Case File Review Protocol

Case file review identifies compliance with program requirements for AC, BI, CAC, CADI, DD, EW programs as well as the Jensen settlement agreement, Positive Support Transition Plans and transition plans; assessing the quality of case management services provided by the lead agency. The lead agency review (LAR) team does a sample draw for each program and reviews those cases while onsite. Below are the steps that are taken throughout the case file review process and who is involved with each step.

Case File Review Step *(for each case)*	**LAR**	**Lead Agency**
1. Initial review of the case file. For a complete list of items that are reviewed see *"List of Items Reviewed"*	X	
2. Upon initial review the evaluator prints a *"Case File Review Compliance Report"* which details the findings of the review. - If compliant the boxes would be greyed and read "Compliant" or "Not Applicable" - If not compliant the boxes would be white and blank or read "Not Compliant"	X	
3. The *"Case File Review Compliance Report"* is then provided to Lead Agency Staff for review. - This is a second review, for accuracy. - Depending on the lead agency's structure this might be reviewed by supervisors, case managers, or assessors. - If a review item was not found by the LAR evaluator this is the lead agency's opportunity to clarify its location or engage in conversation to promote understanding of how a policy is being monitored. - The lead agency may write notes or attach documents to the *"Case File Review Compliance Report"* and return it to the lead agency review team.		X
4. The LAR evaluator notes any items that were provided, in follow up, by the lead agency and determines their compliance based on monitoring protocol. The *"Case File Review Compliance Report"* is then updated by the LAR evaluator and the case file's review is finalized.	X	
5. Once steps 1-4 have taken place for every case file included in the sample, case file review is considered complete. In preparation for the final exit meeting with lead agencies, copies of every case's final *"Case File Review Compliance Report"* will be printed for the lead agency.	X	

CASE FILE REVIEW COMPLIANCE REPORT (refer to *List of Items Reviewed* for more details)

PMI:	***Waiver:***	***County:***
First Name:	***Last Name:***	***Reviewed On:***

Assessment & Support Planning

Face to Face Visits Documented	1		
Current Assessment	2	Current Support Plan*	18
Current Screening	2	Support Plan Signed*	18
DD Screen doc Signed	2	Outcomes & Goals*	19
Under 18 Form	3	Needs Identified*	20
AC Disclosure (DHS -3548)	4	Health & Safety*	21
AC Eligibility (DHS-2360/A)	5	Natural Supports/Services*	22
BI Form (DHS-3471)	6	Risks are Identified*	23
CAC Application (DHS-7096 or 3614)	7	Services in Plan*	24
DD LOC	8	Service Details*	25
Obra Level One	9	Emergency Back-up Plan	26
Related Conditions Checklist	10	Choice in planning process	27
Public Guardian	11	Plan to Move	28
Release of Information	12	Employment Assessed Annually	29
Right to Appeal	13	Info on Competitive Employment	30
Notice of Privacy Practices	14	Employment Decision Documented	31
LTSS Asses. & Prog. Info (DHS-2727)	15	Offered Employment Experiences	32

Development of a Person Centered Plan: See page 3

What is important to a person*	33	Action Steps to achieve goals	39
Person's Strengths Identified*	34	Rituals & Routines	40
Preferred Goals & Outcomes*	35	Social, Leisure, Religious Activities	41
Other Health Concerns*	36	Preferred Work documented	42
Global Dream Statement*	37	Preferred Living Setting	43
Support Plan Monitoring*	38	Opportunities for Choice	44

Support Plan Record Keeping Process: See page 3

Written in plain language*	45	Involvement in Planning	49
Alternative HCBS Services*	46	Plan given to Individual	50
Strategies for Solving Conflict*	47	Plan given to others involved	51
Method to request updates*	48		

Provider Signatures Compliance: 16

*Item must be found in a current support plan

List of Items Reviewed

These items can be found in the person's support plan, CL tool (signed, dated and sent to the individual), MnCHOICES Assessment, a separate person-centered plan (signed and dated), case notes, or other **lead agency generated documents**. Items indicated with an asterisk (*) must be evidenced in a current support plan.

Assessment and Support Planning

Items	AC	BI	CAC	CADI	EW	DD
1. Documentation that face-to-face visits with the person has occurred within the required timelines for each HCBS program.	X	X	X	X	X	X
2. Current assessment/screening documents. (DHS-3428, DHS-3067 or MnCHOICES Assessment). Signed and dated by all required parties (Legacy DD Screening).	X	X	X	X	X	X
3. Supplemental Form for Assessment of Children under 18 (DHS-3428C or MnCHOICES Assessment) is completed at the time of assessment.		X	X	X		
4. Alternative Care Program Client Disclosure Form (DHS-3548) is completed and signed annually.	X					
5. Alternative Care Program Eligibility Worksheet (DHS-2630 or DHS-2630A) is completed and signed annually.	X					
6. BI Waiver Assessment and Eligibility Determination form (DHS-3471 or MnCHOICES Assessment) is completed annually and signed by the person.		X				
7. CAC Application (DHS-3614) or Request for Physician Certification of Level of Care (DHS-7096) is completed annually by the physician.			X			
8. Level of Care for ICF/DD and DD Waiver Services document (DHS-4147A or MnCHOICES Assessment) is completed and signed (legacy) within the last year.						X
9. OBRA Level One Screening form is completed via (DHS-3426 or MnCHOICES Assessment).	X	X	X	X	X	
10. 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
11. HCBS case manager is not performing the duties for public guardianship, including signing documentation.	X	X	X	X	X	X
12. A Release of Information allowing the lead agency to share private information is signed by the person annually.	X	X	X	X	X	X
13. Right to Appeal information has been provided to the person in the last year. Evidence of person's signature and date is required.	X	X	X	X	X	X
14. Notice of Privacy Practices/HIPAA information has been provided to the person when private information is collected. Evidence of person's signature and date is required.	X	X	X	X	X	X
15. 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
16. 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
17. Timeline between assessment date and completion of the support plan is equal to or less than 60 days.	X	X	X	X	X	X

