or in another informal relationship. In 2006, 11% of participants were cared for by an unpaid caregiver. In the past year, 40% of participants were cared for by an unpaid caregiver (see Chart B in the appendix).

While many changes that we've seen represent improved services for participants, there is one notable exception:

- **Increasingly limited resources affect counties in a number of ways.** For example, Counties have had great difficulty hiring new staff or replacing staff as they retire. As a result, staff has to manage higher case loads, find difficulty keeping current with policy changes are less likely to monitor providers closely and are unable to keep timely visits to participants.

Stable aspects of the waivers

While we noted some consistent strengths and improvements above, there have also been some consistent challenges demonstrated by counties:

- Most counties are **not meeting the expected threshold for on-time screenings.** Most counties see less than 80 percent of participants on time, within 15 calendar days of a referral, for screenings across the elderly and CCB programs. In 2005, sixty-five percent (65%) of elderly initial screenings, 50% of CCB initial screenings and 89% of DD initial screenings were completed on time. Slight improvements suggest that this trend may be shifting; in 2011, 69% of screenings were completed within required timelines for the elderly programs, 59% for the CCB programs and 91% for the DD programs.
- Visits are a critical tool in ensuring participants are safe and their needs are being met. The review found that case managers usually visit participants regularly, and plan visits so they happen both where participants live and during any activities they might participate in (such as employment). There are disparities in the amount of visits participants receive, however. While the majority of participants are being seen regularly with visits exceeding or meeting requirements in 86% of cases, a growing number of cases had visits documented that were less frequent than program requirements. Specifically, 13% of CCB participants and

12% of DD participants were not visited at least bi-annually as required in the past year, compared to 6% of CCB participants and 7% of DD participants that did not meet program requirements in 2006 (see Chart C in the appendix).

- There are still **care plans that have not been signed by either the participant or their legal representative**, suggesting that their needs/preferences have not been documented. We have seen several counties where this has happened just once or twice, but several others where this has been a pattern. In 2006, there were 4 counties where there was more than one occurrence of care plans not signed by the participant. In the past year, there were 6 counties where there was more than one occurrence of care plans not signed by the participant.
- There continues to be **a lack of providers in specialized service areas**: respite/crisis respite, behavioral services and others (see Chart N in the appendix). Counties have struggled to find a way to access these services, and have used RFPs and regional alliances to fill the gap as much as possible.

Recent downward trends

- Despite the overall improvements in compliance with technical requirements since 2006, **compliance with certain technical requirements deteriorated over the past year.** For example, in 2010, 86% of DD participants had a complete, current ICF/DD level of care documentation, while 69% of DD participants we reviewed in this past year had this documentation (see Chart F in the appendix). Similarly, in 2010, 64% of DD participants diagnosed to have a related condition (22 participants) included a related conditions checklist in the case file. In the past year, 14% of DD participants diagnosed to have a related

condition (21 participants) included a related conditions checklist in the case file (Chart G in the appendix). Finally, in 2010, 92% of all waiver participants had complete documentation of informed consent. Over the past year, 84% of all waiver participants had complete documentation of informed consent (see Chart D in the appendix). The deterioration of compliance of these technical requirements was found in multiple cohorts. This could be attributed to several factors; however, we had hoped that communicating findings from other counties would have provided enough information about requirements to help counties to make changes even before they had been reviewed. It was clear this year that had not happened to the degree we hoped.

- Despite the overall improvements in compliance with CCB care plan requirements since 2006, **compliance with CCB care plan requirements deteriorated over the past year.** For example, in 2010, 76% of care plans for CCB participants included a completed backup plan. Over the past year, 67% of care plans for CCB participants included a completed backup plan. Additionally, in 2010, 94% of care plans for CCB participants included emergency contact documentation. Over the past year, 86% of care plans for CCB participants included emergency contact information (see Chart E in the appendix). The deterioration of compliance of these care plan requirements was found in multiple cohorts.

Areas of continued challenge and need for DHS support

- Some counties report that the **difficulties they have in securing providers is exacerbated by system limitations and differences.** While the survey of county staff note an improvement in finding and monitoring qualified providers (see Chart K in the appendix), some counties find difficulty in securing providers for high incidence services

(i.e. respite care, transportation, chore services) due to reimbursement limits and requirements (see Chart N in the appendix). For example, there are inconsistencies in what is allowed and maximum rates across waivers. Travel time is not billable for most services, so service providers may refuse to serve individuals to whom they would have to travel a great distance. Finally, we have heard that allowable reimbursement rates are too low for some services, such as respite care and PCA, to secure high-quality providers.

- **Some counties report that there is a growing need to provide culturally-diverse services for their waiver population**. For example, counties have not only had a growing need to find interpreter services, but also have a growing need for specific services such as PCA and foster care services geared toward minority populations.
- While some counties have strong case management processes, others struggle when switching between different waivers and/or health plans to meet the various care plan and documentation requirements. **DHS could help by creating some basic tools and requiring counties and/or health plans to use these tools**. The most frequently requested tool is a checklist showing the requirements for each waiver. Counties have developed their own checklists in the absence of one from DHS, and we have presented some of these tools at conferences and on the Yahoo group website. Counties have found the new universal care plan used for managed care participants has streamlined their work.
- Keeping up with the pace of program changes remains difficult for case managers; DHS could relieve some of the burden the changes place on county staff with timely information and training. **Communication that explains the changes, what the changes mean for case managers and administrators, and how to get additional information would be**

helpful. Staff reports that communication about policy changes is often uncoordinated; there is not one system for notifying staff about changes. Many staff reported that they have missed crucial policy updates because updates come through so many sources, including bulletins, the DSPM manual, conversations with DHS staff and trainings.

