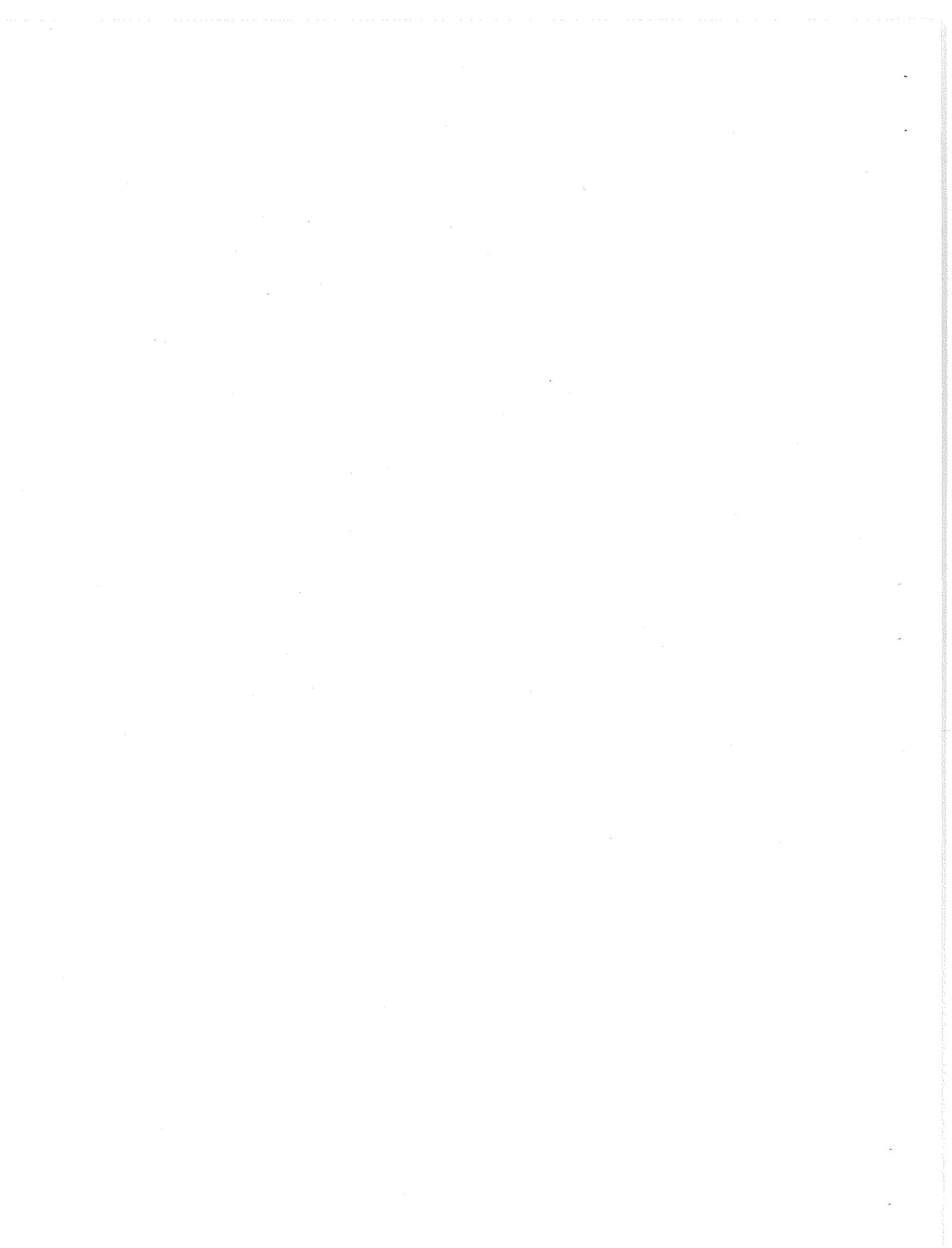


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**Quality Management 2008:  
The Development and Activities of the  
Quality Management, Assurance, and  
Improvement System for Minnesotans  
Receiving Disability Services**

A Preliminary Report to the  
Minnesota Legislature



Quality Management 2008: The Development and  
Activities of the Quality Management, Assurance,  
and Improvement System for Minnesotans Receiving  
Disability Services

