Response to Corrective Actions

Beginning immediately, ensure that at least 80% of LTC Screenings for the EW and the AC programs occur within 10 days of referral. State legislation requires that LTC screenings should be conducted within 14 days (10 business days) of a request for screening, which is defined as the date the assessment is requested. Currently, 70% of screenings for EW and AC participants occur within the 10 business day timeframe. If a screening cannot take place in the required time period, document the reason for the delay in the participant’s case file. Houston County PH LTCC will track the date of referral for all requested LTCC on the referral screen. Assignment for Long Term Care Consultation will be made immediately, and client contacted for LTCC with in 14 days (10 business days). Contact will be noted in client’s case file. If client is unable to have LTCC within said time frame, notation in client files will be made. All referral dates will be entered on DHS 3427 form when submitted into MMIS.

Beginning immediately, ensure that all DD individual service plans have the two required signatures. It is required that the DD individual service plan is signed and dated by the case manager and either a participant with their own guardianship or a participant’s legal representative. Thirty-eight percent of DD individual service plans (3 out of 8 cases) do not include the two required signatures and another DD care plan is signed, but not dated by the participant or their legal representative. Effective immediately, all DD individual service plans will have the required signature and date by the case manager and a participant with their own guardianship or a participant’s legal representative. This will be completed by taking the following steps:

- The Case Manager will sign and date all individual service plans
- The Case Manager will ask the participant to sign and date the individual service plan
- If the participant is unable to sign and date the individual service plan, the participant’s legal representative will be asked to sign and date the individual service plan
- If the participant refuses to sign the individual service plan, leaves the meeting without signing, becomes too anxious or agitated to sign and date the individual service plan, the Case Manager will document this refusal, the appropriate reason why the participant did not sign, and the Case Manager will sign and date this documentation
- If, for any reason, the participant’s legal representative refuses to sign the individual service plan, that is unacceptable and further investigation will be needed to assure that this legal representative is looking out for the participant’s best interests.

How Corrective Action Plan will be monitored:

- The Social Service Supervisor will check individual service plans to assure the required two signatures are there, or will check to assure documentation was recorded as to why signature(s) were not obtained.
- This will be checked on a monthly basis and participants will be chosen at random at the discretion of the Social Service Supervisor
- This monitoring will be on-going

Within the next 30 days, for DD waiver participants that have a related condition as a primary diagnosis, complete the Related Conditions Checklist and maintain documentation that the checklist
has been completed. Of the DD cases reviewed, one participant had a related condition as a primary
diagnosis, but that participant did not have a Related Conditions Checklist in the case file. Effective
immediately, all DD waiver participants that have a related condition as a primary diagnosis will have a
Related Conditions Checklist maintained in the hard copy file. This will be completed by taking the following
steps:

- The Case Manager will complete the Related Conditions checklist for necessary DD waiver
  participants.
- When a Case Manager completes the Waiver screening, the Case Manager will complete the Related
  Conditions checklist, (as appropriate), for all DD waiver participants that have a related condition
  as a primary diagnosis.
- After the completion of the Related Conditions Checklist, the Case Manager is responsible for
  making a copy of the checklist and providing the copy to the Social Service Supervisor.
- The Social Service Supervisor will create a spreadsheet documenting who is a waiver participant
  that has a related condition as a primary diagnosis and when the Related Conditions Checklist was
  completed.

How the Corrective Action Plan will be monitored:

- The Houston County Waiver Review Team will meet two times per month. At this team meeting, the
  Social Service Supervisor will check with the Case Managers to assure that the listing of clients
  under “Related Conditions” is accurate.
- If there are changes needed, the will be made during the Waiver Review Team meeting.
- This process will be on-going.

Response to Recommendations:

Streamline the contracting process by creating one umbrella contract for all HCBS programs across
agencies. Execute multi-year contracts with contract renewal dates staggered over several years to
reduce the amount of contract maintenance required. Include the rates or rate setting tools in contracts
or contract attachments. This is especially important for residential rates that take up a substantial
portion of your budget, such as corporate foster care and assisted living providers. Require Assisted
(Customized) Living, homemaker and other providers to send case managers reports on individual
participants on a regular basis. Specify the reporting requirements in contract attachments. Houston
County Human Service Director and Public Health Director will discuss options related to Public Health
utilizing the Region 10 contract manager for all waiver contracts. Houston County Public Health currently has
a provider report form for clients who are CL and 24 Hour CL facilities that are submitted quarterly to the
CM. We will add this as an attachment to the contract during next cycle when we will be using the approved
DHS contract for elderly waiver services.