Items	AC	BI	CAC	CADI	EW	DD
18. *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
19. *The person's outcomes and goals are documented in the person's support plan.	X	X	X	X	X	X
20. *The needs that were identified in the assessment/screening process are documented in the support plan.	X	X	X	X	X	X
21. *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
22. *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
23. *Risks are identified in the support plan.	X	X	X	X	X	X
24. *The services a person is receiving are documented in the support plan.	X	X	X	X	X	X
25. *Service details are included in the support plan. Service details include: provider name, type, frequency, and cost.	X	X	X	X	X	X
26. 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
27. 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
28. Has the person chosen a different living arrangement than their current living arrangement? If so, a plan is in place on how to help that individual move to their preferred setting. • *If it is noted that the person would like to move, the case manager and/or others are assisting the person with planning and identifying needs and barriers for a move. This may include building independent living skills, touring housing, researching alternative services etc.*	X	X	X	X	X	X
29. The person's (aged 16 to 64) employment opportunities and goals are assessed annually.		X	X	X		X
30. The person (aged 16 to 64) was provided information to make an informed decision about competitive, integrated employment. It is noted what information was provided to the person.		X	X	X		X
31. The person's (aged 16 to 64) decision about employment is documented.		X	X	X		X
32. 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 plans reviewed must reflect at least 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).

Items	AC	BI	CAC	CADI	EW	DD
33. *The support plan includes details about what is important to the person.	X	X	X	X	X	X
34. *The person's strengths are included in the support plan.	X	X	X	X	X	X
35. *The support plan describes outcomes and goals as related to the person's preferences.	X	X	X	X	X	X
36. *The support plan incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.)	X	X	X	X	X	X
37. *The support plan includes a global statement about the person's dreams, hopes, or aspirations.	X	X	X	X	X	X
38. *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
39. Action steps describing what needs to be done to assist the person in achieving their goals.	X	X	X	X	X	X
40. The person's current rituals and routines are described.	X	X	X	X	X	X
41. Social, leisure, or religious activities the person wants to participate in are described.	X	X	X	X	X	X
42. The person's preferred work (aged 16-64) is described.	X	X	X	X	X	X
43. The person's preferred living setting is described.	X	X	X	X	X	X
44. 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 plans reviewed 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).

Items	AC	BI	CAC	CADI	EW	DD
45. 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
46. The support plan records the alternative home and community-based services that were considered by the person.	X	X	X	X	X	X
47. 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
48. The support plan includes a method for the person to request updates to the plan as needed.	X	X	X	X	X	X
49. 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

Items	AC	BI	CAC	CADI	EW	DD
50. Documentation that the current support plan was distributed to the person. It is best practice to provide a copy to the person and their guardian if applicable.	X	X	X	X	X	X
51. 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

Positive Support Transition Plan items

These items must be included on DHS-6810 and/or DHS-6810A.

Items	AC	BI	CAC	CADI	EW	DD
PSTP is present and completed on the required form (DHS-6810)	X	X	X	X	X	X
PSTP is complete and signed by all required parties	X	X	X	X	X	X
PSTP modified according to team's recommendations	X	X	X	X	X	X
PSTP review form(s) (DHS- 6810A) is present, completed and signed by all required parties	X	X	X	X	X	X
PSTP modifications were completed timely	X	X	X	X	X	X
PSTP reviews completed at the stated intervals	X	X	X	X	X	X
Integration between PSTP, PSTP review form(s), and HCBS Support Plan	X	X	X	X	X	X

Jensen Settlement Agreement items

These items must be included on a formal person centered plan that is separate from the HCBS support plan.

Items	AC	BI	CAC	CADI	EW	DD
The person has both a current HCBS Support Plan (CSSP, ISP, etc.) and a separate Person Centered Plan which is dated within 366 days.	X	X	X	X	X	X

Transition summary and follow-up items

For transitions after July 1, 2016, items must be documented on the "My Move Plan Summary" (DHS-3936A). All items must be dated within one year of the transition.

Items	AC	BI	CAC	CADI	EW	DD
The person's "move to address" is documented.	X	X	X	X	X	X
The person's "move date" is documented.	X	X	X	X	X	X
How the person will get to his/her new home is documented.	X	X	X	X	X	X
The date the person's belongings will arrive is documented.	X	X	X	X	X	X
Who will deliver the person's belongings is documented.	X	X	X	X	X	X
The case manager has signed the person's move plan.	X	X	X	X	X	X
A plan is in place for managing the person's medications.	X	X	X	X	X	X

Items	AC	BI	CAC	CADI	EW	DD
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
A plan is in place to ensure the person can attend upcoming appointments.	X	X	X	X	X	X
The person knows how to contact members of their support team.	X	X	X	X	X	X
The person and/or guardian has signed their move plan.	X	X	X	X	X	X
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 in anywhere in the file)	X	X	X	X	X	X

OR

Items	AC	BI	CAC	CADI	EW	DD
Documentation that the person did not want assistance coordinating his/her move or that the case manager was not aware of a planned move. (May be documented anywhere in the file)	X	X	X	X	X	X

If you have additional questions, please contact the Lead Agency Review Team or visit our project website.