- ITV trainings are frequently used by county staff; county staff offer suggestions to make this resource more valuable to counties. There are a limited number of ITV sites and county staff members may have to travel to access trainings which present a barrier to participating in ITV trainings, particular with increasing budget constraints. The majority of counties **requested DHS to provide training on requirements for each HCBS program and how to complete required documentation** for each program. Counties have also mentioned that the quality of the trainings could be improved by providing more accurate descriptions of the training, having presenters provide cases, examples and additional materials to attendees, and include question-and-answer periods. Finally, they requested that presenters avoid reading directly from PowerPoint slides. However, counties have acknowledged that DHS has made efforts to improve trainings.
- While DHS offers a number of resources, **the resources are not available to all programs**. Case management staff in the EW and AC programs would like to have access to the same RRS resources that the other programs are using. Many counties report that their Regional Resource Specialist is an invaluable resource in administering HCBS programs; they are used as an information source and can link counties with the appropriate staff person at DHS. The Regional Resource Specialist works closely with county staff in the DD, CAC, CADI and BI programs. County staff members that work with the EW and AC program would also like an

online manual similar to the DSPM where they could access program requirements and policies. Counties report that eDocs has been a great resource in getting the most up-to-date forms Staff members regularly use Policy Quest and like that there is a searchable FAQ section. Some staff reported that Policy Quest is slow to respond to questions, or does not fully answer their question, causing delays in helping participants.

- **Counties have frequently asked for clear guidance** on these specific items:
    1. Care planning practices that fulfill requirements and represent individualized planning for participants;
    2. The requirements of each waiver;
    3. The services that are authorized within each waiver;
    4. Appropriate levels of reserves/financial allowances;
    5. The best ways to monitoring providers when they have limited resources;
    6. Expectations regarding meeting provider contracting requirements as DHS transitions towards state-managed provider contracting;
    7. Collaborating within a region to develop alliances for service development, particularly home-care and employment services; and
    8. The use of technology to fulfill requirements (e.g. using Skype for consumer visits).

Lessons learned about the review process

- **The data-driven approach to the review has been effective** in engaging counties in interpreting findings and understanding recommendations and corrective actions. Counties engage with data several times during the review process. County staff members are asked to share their

opinions and talk through data findings to help the Review Team understand the context behind the data. Staff members often comment they really feel "heard" by this process and we have done a good job of capturing the local strengths and weaknesses in our findings. County staff reports that the review process is an opportunity to reflect on what they do well and what they can do better; it also helps them to understand requirements. Finally, they look to the review as an opportunity to get feedback, learn and improve their programs. They provide similar feedback during the review process itself and during later surveys conducted as part of the follow-up process.

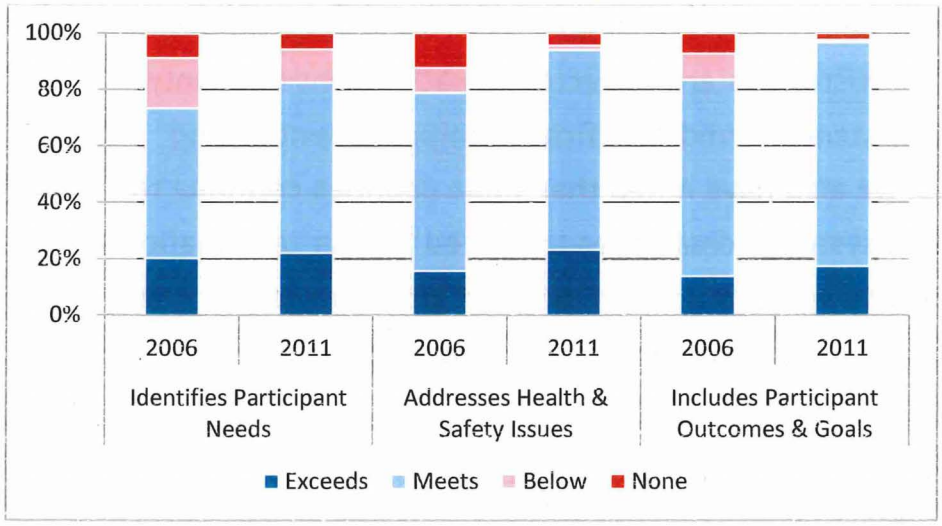
- **The scope of the review focuses on how well needs of local participants are met**, not just compliance, and this helps contribute to county buy-in. Counties appreciate the opportunity to brainstorm with DHS staff on how to better serve participants by getting the most out of their relationships with contracted providers, streamlining documentation requirements and developing needed services. Case managers report an interest in learning strategies to help them be more efficient with their time so they can focus on their work in the field.
- Publishing the waiver review reports, promising practices and interesting tools through the DHS web site and Yahoo Group, as well as our other communication efforts has increased statewide compliance with program requirements over the past six years. County staff members indicate that they accessed other counties' reports prior to their own review to clarify documentation requirements and to examine what will be addressed during the review process. **Counties have accessed helpful tools for HCBS programs** and learned about best practices in program administration through the Yahoo Group, and by attending sessions

about the Initiative at the Odyssey Conference, and by contacting counties for whom we have noted related promising practices.