A Preliminary Report to the Minnesota Legislature

Minnesota Department of Human Services  
Disability Services Division

January 15, 2008

Prepared by the Department of Human Services  
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## I. INTRODUCTION

Minnesota Statutes, section 256B.096, requires the Commissioner of the Department of Human Services (DHS) to provide a preliminary report to the legislature on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. This includes: (a) priorities for meeting the federal requirements; (b) progress on development and field testing of the annual survey; (c) appropriations necessary to implement an annual survey of service recipients once field testing is completed; (d) recommendations for improvements in the incident reporting system; and (e) a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

## II. BACKGROUND

Today, Minnesota's four Medicaid Home and Community-Based Services (HCBS) waiver programs for persons with disabilities support nearly 30,000 individuals at an annual cost of nearly 1.25 billion dollars. Half of this amount (almost \$625 million) is federally-funded, contingent upon the periodic approval of our HCBS waiver applications and ongoing compliance with federal statutory assurances and waiver program requirements. Minnesota, like most other states, has been confronted with the need to develop approaches to quality management that respond to the rapid changes in size, complexity, and participant direction in its community-based programs. In addition, increased federal requirements for states to demonstrate effective quality management in HCBS programs continue to challenge Minnesota's existing quality management system and methods.

The federal quality management requirements for waiver programs are found in the HCBS waiver application, which every state must submit to obtain program approval from the Centers for Medicare and Medicaid Services (CMS). Based upon CMS' HCBS Quality Framework, the waiver application provides states with substantial guidance regarding their responsibility in managing HCBS programs. Within the context of the waiver application, the HCBS Quality Framework establishes state responsibility for implementing the quality management functions of *discovery*, *remediation*, and *continuous improvement* across seven domains of HCBS program design:

- Participant Access;
- Person-Centered Service Planning and Delivery;
- Provider Capacity and Capabilities;
- Participant Safeguards;
- Participant Rights and Responsibilities;
- Participant Outcomes and Satisfaction, and;
- System Performance.

In 2005, the Minnesota Legislature requested a study of regional and local quality assurance models for disability services that might be adopted as part of a statewide quality management system. In response, DHS established a Quality Assurance (QA) Panel and charged it with responsibility to recommend a statewide, local or regionally-based approach to quality management of all publicly funded, community-based disability service programs. The Commissioner added expectations that the recommended approach: (a) be suitable for all community-based services across all population groups and all ages; (b) meet federal quality management requirements; (c) reflect contemporary concepts of quality in home and community-based services; (d) be outcome-based; (e) be valid and reliable in its assessments; (f) exhibit cost-effectiveness in yielding needed products; and (g) be founded on previous experiences in Minnesota and elsewhere.

The resulting recommendations from the QA Panel for a comprehensive statewide quality management, assurance, and improvement system were presented to the 2007 legislature ([www.qapanel.org](http://www.qapanel.org)). These included the development and implementation of:

1. a State Quality Commission to assure that quality and quality improvement in services and supports for persons with disabilities are approached with seriousness, integrity, creativity, and cost effectiveness in all parts of Minnesota;
2. six Regional Quality Councils to provide leadership in setting and responding to regional and statewide priorities for establishing and maintaining high quality and continuously improving home and community-based services;
3. an annual survey of service recipients to determine and report the quality and outcomes of services and supports provided to individuals with disabilities;
4. an outcome-based quality review program to assess measures that are directly related to service quality and to the program improvements that make people's lives better; and
5. an improved system for critical incident reporting, investigation, and analysis that provides necessary protections, assures timely and appropriate response, and gathers and analyzes data to guide quality improvement initiatives.

According to CMS, states cannot be in compliance with federal HCBS waiver regulations unless they engage in the *remediation* of concerns that are *discovered* through quality *improvement* processes. Furthermore, with every five-year HCBS waiver application renewal and annual waiver program report, CMS has stated that expectations for states to demonstrate continuous improvement in HCBS services will continue to increase, with prior improvements setting a new and higher standard for each successive review. As a whole, the five recommendations from the QA Panel delineate the components of an integrated and comprehensive quality management program which would enable our state to

effectively develop, implement, and fulfill the functions of quality management, thus meeting federal requirements and state responsibilities for continuous improvement in our HCBS programs. Of these five original recommendations, preliminary activities to design, test, and further refine two of them – survey development and recommendations to improve the incident reporting system – were passed into law as foundational components of a statewide quality management, assurance, and improvement system.

