Support Planning Professional Learning Community (SPPLC)
May 29, 2019
To ask a question during the presentation use the Q&A Panel in WebEx

Select “All Panelists”, type your question, and click Send.
Announcements

Lead Agency Review
Announcements

Upcoming SPP LC Webinars:

• June 26: Environmental Accessibility Adaptation (EAA) Home Modification Assessment and Installation for Home and Community-Based Services (HCBS)

• July 31: Canceled due to Odyssey Conference

• Registration is open for the rest of the year. Please register to receive updates and PowerPoint handouts.

OBRA Level II Training

• June 26, 2019; 1:00 – 4:00 pm
Person-Centered Practices in Support Planning

- Online modules
- Available in TrainLink under Disability Services (formerly Continuing Care)

Minnesota Age & Disability Odyssey Conference

- July 31 – August 1, 2019
- Duluth Entertainment Convention Center
Lead Agency Review

Presented by: Liz Banini, Maggie Munson, & Cate McKay
Agenda

• History & Purpose of the Lead Agency Review Project
• Overview of Lead Agency Review Process
• Round 3 (2015-2018) Summary of Reviews
• What to Expect in Round 4 (2019-2022)
• MnCHOICES Support Plan
• Q&A
The Lead Agency Review evaluation process began in 2006, and includes assuring compliance, a discussion of key performance measures, identifying best practices, and collecting feedback on DHS resources.

The goal of the Lead Agency Review is to determine how Minnesota’s Home and Community-Based Service (HCBS) programs are operating and meeting the needs of the people they serve.
1. Support lead agencies.
2. Encourage collaboration amongst agencies and the sharing of ideas.
3. Seek out and highlight best practices.
4. Gather, share and interpret quantitative and qualitative data.
5. Advance lead agencies use of managing by performance.
6. Use a review process that is constructive.
7. Assure compliance.
8. Engage lead agencies.
9. Listen to lead agencies’ suggestions.
10. Acknowledge the shared accountability of DHS and lead agencies.
Driven by Policy

Centers for Medicare and Medicaid Services (CMS)

The Olmstead Plan

Person Centered Informed Choice and Transition Protocol

Policy Changes
Lead Agency review is completed in 3 year cycles.

On average a lead agency can expect to be reviewed once every 3-4 years.

The review begins about 3 months before the visit and concludes about 3 months after the site visit.

There are 3 stages to a review.
Review Process, cont.

Pre-Visit Activities

- Kick-off teleconference
- Lead agency survey
- Learning about LA procedures
- Gathering data to share
Review Process, cont.

• Average visit lasts 4 days
• Case file review
• Meetings with sup., directors, mgrs.
• Focus groups
Review Process, cont.

Post-Site Visit

- Remediation & Corrective Action Planning
- Sharing innovations & feedback with DHS
- Summative reporting
Round 3: Overview

3 Years and 3 Months
August, 2015-November 2018

Lead Agencies
4 Alliances, 76 Counties, 2 Tribal Nations

Case Files
Number of case files reviewed

3
82
6,700
Round Three Themes

**Person Centered Practices**
1. System changes to HCBS Waiver Programs

**Community Access & Inclusion**
2. In accordance with Minnesota’s Olmstead Plan

**Lead Agency Enrolled Vendors**
3. Understanding lead agencies processes for tracking and managing providers

**Positive Supports and Jensen Settlement**
4. Positive Support Transition Plans
   - Formal Person Centered Plans
Case File Review

10% Program Enrollment

51 Measures
Increased from 41 in July, 2016

Areas Reviewed
- Transition, PSTP, & Jensen
- Assessment & Support Planning
- Development of a plan using person centered planning elements*
- Development of a plan using person centered record keeping and documentation*

*Began in July 2016.
Corrective Actions

Most common number of corrective action

Number of possible Corrective Actions for lead agencies.

Total number of individual corrective action plans required during round three of reviews.
<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99%</td>
<td>LTSS Assessment and Program Information/Signature Page is completed and signed annually</td>
</tr>
<tr>
<td>98%</td>
<td>Documents are signed correctly when a person has a public guardian</td>
</tr>
<tr>
<td>97%</td>
<td>A Release of Information to share private information is signed annually</td>
</tr>
<tr>
<td>79%</td>
<td>Service details are included in the support plan (frequency, type, cost and name of provider)</td>
</tr>
<tr>
<td>82%</td>
<td>The needs that were identified in the assessment/screening process are documented in the support plan</td>
</tr>
<tr>
<td>82%</td>
<td>Natural supports and/or services are included in the support plan</td>
</tr>
</tbody>
</table>
Case File Review Results: Development of a Plan that is Person Centered

• Includes 12 separate measures, which are elements of person centered planning.