- We continue to proceed on a follow-up process that verifies if systemic and incidental inconsistencies are corrected at each reviewed county. While we have consistently found significantly improvement during follow-up reviews, we also have noted that some counties continue to have incidental and systemic challenges that need further remediation. Counties continue to express their appreciation for the review as a way for them to maintain compliance with federal and statewide requirements.
- Communication of findings of individual reviews appears not to be effectively communicated to other counties based on the results of the past year. In future reviews, a communication plan focused on inspiring broader change could help ensure that findings are more widely distributed even before all reviews are completed.

Appendix: Supporting Data

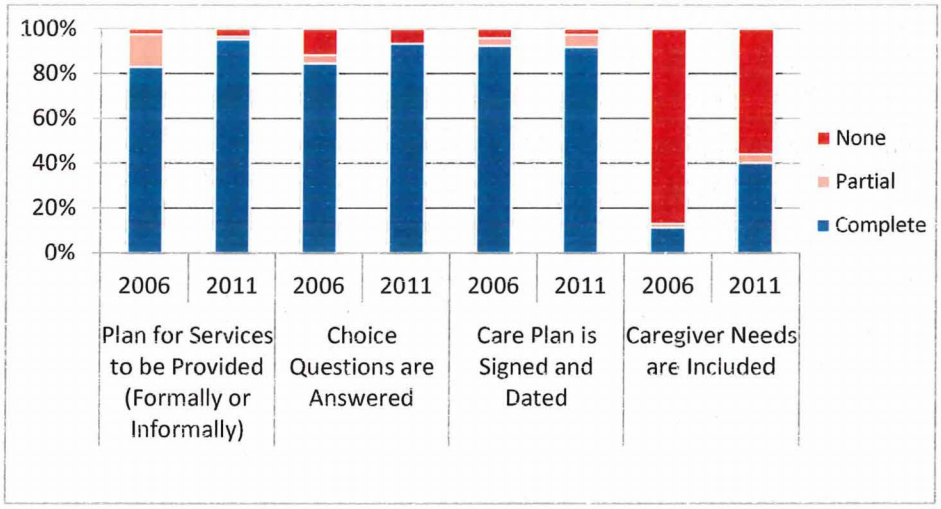
Chart A: Percentage of reviewed care plans meeting expectations



Care plans showed improvement in documenting both health/safety issues and in participant

Exceeds - care plan has higher than expected level of documentation. Meets – care plan has the expected level of documentation. Below – care plan has lower than expected level of documentation. None – care plan does not have this documentation. The fields were calculated by dividing the number of care plans with a particular level of documentation by the total number of case files reviewed.

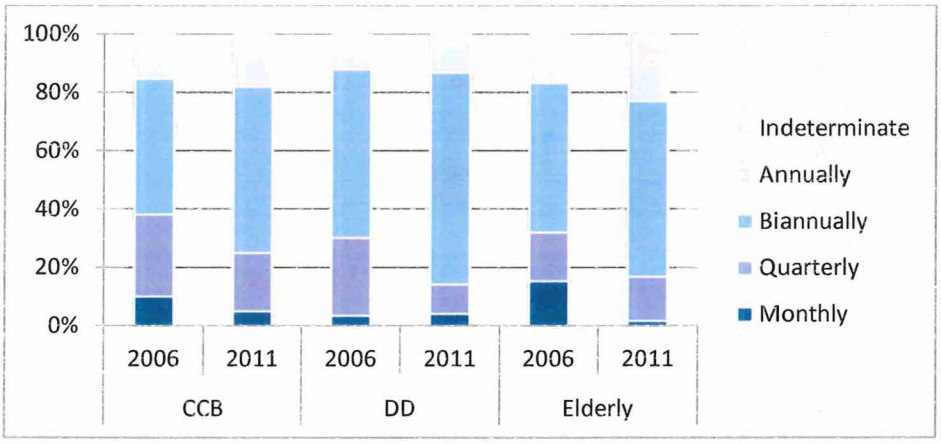
Chart B: Percentage of reviewed care plans meeting expectations



Care plans showed improvement in documenting caregiver needs

Complete - detailed documentation consistent with screening, assessment and other documents within the case file. Partial - brief documentation and/or inconsistencies noted with screening, assessment and other documents within the case file. None – no documentation present. The fields were calculated by dividing the total number care plans with a particular level of documentation by the total number of case files reviewed.

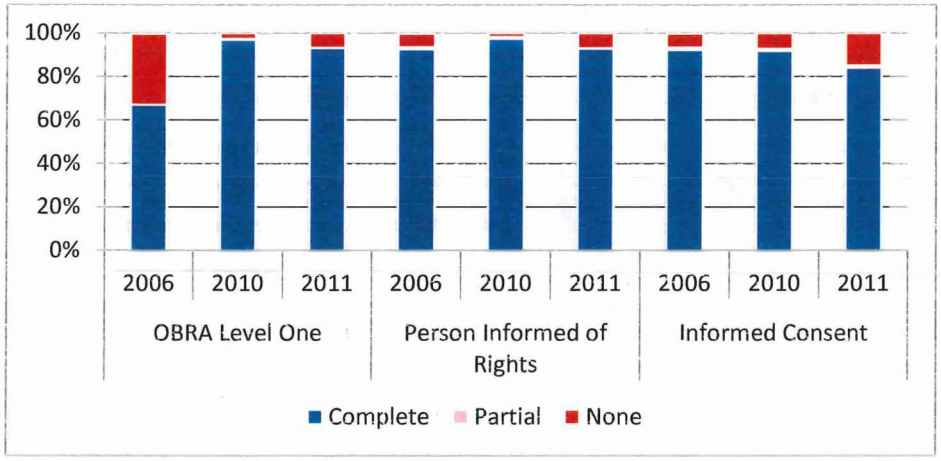
Chart C: Frequency of face-to-face case manager contact



