
OLMSTED COUNTY

Home and Community Based Services Lead Agency Review

Corrective Action Plan

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1) Complete LTSS MnCHOICES assessments within 20 days of referral

Barriers identified in the review: Assessors being unable to schedule an initial assessment; Different processes for intake workers when referring for assessment.

Baseline (performance at the time of the review):

For people who newly opened to a waiver program in SFY 2015.

18% were not assessed within time frame:

10/61 (16%) for CCB

13/71 (18%) for EW/AC

2/7 (29%) for DD

Root Cause Analysis

Referral date in screening document isn't being updated on previous referrals ("new" screening but previous assessment)

Client barriers (DD & CCB)

- 1) language/interpreter
- 2) scheduling conflicts
- 3) family desire to wait.

Multiple parties to schedule assessment around

Timeline for getting referral assigned (worker schedules)

Prior to May/June we didn't have a specialized team.

The PUR fell during MnCHOICES implementation (technology problems)

Reference:

MN Statute 256B.0911

Identified Solution

Clearly document client barriers

Implement a tickler system for EW (PhDoc)

Intake will identify a due date when sending referral

Automated spreadsheet for tracking. Educate assessors on referral dates in screening document

Action Steps

- 1) Clarify statute 20 day statute requirement (is it working or calendar days?)
- 2) Explore possibility of tickler system outside of PhDoc
- 3) Educate assessors on referral dates in screening document
- 4) Analyze barriers in existing data
- 5) Require staff to document on LTCC why an assessment is late
- 6) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

2) Include details about the person's services in the support plan.

Barriers identified in the review: Different forms and processes used to document; Person-centered 16 practices not being followed– staff need training; File case review process not effective in many programs; Process of using non-enrolled Tier 2 vendors receiving needed DHS documentation/information.

Baseline (performance at the time of the review):

40% of cases reviewed across all programs contained did not contain all of the required service information:

22/40 (55%) for CADI

5/7 (71%) for BI

35/48 (73%) for DD

1/45 (2%) for EW

Root Cause Analysis

Budget worksheet not full completed (missing service cost) or it is not included with the plan

There's a staff training need

Reference:

MN Statute 256B.0915

MN Statute 256B.092

Identified Solution

Short-Term:

Identify the form that must be completed

Train staff to provide the form to the client

Include the budget worksheet within the audit/file review requirements

Long-Term:

MnCHOICES CSSP will auto-fill

Action Steps

- 1) Staff training
- 2) Include the budget worksheet in the file review requirements
- 3) Train ISP staff to include budget worksheet and to tie this to the signature page
- 4) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

3) Conduct face-to-face visits in accordance with program requirements.

Barriers identified in the review: Scheduling conflicts with families; Different processes/protocols used.

Baseline (performance at the time of the review):

CAC, CADI and BI = 2 face-to-face / year; DD workers provide semiannual monitoring visit/year; Elderly = 1 face-to-face / year

Over all programs, 10% were not visited within requirements:

1/9 (11%) for CAC

2/40 (5%) for CADI

2/7 (29%) for BI

11/48 (23%) for DD

Root Cause Analysis

A client or his/her family may decline a mid-year visit

There was a miscommunication to staff of the face-to-face visit requirements

There is a lack of tracking mechanism to help workers remember to do visits

Case manager workload

Travel for out-of-county visits

Reference:

MN Rule 9525.0024

Identified Solution

Clarify requirements to staff that visits need to be face-to-face and not via phone

Update the audit tools to include the face-to-face visit requirement

Review the 6 month visit form (non 245D) to see if it needs to be updated

Use support staff to set up monthly visit reminders

Review requirement with new and seasoned staff.

Action Steps

- 1) Data analysis around what percentage of families/clients decline visits and in what settings
- 2) Consider including client visit refusals in the file review requirements
- 3) Do a form review to determine what forms can be streamlined, what can be purged, and what is required
- 4) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

4) Ensure that each person's support plan includes outcomes and goals.