• A plan that is developed including at least 9 of the 12 elements is considered compliant.

2018

• 85% included 9 of the 12 elements.

• Files reviewed in 2018, on average, included two more elements than files reviewed in 2016.

• Of 21 lead agencies reviewed, 9 required corrective action planning.
Case File Review Results:
Person Centered Planning Elements

12 measures: At least 9 measures must be present in the plan for it to be compliant

- The support plan includes details about what is important to the person.
- The person’s strengths are included in the support plan.
- The support plan describes goals or skills that are related to the person’s preferences.
- The support plan incorporates other health concerns; mental, chemical, chronic medical.
- The support plan includes a global statement about the person’s dreams and aspirations.
- The support plan identifies who is responsible for monitoring implementation of the plan.
- Action steps describing what needs to be done to achieve goals or skills are documented.
- The person’s current rituals and routines (quality, predictability, and preferences) are described.
- Social, leisure, or religious activities the person wants to participate in are described.
- The person’s preferred work activities are identified.
- The person’s preferred living setting is identified.
- Opportunities for choice in the current environment are described.
### Case File Review Results:
**Development of a Plan that is Person Centered**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92%</td>
<td>The support plan incorporates other health concerns</td>
</tr>
<tr>
<td>92%</td>
<td>The person’s preferred living setting is identified</td>
</tr>
<tr>
<td>88%</td>
<td>Social, leisure or religious activities the person wants to participate in are described</td>
</tr>
<tr>
<td>28%</td>
<td>The support plan includes a global dream statement about the person’s dreams and aspirations</td>
</tr>
<tr>
<td>63%</td>
<td>The person’s current rituals and routines are described</td>
</tr>
<tr>
<td>68%</td>
<td>The support plan identifies who is responsible for monitoring implementation of the plan</td>
</tr>
</tbody>
</table>
Development of a Plan that is Person Centered

- Support plan monitoring
- Global statement about dreams
- Action steps to achieve goals
- Other health concerns
- Strengths identified
- Rituals and routines
- Opportunities for choice
- Goals or skills described
- What is important to person
- Social, leisure, religious activities

- Q3-CY2016
- Q4-CY2016
- Q1-CY2017
- Q2-CY2017
- Q3-CY2017
- Q4-CY2017
- Q1-CY2018
- Q2-CY2018
- Q3-CY2018
- Q4-CY2018
Case File Review Results:
Person Centered Record Keeping Process

- Includes 7 separate measures, which are elements of person centered record keeping.
- A plan that is developed using all 7 of the person centered elements is considered compliant.

2018

- 75% included all 7 elements.
- Files reviewed in 2018, on average, included two and a half more elements than files reviewed in 2016.
- Of 21 lead agencies reviewed, 12 required corrective action planning.
Case File Review Results: Person Centered Record Keeping

7 measures: All 7 measures must be present for the plan to be compliant

• The support plan is written in plain language.
• The support plan records the alternative home and community-based services that were considered by the person.
• The support plan includes strategies for solving conflict or disagreement within the process.
• The support plan includes a method for the individual to request updates to the plan.
• The person's level of involvement in the planning process is described.
• Documentation that the plan was distributed to the individual.
• Documentation that the plan was distributed to other people involved.
Case File Review Results:
Person Centered Record Keeping

- The person’s level of involvement in the planning process is described: 94%
- The support plan is written in plain language: 92%
- There is documentation the plan was distributed to the individual: 83%
- The support plan includes a method for the individual to request updates to the plan: 73%
- The support plan includes strategies for solving conflict or disagreement within the process: 73%
- The support plan records the alternative home and community-based services that were considered by the person: 75%
Person Centered Record Keeping

- Written in plain language
- Strategies for solving conflict
- Method to request updates
- Alternative HCBS services
- Involvement in planning
- Plan given to others involved
- Plan given to individual
Person centered compliance measures, per fiscal quarter

Development of person-centered plan
Person-centered record keeping
Case File Review Results: Employment Measures

Individuals 16-64 years old
Not requiring corrective action planning at this time

- **98%** Information on competitive employment opportunities is provided annually
- **93%** A decision about employment has been documented
- **86%** The person was provided information to make an informed decision about employment
- **78%** The person was offered experiences to help them make an informed decision about employment
Case File Review Results: Additional Samples

**Jensen Settlement Members**
128 Cases Reviewed

Of individuals had a formal Person Centered Plan created or reviewed in the last 365 days.