Most participants are visited by case managers at least biannually. However, a growing number of participants are not visited as frequently as the programs

Calculated from the frequency of face-to-face visits between the participant and the case manager during the 18 months prior to the date the case file was reviewed.

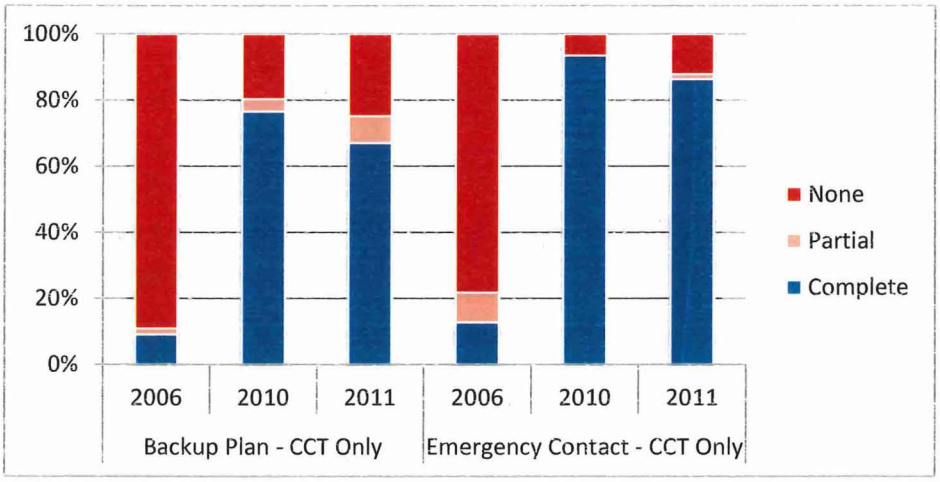
Chart D: Percentage of reviewed case files containing required documentation



Complete - full documentation within required timeframe. Partial – documentation exists but is missing some elements, such as a date. None – no documentation present. The fields were calculated by dividing the total number of cases with a particular level of documentation by the total number of case files reviewed.

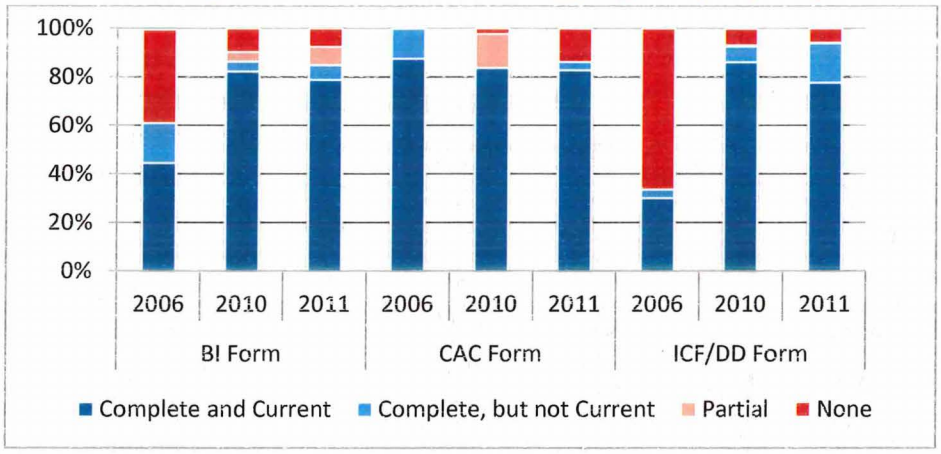
Counties have shown great improvement in meeting the program-specific requirements since 2006. However, in 2011, counties struggled notably more to meet these requirements than in 2010.

Chart E: Percentage of reviewed CCB care plans containing requirements



Complete - full documentation within required timeframe. Partial – documentation exists but is missing some elements, such as a date. None – no documentation present. The fields were calculated by dividing the total number of cases with a particular level of documentation by the total number of case files reviewed.