Barriers identified in the review: Different processes and documents used by staff; Training/implementation of person-centered practices and supports; Enhance/improve the efficacy of the case file review process.

Baseline (performance at the time of the review):

Overall, 12% of CSSPs did not contain outcomes or goals:

1/9 (11%) for CAC

8/40 (20%) for CADI

2/7 (29%) for BI7/48 (15%) for DD

Root Cause Analysis

Goals need to be on Olmsted County specific CSSP form.

Goals that are coming from external providers are being attached to the plan instead of included directly

Timeline constraints

Reference:

MN Statute & Rule

Federal Funding Requirement

Identified Solution

Have goals/outcomes in the Olmsted County plan (not attached)

**Case Manager responsible for these

Use service authorization with external providers as a tool to engage timeliness in providing case managers with goals

Give permission to Case Managers to establish goals in the absence of provider-developed goals

Action Steps

- 1) Olmsted County CSSP has been revised to include individual goals/outcomes for Case Manager use
- 2) The community agency workgroup will decide on the format and implementation of the support plan outcomes and goals
- 3) Clarify the accountabilities with providers
- 4) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

5) Include back-up plan in the support plan for all people receiving HCBS waiver services.

Barriers identified in the review: Different processes and documents used by staff across programs; Training/implementation of person-centered practices and supports; Documentation not completed; Enhance/improve the efficacy of the case file review process for programs.

Baseline (performance at the time of the review):

Overall, 6% of cases reviewed across all programs did not include this information:

1/9 (11%) for CAC

2/40 (5%) for CADI

7/48 (15%) for DD

Root Cause Analysis

Staff training needs

This requirement is not included in the file review process

The Olmsted County CSSP does not currently include a back-up plan (we're using a separate back-up plan)

Reference:

Federal Funding Requirement

Identified Solution

Interim/Short-Term Plan:

Use the Olmsted County CSSP that includes the back-up plan with required pieces highlighted

Fully complete the CSSP and back-up plans

Long-Term Plan:

Use the DHS developed CSSP when it becomes fillable from MnCHOICES

Action Steps

- 1) Include the back-up plan as a requirement in the file review process
- 2) Educate staff to use the SSIS form
- 3) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

6) Obtain signed documentation the person received information on how his/her private data will be used.

Barriers identified in the review: Different processes and documents used by staff across programs; Documents not completed; HIPAA not obtained within the yearly timeline; File case review not effective.

Baseline (performance at the time of the review):

Overall, 13% of cases reviewed across all programs did not include this information:

1/9 (11%) for CAC

4/40 (10%) for CADI

16/48 (33%) for DD

Root Cause Analysis

Staff are not using the updated CSSP ROI with check boxes

Staff are not aware of timelines

Multiple old/outdated versions of forms, both on paper and computer files

The number of staff to Program Managers supervise inhibits their ability track consistency by workers

Reference:

MN Statute 256B.0911 and 13.04

Identified Solution

All groups will use the same updated ROI

Use internal file reviews to capture the use of most recent forms

Action Steps

- 1) Clarify timelines with staff
- 2) Inform staff of correct form, where to access form, and how to complete form
- 3) Maximize technology opportunities for forms
- 4) Include in the file review process:
 - 1 data practices checked
 - 2 signature page checked and signed
 - 3 two lines of ROI initialed
- 5) Case Aide pre-assemble packets of paperwork for workers
- 6) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

7) Complete the BI Waiver Assessment and Eligibility Determination form (DHS – 3471) for all persons not assessed through MnCHOICES.

Barriers identified in the review: Current form (DHS—3471) not used; Current form not completed; Form not completed in the yearly timeline.