Provide training for case managers on basic provider contractual expectations, such as staffing levels and
provider reporting requirements. During site visits and through their interaction with providers, case
managers can help verify that expectations and participant outcomes are being met. Consider developing
a simple tool to document this information during face-to-face visits. Case management visits are one of
the most effective methods of monitoring provider performance, as case managers frequently observe
staff while visiting participants. If case managers identify persistent problems with providers, they
should alert the contract manager. After the contracts are renewed and signed by appropriate personnel at
the beginning of each year, the Social Service Supervisor will review provider contracts and share necessary
changes and updates at the Waiver Review Team Meetings which are held two times per month. Also, on a
yearly basis, the Directors of provider programs will be invited to meet with the Waiver Review Team to discuss
these expectations. The Case Managers will be responsible for verifying expectations to providers on an on-
going basis throughout the year and discussing necessary training and education requirements with the Waiver
Review Team according to the provider contract. Regarding PH contracts, all contracts will be reviewed with case managers annually. HCPH will begin to develop a formal QI tool to use to document provider performance and follow-up.

While Houston County has generally managed allocations well, there is room in the CCT budget to develop services to relocate persons with disabilities out of nursing homes, such as technology supports. Typically, for a county of Houston County’s size, reserves $150,000 to $200,000 for the CCT waiver budget would be more than adequate to manage the financial risks in these programs. Relocation screenings are scheduled on a regular basis and as requested by a client. The CCT Case Manager also monitors available openings and meets with the clients on a regular basis to discuss these options. One area that is a need in Houston County is more appropriate and available housing options for clients with nursing levels of care.

Provide more guidance, oversight and support for case managers in Social Services through systematic policy communication and a more structured orientation process. Consider partnering with neighboring counties for help develop policy and program expertise. Providing more supervision will help the County prepare for a seamless transition during times of staff turnover or retirement. This will also help ensure that all case managers understand expectations for documentation and standardize the good practices used by individual case managers. The Social Service Supervisor meets on a monthly basis with Waiver Supervisors and Waiver Lead Workers from eleven different counties in Region 10. As a group, and a goal beginning in 2009, we are continually trying to standardize policy and procedure across our regional area. This will be one point of interest that Houston County will bring to the Region 10 meetings is how to standardize guidance, support, oversight, orientation, and policy communication to assure a seamless transition not only within Houston County, but from one county to another.

Work with neighboring counties to fill service and provider gaps and increase provider capacities in more sparsely populated areas. Together, use a Request for Assistance (RFA) process or work with existing provider networks to respond to Houston County’s unmet long term care service needs for HCBS participants, such as personal care, in-home supports, transportation and other homecare services. Houston County Human Services and Public Health already partner with Winona County and Fillmore County regarding numerous programs, as well as the Region 10 group collaboration. The Social Service Supervisor meets on a monthly basis with waiver supervisors and waiver lead workers from eleven different counties in Region 10. As a group we are continually trying to standardize policy and procedure across our regional area. A goal for Region 10 will be to continue working on how to fill in service gaps and provider gaps across county lines.

For elderly program, consider adopting one care plan format that includes all required elements, including participant needs, services to be provided, health and safety concerns, goals and outcomes and signature pages with choice questions. Work with you health plans to adopt a single care planning format for these populations. Train staff on how to use these formats; this will provide for thoroughness and consistency across cases. It is the understanding of Houston County that DHS and the health plans have formed a work group to evaluate the issue of adopting one care plan format. As a small county agency we do not have the capacity and/or resources to develop and implement a standardized care plan form to be used for all the elderly programs.

Develop a plan for how Houston County will maintain strong relationships across Public Health and Human Services when the agencies move to different buildings. Currently, public health nurse and social workers are located in the same building and can easily consult with one another on cases. Houston County will need to develop strategies for maintaining these strong relationships after the move, such as...
providing desk space for case managers to work in one another’s offices. Houston County Human Services and Public Health have a very strong connection and a good working relationship. The buildings, although separate are both located in the same town, and minutes from each other. Both departments are also connected to the same phone line system, and use email very effectively for enhanced communication. Although there is no dedicated desk space in either building for the respective disciplines at this time, there are numerous meeting rooms that we can (and will) be utilized to keep up good communication. Also, Houston County Human Services Supervisor and Case Managers will notify Public Health Case Managers of our meetings held twice per month and invite Public Health Case Managers for case consultation on a regular basis and Public Health will do the same for Human Services.

As participants are added to case managers’ caseloads, monitor workloads closely and make necessary adjustments when appropriate. The elderly (EW and AC) and disability programs (CCT) have the potential to grow rapidly in Houston County, especially the EW and CADI programs. Participants in the CADI program in particular often have complex needs that require more intensive case management services. The Houston County Social Service Supervisor will continue to work very closely with the CCT Case Manager to assist with any necessary changes to case load size. The Case Managers for the CCT and the MR/RC Waiver meet together two times per month and work closely to assure that as program participant's needs change they continue to be on the correct Waiver program. Also, effective June, 2009, the CCT Case Manager has begun to train another Waiver Case Manager to be a back up for the CCT program to try and assist with the high volume of CCT cases. Houston County Public Health Director will continue to monitor the EW and AC program caseloads make necessary adjustments as needed.