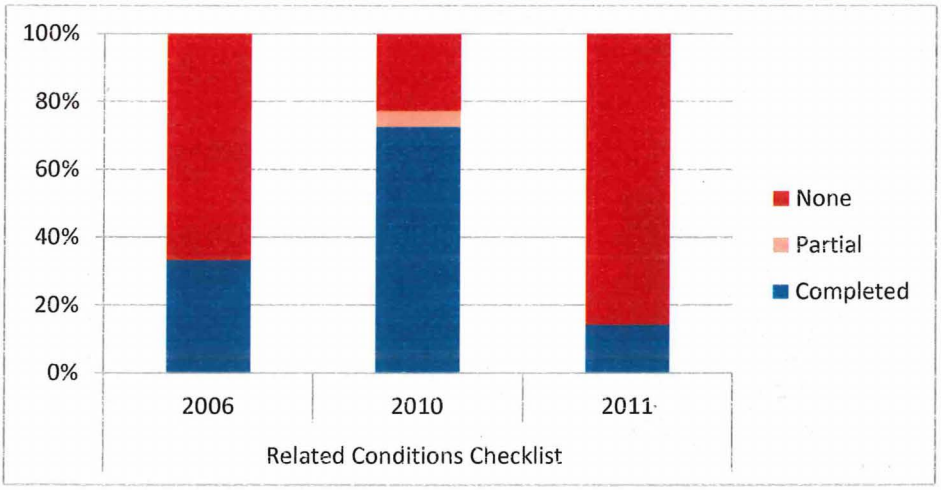
Chart F: Percentage of reviewed cases containing program-specific requirements



Complete and current – the form is complete and signed within the 12 months prior to the review. Complete and not current – the form is complete, but dated more than 12 months prior to the review. None – the form was not present.

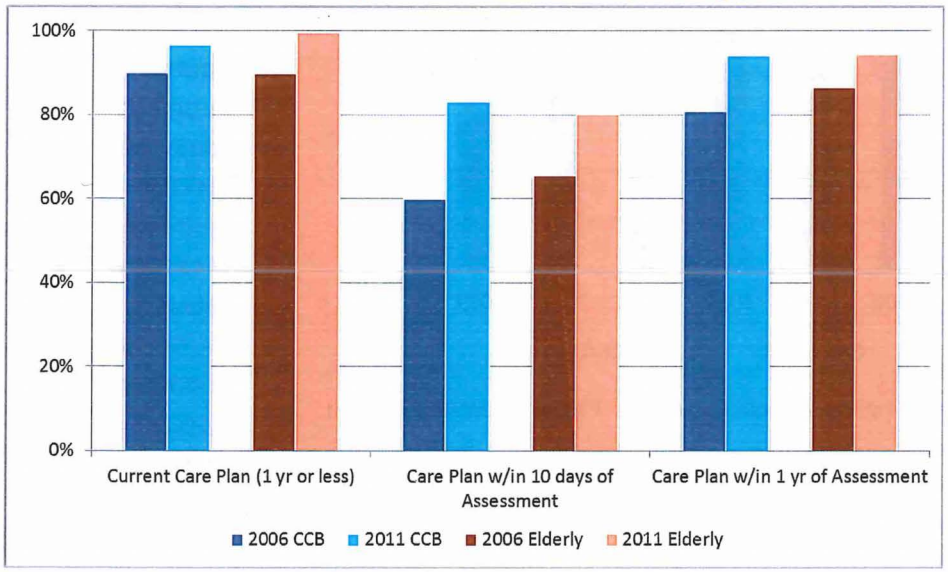
Counties have struggled to comply with the checklist requirement for DD cases where related conditions was the primary diagnosis, especially over the past year.

Chart G: Percentage of reviewed DD related conditions cases meeting requirements



Complete - full documentation within required timeframe. Partial – documentation exists but is missing some elements, such as a date. None – no documentation present. The fields were calculated by dividing the total number of cases with a particular level of documentation by the total number of case files reviewed.

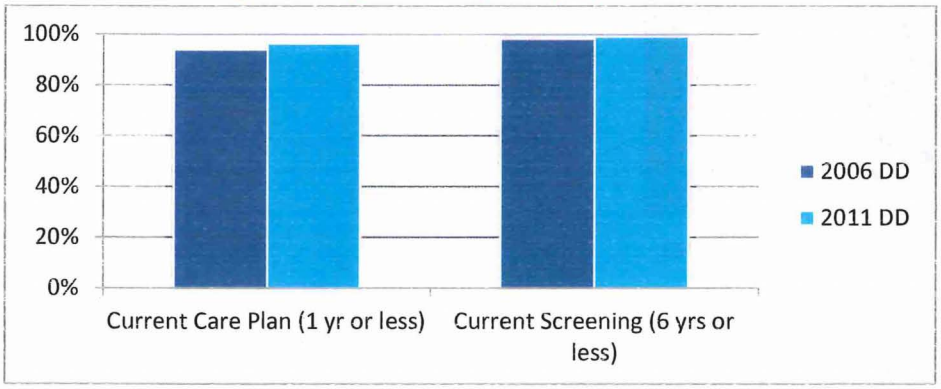
Chart H: Timeliness of screening, assessment and care planning (CCB and AC/EW)



Overall, there have been improvements in timeliness over the past six years, but about 20 percent or more of care plans are not developed within the required timeframes.

Current care plan - care plan was completed during the 12 months prior to the review. Care plan within 10 days of assessment - care plan was completed within 10 days of the face-to-face assessment; this is only a requirement for CCB cases. Care plan within 1 year of assessment – care plan was completed within 1 year of the last face-to-face assessment.

