

Resource: Guide for emergency backup planning

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This page provides best practices, guidance and resources for case managers and care coordinators to help people develop and document backup plans for staffing emergencies.

Background

The direct care workforce shortage in Minnesota is impacting people with disabilities and older adults as they struggle to find care in their own homes and communities. It is critical for people to have individualized backup plans in place to maintain support in the event of an unexpected staffing emergency. Backup planning **before** an emergency occurs will help each person make an informed choice based on their individualized goals and preferences.

Applicability

This page applies to the following programs and services when the person needs a coordinated services and supports plan (CSSP) or collaborative care plan (CCP):

- [Alternative Care \(AC\)](#)
- [Brain Injury \(BI\) Waiver](#)
- [Community Access for Disability Inclusion \(CADI\) Waiver](#)
- [Community Alternative Care \(CAC\) Waiver](#)
- [Developmental Disabilities \(DD\) Waiver](#)
- [Elderly Waiver \(EW\)](#)
- [Essential Community Supports \(ECS\)](#)
- [Personal care assistance \(PCA\) services](#)
- [Rule 185 case management.](#)

Responsibilities

Case managers and care coordinators play a critical role in supporting people to make an informed choice about their service and support options. This includes informing people of their options should their first choice become unavailable.

To support people in developing and monitoring their emergency backup plans, case managers and care coordinators must:

- Inform the person and their legal representative (if applicable) of service and support options
- Finalize the written support plan, including discussing and documenting the emergency backup plan with the person
- Provide ongoing monitoring and assessment of the person's services as identified in their support plan, including monitoring the person's needs and the adequacy of their support plan
- Review and understand provider emergency backup plans if the person receives home care services (including PCA services), resides in a provider-controlled residential setting or receives other essential services.

For information about other case manager and care coordinator responsibilities, see [CBSM – Support planning for long-term services and supports \(LTSS\)](#) and [CBSM – Waiver, AC and ECS case management.](#)

The following sections provide more information about responsibilities specific to emergency backup planning.

Developing the emergency backup plan

The case manager or care coordinator must discuss and develop emergency backup plans with the person and their legal representative (if applicable). The case manager or care coordinator will provide information to ensure the person can make an informed choice about the people, organizations, providers, services and technology that may be available to provide support during a staffing emergency.

The backup plan must focus on the person's needs, desires and preferences for service delivery. The support the person chooses as part of their emergency backup plan does not need to include only

formal supports and services. The person may choose to receive emergency backup support through assistive technologies, family members, friends, community organizations or other informal supports. Exploring preferences and choices with the person may lead to identifying unique and innovative backup support — something not necessarily part of their regular list of options. Each person's strengths, needs and supports are unique. A backup plan should reflect each person's individual circumstances and choices.

Important topics to discuss include, but are not limited to:

- Plan for short-term staffing emergencies (e.g., staff are late, staff did not show up)
- Plan for long-term staffing emergencies (e.g., staff resigned, staff are unable to work, primary caregiver is unable to care for the person, provider terminates services, residential site closes)
- From whom the person wants to receive support during a staffing emergency (e.g., family, friends, organizations, providers, assistive technology, formal and informal caregivers)
- What specific support the person needs and wants
- When the support will occur (i.e., frequency, duration).

Planning for staffing emergencies **in advance** will help the person make an informed decision about the services and supports available to them.

Documenting the emergency backup plan

Case managers and assessors (when applicable) can use the "Emergency and Backup Plan for Services and Supports" section of the CSSP to document the emergency backup plan. Care coordinators can use the applicable section of the CCP.

The case manager or care coordinator must continue to monitor the person's services, including the adequacy of the support plan and appropriateness of the emergency backup plan. The person and case manager or care coordinator should update the emergency backup plan as needed.

Additional resources

The following resources may help case managers and care coordinators have discussions with people about services and supports available to them.

Workforce shortage background and information

[DHS – Direct care workforce shortage in Minnesota](#): Information about the background of the direct care workforce shortage crisis in Minnesota, state-sponsored workgroups, and additional resources.

[DHS – Direct care workforce resources](#): A list of programs and resources available to help people plan for staffing shortages. Resources are available for counties and tribal nations, provider agencies and people interested in a career as a direct support professional.

Service options and informal supports

[Disability Hub MN – Services and supports](#), [Disability Hub MN – Modifications and accommodations](#) and [Housing Benefits 101 – Assistive technology](#): Information and resources about natural supports and assistive technology, which may help a person decrease reliance on formal services.

[DHS – CDCS training \(video\)](#), [DHS – CDCS overview](#) and [DHS – CSG overview](#): Information about consumer directed community supports (CDCS) and the Consumer Support Grant (CSG), which are self-directed service and support options that give people choice and flexibility with their service options, including hiring their own support staff (e.g., parents, spouses, relatives and friends).

[PCA Policy Manual](#): Policy manual about PCA services, which are self-directed services and supports that allow people to hire their own support staff (e.g., family, friends and neighbors).

[CBSM – Remote support](#): Information about remote support policy. Effective Jan. 1, 2022, remote is a permanent allowable delivery method for many services available through certain programs. Remote support is not a service. It is a method to deliver an allowable service when certain requirements are met.

[Minnesota Guide to Assistive Technology](#): Guide to increase awareness of assistive technology and provide information to help with the consideration, selection, acquisition and use of assistive technology.

Finding support

[Direct Support Connect](#): An online job board to help people find and hire direct support workers in Minnesota. Users can create a profile, view worker profiles and contact workers to schedule an interview.

[Find support on MinnesotaHelp.Info](#): An online resource database with information about community services for people to sustain and improve their daily lives. It includes information about health care, child care, job training, education, recreation, retirement, disability services and social services.

[Senior LinkAge Line \(SLL\)](#): A free service that connects older adults and their families with the help they need. This service is provided by the Minnesota Board on Aging, in partnership with Minnesota's Area Agencies on Aging.

Transition planning

[CBSM – Guide to support a person with a residential service termination](#): Information about a case manager's role in supporting a person with a residential service termination, including service options that may be available to people.

[DHS – Person-centered practices](#): Information about the Person-Centered, Informed Choice and Transition Protocol, which helps lead agencies use and implement person-centered practices.

[CBSM – My Move Plan Summary](#): Information about the My Move Plan Summary, which is a summary of the person's plan when they move from one residence to another and do not intend to return. The case manager, care coordinator or support planner creates the My Move Plan Summary with the person.

[Supporting My Move: A Case Manager's Role \(TrainLink\)](#): A course that guides case managers through their responsibilities in supporting a person to find a new home. This course also addresses different moving supports, services and tools to help people plan for successful moves, including information about Housing Stabilization Services (HSS). This learning module is located in [TrainLink](#). You must have a Unique Key to register. If you do not have a Unique Key, see [TrainLink – Unique Key Request Form](#).

In [TrainLink](#), follow these steps:

1. Under Learning Center, click Disability Services
2. Under Courses and Classes, click Find a Course
3. In the Search by Class Name field, search for HOUSING_CM
4. Click Select next to Supporting My Move: A Case Manager's Role
6. Enter your Unique Key and click OK.

Feedback and questions

DHS values your feedback. Submit questions or comments about disability services using the [DSD Contact Form](#). Submit questions or comments about aging services by emailing dhs.aasd.hcbs@state.mn.us.