**Positive Support Transition Plans**
145 Cases Reviewed

Of cases reviewed had a completed PSTP, including appropriate reviews.

**Transition (Move) Planning**
109 Cases Reviewed

Of cases reviewed had a completed My Move Plan Summary, or indication the move was unknown to the case manager or the individual denied planning.
# Case Manager & Assessor Survey

The following table presents the responses from Case Managers and Assessors compared to the results found in case file reviews for including person centered measures into the assessment and support planning process:

<table>
<thead>
<tr>
<th>Person Centered Measure</th>
<th>Survey Response</th>
<th>Case File Review Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person’s strengths.</td>
<td>82%</td>
<td>78%</td>
</tr>
<tr>
<td>The goals to be achieved that are related to the person’s preferences.</td>
<td>81%</td>
<td>80%</td>
</tr>
<tr>
<td>Action steps for goals</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>Opportunities for choice on a daily basis</td>
<td>75%</td>
<td><strong>88%</strong></td>
</tr>
<tr>
<td>The person’s daily activities, rituals or routines.</td>
<td>84%</td>
<td>63%</td>
</tr>
<tr>
<td>The person’s dreams and wishes for the future.</td>
<td>86%</td>
<td>28%</td>
</tr>
<tr>
<td>Where and with whom the person wants to live.</td>
<td>87%</td>
<td><strong>92%</strong></td>
</tr>
<tr>
<td>The social, leisure or religious activities the person wants to engage in.</td>
<td>88%</td>
<td><strong>88%</strong></td>
</tr>
<tr>
<td>Preferred work</td>
<td>86%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Table: Case Managers and Assessors responses to including person centered measures into the assessment and support planning process compared to results found in case file review.
Questions
Round 4: What to expect in 2019-2022

Data Sharing & Collecting
- Annual Long Term Care Data
- Lead Agency Staff
- External Partners

On-Site Visit
- Average Visit 4 Days
- Case File Review
- Face to Face Meetings

Follow-Up & Reporting
- Remediation and Corrective Action Planning
- Sharing Best Practices and feedback
- External Reporting
Round Four Themes

Equity
Identifying and addressing disparities

1. How are lead agencies engaging with underserved and emerging communities?
2. What steps are being taken to ensure equitable access?

Community Integration
Creating connections and building opportunities

2. Person-centered Practice, Choice, Employment and Housing
3. How are individual’s being supported in their environments to navigate and lead the lives they want?

Program Sustainability
Operational data for lead agencies to better support the individuals they serve.

3. How service utilization and cost impact a person’s choice in employment, housing, and participation in the community.
Round Four: Case File Review

- New Measures added for Round 4: 0
- Measures being reviewed during Round 4: 43
- Measures if the individual has moved: 13
- Areas that are being reviewed:
  - Assessment & Support Planning
  - Development of a Plan that is Person Centered
  - Support Plan Record Keeping
  - Transition*
Development of a Plan that is Person Centered

The support plan must reflect nine of the twelve high impact elements described in the development of a person centered plan according to The Person Centered, Informed Choice and Transition Protocol (DHS-3825) and included below. Items indicated with an asterisk (*) must be evidenced in a current support plan.

<table>
<thead>
<tr>
<th>Measurement</th>
<th>CAC</th>
<th>CADI</th>
<th>BI</th>
<th>DD</th>
<th>EW</th>
<th>AC</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 *The support plan includes details about what is important to the person.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>26 *The person’s strengths are included in the support plan.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>27 *The support plan describes outcomes and goals as related to the person’s preferences.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>28 *The support plan includes a global statement about the person’s dreams, hopes, or aspirations.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>29 *The support plan incorporates other health concerns (e.g. mental health,</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Support Plan Measures

If it must be evidenced in the support plan, it can be found **ANYWHERE** in the support plan.
What do you consider the support plan?

- The CSP, CSSP and Signature Page
- The Collaborative Care Plan and Signature Page
- An approved CDCS Plan*
  *only when a current, signed CSP/CSSP is also present
MnCHOICES
CountyLink

- CADI Example
- DD Example
10. A support plan that was completed in the last year including being signed by all required parties.

Compliant if signed and dated by individual (if possible) and guardian (if necessary). Needs one or the other based on guardianship status.

