

Round Four Case File Review: List of Items Reviewed

Case file review identifies compliance with program requirements for CAC, CADI, BI, DD, EW (MCO and FFS) and AC programs; assessing the quality and consistency of assessment and support planning by the lead agency. The lead agency review (LAR) team does a random sampling for each program and reviews those cases for compliance during the review process.

Assessment and Support Planning

Assessment and support planning measurements are found in the person's support plan, MnCHOICES or legacy assessment and case notes. Items indicated with an asterisk (*) must be evidenced in a current support plan¹.

| Measurement | | CAC | CADI | BI | DD | EW | AC |
|-------------|---|-----|------|----|----|----|----|
| 1 | Documentation that face-to-face visits with the person has occurred within the required timelines for each HCBS program. The previous eighteen months of face to face visit documentation are reviewed. | X | X | X | X | X | X |
| 2 | Current DHS-3428 , DHS-3067 or MnCHOICES Assessment. Signed and dated by all required parties (Legacy DD Screening). | X | X | X | X | X | X |
| 3 | LTSS Assessment and Program Information and Signature Page (DHS-2727) is completed and signed annually by the person. Does not include MCO EW or assessments completed using legacy assessment tools. | X | X | X | X | X | X |
| 4 | Evidence that right to appeal information has been provided to the person in the last year. | X | X | X | X | X | X |
| 5 | Alternative Care Program Client Disclosure Form (DHS-3548) is completed and signed annually. | | | | | | X |
| 6 | Alternative Care Program Eligibility Worksheet (DHS-2630 or DHS-2630A) is completed and signed annually. | | | | | | X |
| 7 | Related Conditions Checklist (DHS-3848) is completed annually for people with a related condition, as indicated by a "V code" or "F78" diagnosis listed on the DD screening document. | | | | X | | |
| 8 | HCBS case manager is not performing the duties for public guardianship, including signing documentation. | X | X | X | X | X | X |
| 9 | Timeline between assessment activity date and the date the CSSP or Collaborative Care Plan was sent to the individual is less than 60 days. | X | X | X | X | X | X |
| 10 | *A support plan (ISP, CSSP, etc.) that was completed in the last year including being signed by all required parties (person and/or guardian, case manager). | X | X | X | X | X | X |
| 11 | *The needs that were identified in the assessment/screening process are documented in the support plan. | X | X | X | X | X | X |

| Measurement | | CAC | CADI | BI | DD | EW | AC |
|-------------|--|-----|------|----|----|----|----|
| 12 | *The person's health and safety concerns identified in the assessment/screening process are documented in the support plan. | X | X | X | X | X | X |
| 13 | *Risks are identified and addressed in the support plan. | X | X | X | X | X | X |
| 14 | In the last year, the support plan or emergency backup plan identifies an emergency contact AND addresses other elements such as, emergency medical care, provider no-shows, weather conditions, etc. based on the person's needs. | X | X | X | X | X | X |
| 15 | *The person acknowledges choices in the support planning process, including choices in providers, services, and living and employment settings. | X | X | X | X | X | X |
| 16 | *The person's outcomes and goals are documented in the person's support plan. | X | X | X | X | X | X |
| 17 | *The services a person is receiving are documented in the support plan. | X | X | X | X | X | X |
| 18 | *Service details are included in the support plan. Service details include: provider name, type, frequency, and cost. | X | X | X | X | X | X |
| 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. | X | X | X | X | X | X |
| 20 | Provider Signatures are acquired, or evidence of two attempts to obtain provider signatures are documented upon completion of the support plan. (Based on person's preference to share support plan) | X | X | X | X | X | X |
| 21 | Has the person chosen a different living arrangement than their current living arrangement? If so, planning has taken place on how to help that individual move to their preferred setting. | X | X | X | X | X | X |
| 22 | The person's (aged 16 to 64) employment opportunities and goals are assessed annually. | X | X | X | X | | |
| 23 | The person's (aged 16 to 64) decision about employment is documented. | X | X | X | X | | |
| 24 | The person (aged 16 to 64) was offered experiences to help them make an informed decision about competitive, integrated employment. It is noted what experiences were offered to the person. This might include alternatives to standard formal services and supports. | X | X | X | X | | |

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 plan¹.