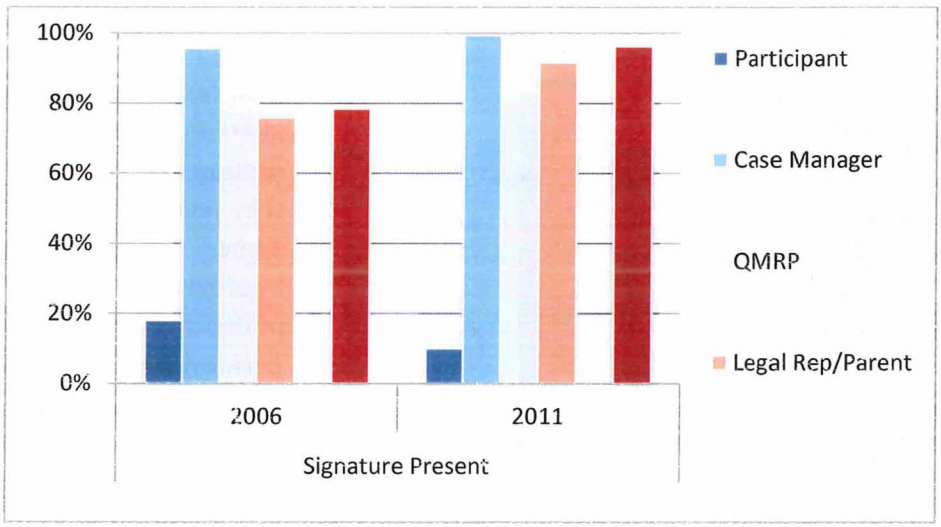
Chart I: Timeliness of screening and care plans (DD)



Virtually every DD care plan and screening document is completed within the required timeframe.

Participants with current care plan - care plan was completed during the 12 months prior to the review. Current screenings – the proportion of screenings dated within six years of the review date.

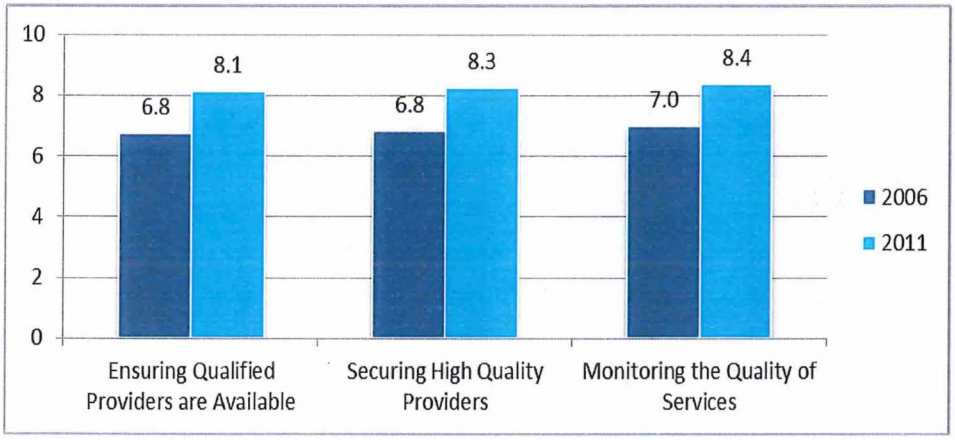
Chart J: Percentage of reviewed DD screening documents meeting requirements



Counties have shown notable improvement in procuring the two required signatures on the screening document.

Signatures are required from the case manager and the participant (if they are their own guardian) or their legal representative (if the participant has a legal representative).

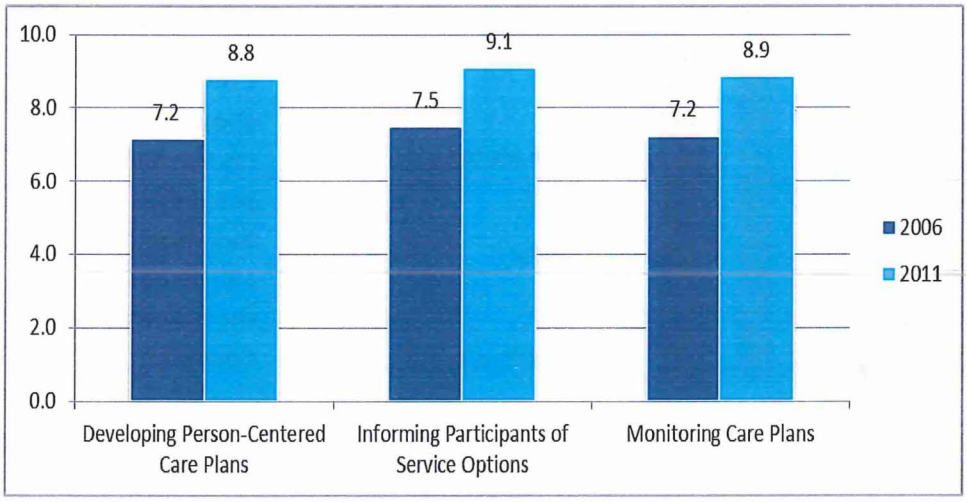
Chart K: County staff ratings of local ability to maintain provider capacity and capabilities



County staff members are self-reporting better success in provider capacity and in person-centered services

Survey respondents were asked "How successful is your County in the following areas?" with 1= Never Successful and 10 = Always Successful.