- DHS-6791D
- Look for a guardian signature based on MMIS Data of guardianship status
Compliant if radial is selected, and there is a signature and date or the measure is described.

- 15. Acknowledgment of choice in providers and services.
- 20. Provider Signatures.
- 38. Record of alternative HCBS services offered to the person.
- 40. Method for the individual to request updates.
- 4. Evidence of Appeal Rights.
- 41. Person’s level of involvement in the planning process.
26. The person’s strengths are included in the support plan.

**Compliant if** there is a description of at least one strength of the individual in the support plan.

**Suggestion:**

- What do you and others like and admire about the individual?

**Example:**

Mohammed is a strong reader and reads books far above his grade level. Mohammed loves computers. He takes pride in problem solving computer related issues for his family and peers at school. (DD – CSP pg.1)
37. The support plan is written in plain language. The plan does not contain acronyms or medical jargon and does not refer to the person as “client” or “member”.

**Compliant if** there is very few acronyms or medical jargon.

**Most common jargon to avoid:**

- ADLs/IADLs
- Diagnosis Codes with no description
- Acronyms for services: HM, SNV, MOW

**Example:**

**Personal Assistance:** Mohammed needs hands on assistance with dressing, grooming, and bathing. He prefers his mom to help with these activities, but is cooperative with other caregivers. (DD – CSP pg.5)
25. The support plan includes details about what is important to the person.

**Compliant if** there is a description of at least one thing that is important to the individual in the support plan.

**Suggestions:**
- MnCHOICES Support Plan: What’s Important to the Individual
- MnCHOICES Assessment: What is important to the individual?

**Example:**

**Quality of Life:** It is important to Delford to continue to practice his religion and faith. It is important to Delford to feel respected and not be discriminated against. He wants to live in an environment where he feels safe and supports his sobriety.

(CADI – CSP pg.3)
16. The person’s outcomes and goals are documented in the person’s support plan AND
27. The support plan describes outcomes and goals as related to the person’s preferences.

16. **Compliant if** there is at least one goal or outcome.

27. **Compliant if** there is at least one goal or outcome related to the individual’s preferences.

**Suggestions:**
- MnCHOICES Support Plan: Short and Long Term Goals
- Related to preference - uses the information we know about the individual to have a meaningful goal, that can drive their support and services.

**Examples:**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delford will attend Alcoholics Anonymous (AA) at least once per week and will remain sober.</td>
<td>02/28/2019</td>
</tr>
<tr>
<td>Delford will find a living environment where he feels safe and supported.</td>
<td>05/31/2018</td>
</tr>
</tbody>
</table>

(DD – CSP pg. 4)
28. The support plan includes a global statement about the person’s dreams, hopes, or aspirations.

**Compliant if** there is a description of at least one dream, hope, aspiration, vision.

**Suggestions:**

- “Someday…”
- “I’d love to…”
- “I wish I could…”
- “I really miss…”

**Example:**

Delford has many strengths including writing and a heart for service; he is a good communicator and has a strong work ethic. **Delford likes to travel and would like to be involved in mission work. His dream vacation would be to go to Israel. He hopes to work with children in the future.** (CADI – CSP pg.1)
A “dream” statement does NOT need the word dream in it!
11. The needs that were identified in the assessment/screening process are documented in the support plan.

**Compliant if** the individual’s assessed needs (for every applicable domain) are described in the support plan.

**Suggestions:**
- Description of the need **NOT** of how the need is being met.
- MnCHOICES Support Plan: Summary of Needs
- MnCHOICES Assessment: Support Planning Implications

**Example:**

**Home Management:** Delford needs assistance with medication management and set up. He needs assistance with meal prep as well as shopping for groceries. Delford needs reminders for housework and assistance with his finances.

(CADI – CSP pg.6)
12. The person’s health and safety concerns identified in the assessment/screening process are documented in the support plan. **AND**
29. The support plan incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.)

**12. Compliant if** at least one health OR safety need is described.

**29. Compliant if** concerns are described beyond primary health and safety needs.

**Suggestions:**
- Description of the need NOT of how the need is being met.
- MnCHOICES Support Plan: Summary of Needs
- MnCHOICES Assessment: Support Planning Implications

**Example:**

**Health Related/Medical:** Delford needs assistance with medication setup and reminders. He may need assistance with transportation to doctor appointments. Delford needs reminders to monitor his blood glucose-ILS helps to set up a daily reminder in his phone.

(CADI – CSP pg.6)
13. Risks are identified and addressed in the support plan.