| Measurement | | CAC | CADI | BI | DD | EW | AC |
|-------------|---|-----|------|----|----|----|----|
| 25 | *The support plan includes details about what is important to the person. | X | X | X | X | X | X |
| 26 | *The person’s strengths are included in the support plan. | X | X | X | X | X | X |
| 27 | *The support plan describes outcomes and goals as related to the person’s preferences. | X | X | X | X | X | X |
| 28 | *The support plan includes a global statement about the person’s dreams, hopes, or aspirations. | X | X | X | X | X | X |
| 29 | *The support plan incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.) | X | X | X | X | X | X |
| 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. | X | X | X | X | X | X |
| 31 | Action steps describing what needs to be done to assist the person in achieving their goals. | X | X | X | X | X | X |
| 32 | The person’s current rituals and routines are described. | X | X | X | X | X | X |
| 33 | Social, leisure, or religious activities the person wants to participate in are described. | X | X | X | X | X | X |
| 34 | The person’s preferred work (aged 16-64) is described. | X | X | X | X | | |
| 35 | The person’s preferred living setting is described. | X | X | X | X | X | X |
| 36 | Opportunities for meaningful choices in their daily life including activities, daily routines, etc. are described. | X | X | X | X | X | X |

Support Plan Record Keeping Process

The support plan must reflect all seven of the high impact elements described in the support plan record keeping process 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 plan¹.

| Measurement | | CAC | CADI | BI | DD | EW | AC |
|-------------|---|-----|------|----|----|----|----|
| 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”. | X | X | X | X | X | X |
| 38 | *The support plan records that alternative home and community-based services were offered to the person. | X | X | X | X | X | X |
| 39 | *The support plan includes strategies for solving conflict or disagreement within the process, including any conflicts of interest and strategies that will be used to resolve possible disagreements are described. | X | X | X | X | X | X |
| 40 | *The support plan includes a method for the person to request updates to the plan as needed. | X | X | X | X | X | X |
| 41 | The person’s level of involvement in the planning process is described including their involvement in service and provider selection, establishment of goals, as well as choosing meeting location, time, planning participants and agenda. | X | X | X | X | X | X |
| 42 | Documentation that the current CSSP or Collaborative Care Plan was distributed to the person. It is best practice to provide a completed support plan to the person and their guardian if applicable. | X | X | X | X | X | X |
| 43 | Documentation that the current support plan was distributed to other people involved, (e.g. planning participants, service providers, informal support, etc.) based on the person’s preferences. | X | X | X | X | X | X |

Transition (Move) Requirements

These measures apply when the individual has experienced a move. As outlined in part two of [The Person Centered, Informed Choice and Transition Protocol](#) (DHS-3825) additional planning is required when a person has moved. This is additional planning that takes place above and beyond the individual’s support plan. This planning must be documented using the “My Move Plan Summary” ([DHS-3936](#)).

| Measurement | | CAC | CADI | BI | DD | EW | AC |
|-------------|--|-----|------|----|----|----|----|
| 44 | Documentation that the person did not want assistance coordinating their move or that the case manager was not aware of a planned move. OR review of measures 45-56. | X | X | X | X | X | X |
| 45 | The person’s “move to address” is documented. | X | X | X | X | X | X |
| 46 | The person’s “move date” is documented. | X | X | X | X | X | X |
| 47 | How the person will get to his/her new home is documented. | X | X | X | X | X | X |
| 48 | The date the person’s belongings will arrive is documented. | X | X | X | X | X | X |
| 49 | Who will deliver the person’s belongings is documented. | X | X | X | X | X | X |
| 50 | The case manager has signed the person’s move plan. | X | X | X | X | X | X |
| 51 | A plan is in place for managing the person’s medications. | X | X | X | X | X | X |
| 52 | The person knows when and who will follow-up with them once they are in their new home, and the person has that individual’s contact information. | X | X | X | X | X | X |
| 53 | A plan is in place to ensure the person can attend upcoming appointments. | X | X | X | X | X | X |
| 54 | The person knows how to contact members of their support team. | X | X | X | X | X | X |
| 55 | The person and/or guardian has signed their move plan. | X | X | X | X | X | X |
| 56 | During transition planning, there is evidence that the person was provided information and options to make informed choices that were meaningful to them. (May be documented anywhere in the file) | X | X | X | X | X | X |