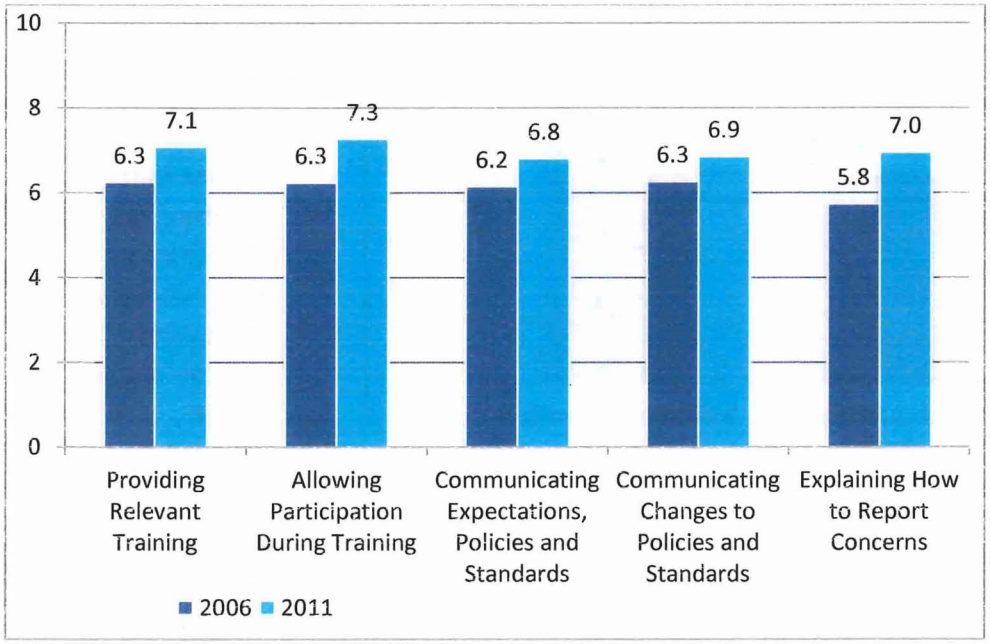
Chart L: County staff ratings of local ability to provide person-centered services



Staff members share in focus groups that they recognize some improvements in DHS performance.

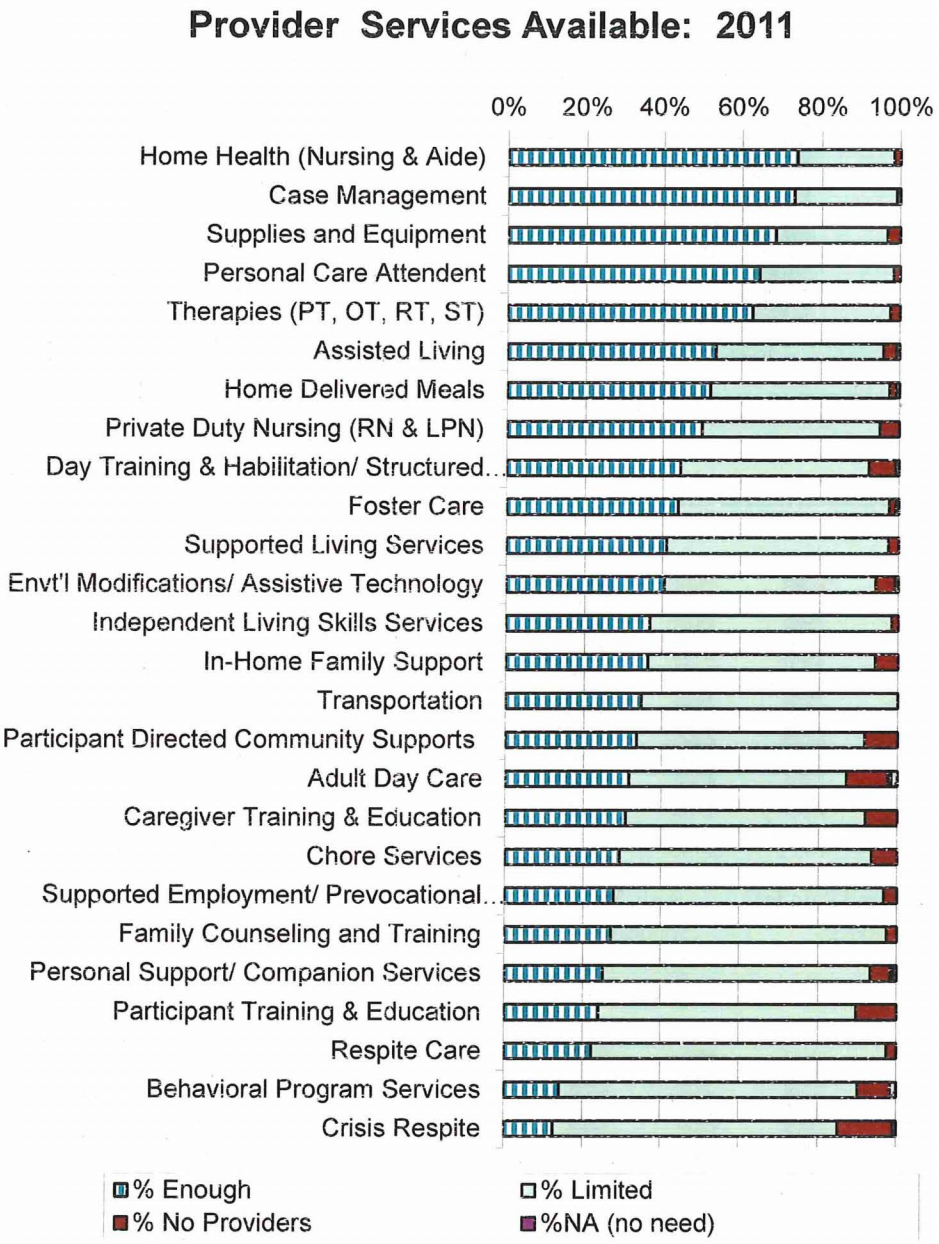
Survey respondents were asked "How successful is your County in the following areas?" with 1= Never Successful and 10 = Always Successful.