**Compliant if** description of at least one risk and a plan to reduce risk or note if there is no remaining risk

**Suggestions:**
- MnCHOICES Support Plan: Risks: How will health and safety issues be addressed?
- MnCHOICES Assessment: Personal Safety Section

**What the risk is:** Delford is at risk for substance abuse when he does not have structure and good supports. Delford meets with his ARMHS worker weekly to develop and increase coping skills. (CADI – CSP pg.7)

**How its being addressed:** Delford's AA sponsor will provide support to assist in maintaining sobriety and provide emotional support. (CADI – CSP pg.5)
17. The services a person is receiving are documented in the support plan.

17. **Compliant if** there is at least one service described in the support plan.

**Suggestion:**

- MnCHOICES Support Plan: Summary of Program and Services
18. Service details are included in the support plan. Service details include: provider name, type, frequency, and cost.

18. Compliant if there is a **Provider Name** is documented for at least one service. AND **Type of Service** is documented for at least one service. AND **Frequency** of service is documented for at least one service. AND **Cost** of service is documented for at least one service.

**Suggestion:** MnCHOICES Support Plan: Summary of Program and Services
19. Natural supports and/or services are included in the support plan. Natural or informal supports include unpaid people in the person’s life, as well as activities available to everyone in the community.

**Compliant if** there is a description of the natural or informal supports in the support plan.

Not Applicable – Person does not have informal or natural supports

**Suggestions:**
- MnCHOICES Support Plan: Informal Caregivers
- MnCHOICES Assessment: Unpaid individuals who provide care and/or assistance to the person

<table>
<thead>
<tr>
<th>INFORMAL CAREGIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Caregiver Relationship</td>
</tr>
<tr>
<td>Lives with Person</td>
</tr>
<tr>
<td>Caregiver Role</td>
</tr>
<tr>
<td>Type of Care</td>
</tr>
</tbody>
</table>

(DD – CSP pg.6)
30. The support plan identifies who is responsible for monitoring implementation of the plan. Including the specific process of how often and by whom the plan will be monitored and reviewed.

**Compliant if** there is a description of who is responsible for monitoring the plan.

**Examples:**

**What will the case manager do?**

Delford's CADI case manager will contact him monthly (and as needed) to review progress towards goals and assist with any needed referrals. When Delford chooses housing....

(CADI – CSSP pg.4)

**Service Notes:**

200 CM units per year-for coordinating and monitoring services and support with problem solving

(CADI – CSSP pg.7)
Lead Agency Review Website

- mn.gov/dhs/hcbs-lead-agency-review
- Announcements
- Tentative schedule
- Protocols
- List of Items Reviewed
- Findings – Lead Agency Reports

- DHS.leadagencyreviewteam@state.mn.us
Thank You!

Liz Banini and Maggie Munson
Dhs.leadagencyreviewteam@state.mn.us
Minnesotahcbs.info
Where to find help now

- **Person Centered Thinking 2-day Trainings**

- **Person Centered Practices Webpage**

- **Olmstead Plan Webpage**

- **DHS Training Archive page**
  - [http://www.dhs.state.mn.us/main/dhs16_143138](http://www.dhs.state.mn.us/main/dhs16_143138)

- **Brain Injury Basics** – YouTube videos

- **Bulletins**
  - [http://www.dhs.state.mn.us/main/id_000305](http://www.dhs.state.mn.us/main/id_000305)

- **Lead Agency Review Website**
  - [mn.gov/dhs/hcbs-lead-agency-review](http://www.dhs.state.mn.us/main/id_000677#)

- **E-List Announcements**
  - [http://www.dhs.state.mn.us/main/id_000677#](http://www.dhs.state.mn.us/main/id_000677#)

- **CBSM Main Page**
  - [http://www.dhs.state.mn.us/main/id_000402](http://www.dhs.state.mn.us/main/id_000402)

- **Disability Hub MN**
  - [http://disabilityhubmn.org/](http://disabilityhubmn.org/)
  - [Quick Reference Guide](http://www.dhs.state.mn.us/main/id_000402)

- **Positive Supports Minnesota**
  - [https://mnpsp.org/](https://mnpsp.org/)
Please take a moment to let us know your thoughts.

Take our Survey:

http://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=155855777726
Audio from today’s session will be available beginning tomorrow morning by dialing:

855-859-2056
Conference ID:
6289309

If you have questions following the session, email to DSD.ResponseCenter@state.mn.us
Thank you for attending!