Baseline (performance at the time of the review):

43% did not contain this complete and current form which must be completed annually: 3/7 (43%) of BI

Root Cause Analysis

BI criteria changed so we moved several BI participants to CADI. When this happened paperwork lost in transition from previous case manager to specialized case manager

Staff training needs

There is no internal file review for BI specific cases. This was previously reviewed as part of the CADI file reviews

Reference:

Federal Funding Requirement

Identified Solution

There is a limited number of staff who do BI case management

Implement a file review process for BI files

MnCHOICES will have a checklist built in

Action Steps

- 1) Train staff about when the form is required
- 2) Include this form requirement in a file review process
- 3) Review this Corrective Action Item at the Performance and Quality Improvement (PQI) Team meetings for progress on a monthly basis.

Communication Plan (upon Approval)

CAP Item	Item to be Communicated	Owner	Method	Due Date
1	Referral date in screening document needs to be updated on existing clients	Corrine/Nanci	Assessment Team Meeting	4/1/16
1	Intake needs to set assessment due date when sending referrals	Nanci	Intake staff meeting	4/1/16
1	Ask Ann Wixon-Meyer to explore a tickler option in SSIS	Corrine	In-Person	4/1/16
1	Ask Carol Williams to update the rotation spreadsheet	Nanci	In-Person	4/1/16
2	CCB Staff told about budget worksheet requirements	Robin/Jennifer	Staff Meeting	3/9/16
2	Request a meeting with the Continuous Improvement and Analysis Unit about updating the audit tools (consider including other AFS units)	Robin/Jennifer	E-Mail	3/9/16
3	Communicate what a form review would look like to the HCBS Program Management Team (Leap Team, Continuous Improvement & Analysis Team. Are we waiting on CSSP?)	Jim	E-Mail	4/15/16
3	Requirements to staff	Robin/Jennifer	Staff Meeting	3/9/16
3	Use of support staff for reminders to staff. Also get feedback from staff.	Nanci	Support staff meeting CCB staff meeting	04/2016
3	Request a meeting with the Continuous Improvement and Analysis Unit about updating the audit tools (consider including other AFS units) (REPEAT from 2)	Robin/Jennifer	E-Mail	3/9/16
4	Communicate CSP revisions to CCB and children's DD staff	Robin/Jennifer	Team Meetings	3/11/16
4	Clarify accountabilities of providers to provide client goals timely	Jim	245D Provider Meeting	April 2016
4	Give permission to staff to create place-holder goals in the absence of provider goals when not received timely	Robin/Jennifer	Staff Meeting	4/28/16
5	Ask Ursula to add "*required" behind necessary pieces of the back-up plan form	Corrine	In-person	3/18/2016
5	Request a meeting with the Continuous Improvement and Analysis Unit about updating the audit tools (consider including other AFS units) (REPEAT from 2)	Robin/Jennifer	E-Mail	3/9/16
6	Communicate ROI policies and location of ROI forms	Jennifer/Corrine	Staff Meeting	4/28/16
6	Ask Lisa Fleissner to use the correct ROI in packet assembly for workers	Corrine	In-Person	3/18/16
6	Request a meeting with the Continuous Improvement and Analysis Unit about updating the audit tools (consider including other AFS units) (REPEAT from 2)	Robin/Jennifer	E-Mail	3/9/16
7	Communicate to staff when DHS form 3471 is required	Jennifer	E-Mail	3/18/2016
7	Request a meeting with the Continuous Improvement and Analysis Unit about updating the audit tools (consider including other AFS units) (REPEAT from 2)	Robin/Jennifer	E-Mail	3/9/16

Task Plan (upon Approval)

CAP Item	Item to be Completed	Owner	Due Date
1	Analyze barriers in existing data	Nancy	4/1/16
3	Data analysis around what percentage of families/clients decline visits and in what settings	TBD	4/1/16
All	Develop a data management plan that will assist in managing data analysis towards completing the Corrective Action Plan.	Jim	4/1/16
All	HCBS managers will participate in a Program and Quality Improvement team that serves that division and address items from the Corrective Action Plan with that team.	HCBS Program Managers Jim	5/1/16