Chart M: County staff ratings of DHS performance



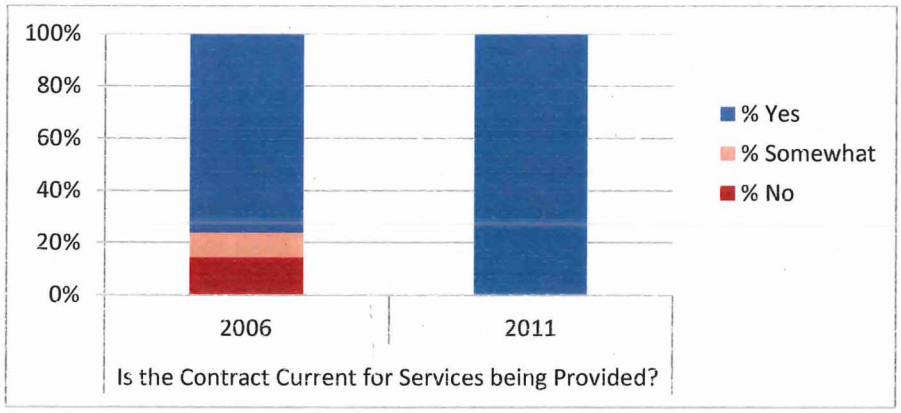
Survey respondents were asked "How successful is DHS in the following areas?" with 1= Never Successful and 10 = Always Successful.

Chart N: Provider service availability in 2011 Waiver Review Counties



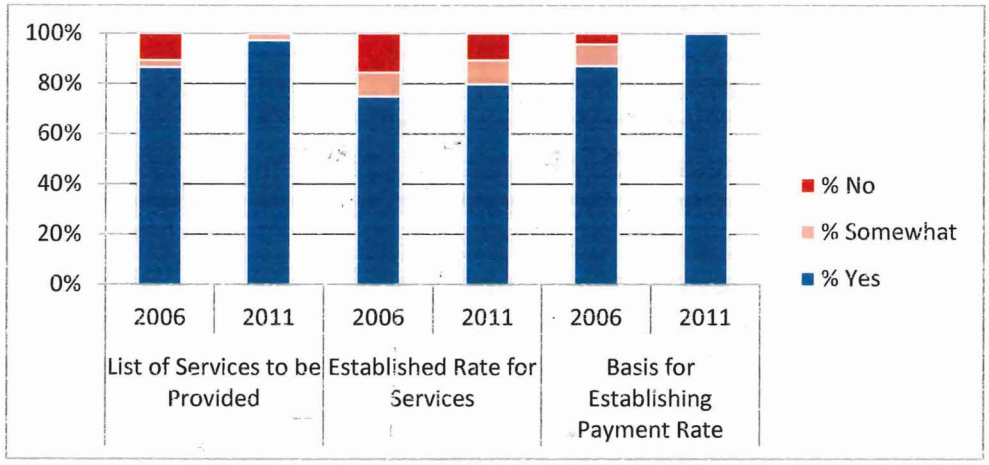
While county staff state that home health aide and case management services are widely available, counties have great difficulty finding behavioral program services and crisis respite for their participants.

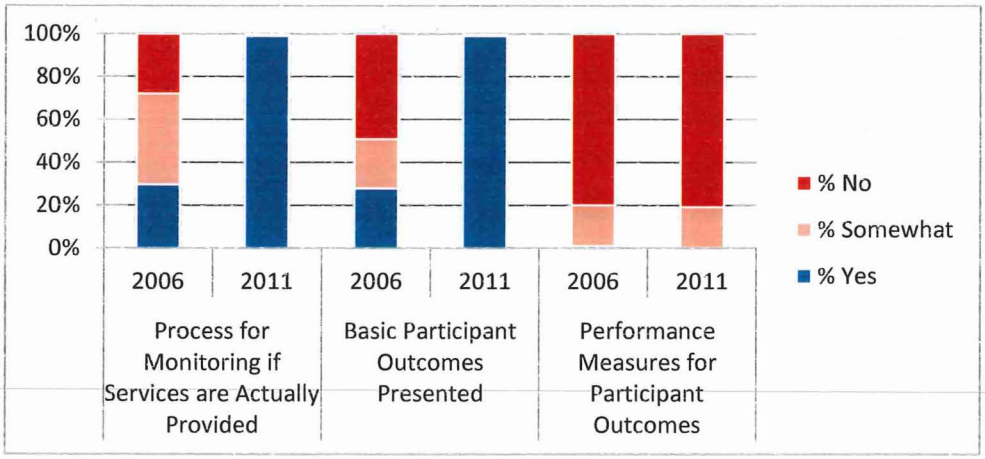
Chart O: Contracts in effect for services



Contract formats and processes have significantly improved over the review period, particularly as counties have adopted the model contract.

Chart P: Percentage of reviewed contracts meeting expectations





Very strong improvements have been seen in the contractual language around monitoring that services are actually provided and that participant outcomes are met.