On November 1, 2007, a Quality Assurance Stakeholder Advisory Group (Advisory Group) [Minnesota Statutes § 256B.096 (2007)] was convened to consult with DHS on the development and implementation of the statewide quality management system. Since that time, the Advisory Group has met on a monthly basis to discuss and develop recommendations to the Commissioner on: (a) the development of an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services; and (b) the identification of information, data sources, and technology needed to improve the state's current system of critical incident reporting. This preliminary report to the legislature details progress made toward meeting these legislative requirements, incorporating the consultative input and feedback received from the present Advisory Group.

### **III. Priorities for Meeting the Federal Requirements**

Under the 2007 legislation, Minnesota's quality management, assurance, and improvement system must serve to improve the quality of services provided to persons with disabilities while also meeting the requirements of the federally approved HCBS waivers under 1915(c) of the Social Security Act. Among DHS' 2008-2009 priorities for meeting federal waiver program quality requirements is the establishment of the foundational quality management activities included in Minnesota Statutes § 256B.096.

#### Survey Development

CMS strongly promotes the use of quality survey tools among program participants to support:

- engaging in a process of *discovery* to collect data – including direct participant experiences – in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement;
- taking actions to *remedy* specific problems or concerns that arise; and
- utilizing data and quality information to engage in actions that assure *continuous improvement* in the HCBS program.

DHS and the Advisory Group will continue to analyze and consider potential HCBS quality surveys according to their ability to support the three functions of

quality management (discovery, remediation, and continuous improvement) in achieving the outcomes expressed within the HCBS Quality Framework.

#### Improve the System of Incident Reporting

CMS also attaches importance to the design and maintenance of critical incident reporting systems which can effectively:

- track the prevalence and patterns of serious adverse events in a program's population (*discovery*), and complete a timely feedback loop on the findings and disposition of incident reports to those who initiated them;
- inform strategies for risk management and error prevention (*remediation*); and
- support efforts to develop and assess quality *improvement* projects with timely, reliable, and comprehensive incident data.

At the level of individual persons receiving community-based services, such a system must facilitate the immediate *discovery* of a critical incident (e.g., serious injury, maltreatment, violation of civil/human rights, etc.), and the timely investigation, analysis, and intervention on behalf of the person receiving services to effectively identify and *remedy* conditions which contributed to the incident. These activities then support the development of strategies for *improvement* in a person's services or environment, based upon what was learned through the stages of discovery and remediation. DHS and the Advisory Group remain committed to identifying the information, data sources, and technology needed to support and strengthen all three functions of quality management within Minnesota's system for critical incident reporting.

With attention paid to designing these components in accord with the HCBS Quality Framework, the quality survey and improvements to the incident reporting system will represent important first steps in moving closer to meeting federal requirements for quality management within our home and community-based programs.

#### **IV. Progress on Development and Field Testing of the Annual Survey**

Currently, DHS and the Advisory Group are exploring options to either develop an entirely new survey to satisfy the provisions of section 256B.096, or adopt and field test a pre-existing HCBS quality survey for use in our state.

Of the three pre-existing surveys under consideration, all would enable the gathering of data which would yield information about the effectiveness and quality of certain aspects of Minnesota's home and community-based services. To varying degrees, the information gathered with each survey would provide information for many of the desired outcomes stated within the seven quality domains of the HCBS Quality Framework. All three surveys can also be modified to more specifically measure indicators of quality deemed important by

the Advisory Group, beyond those already measured by each survey in its current form. Two of these surveys – National Core Indicators (NCI) and Participant Experience Survey (PES) – are being used in many other states in support of their own HCBS program quality management strategies. One of them (PES) was developed under CMS’ National Contract for Quality to assist states in meeting federal quality management requirements. The third pre-existing survey, the Consumer Experience Survey (CES), was originally developed by DHS for use in measuring quality indicators among persons 65 and older receiving services through the HCBS Elderly Waiver program.

It is possible that choosing and implementing any pre-existing survey instrument could limit Minnesota’s opportunity to fully tailor a quality survey in line with local definitions of and expectations for quality. This could become a consideration if research into the merits of the pre-existing surveys fails to yield an acceptable choice for meeting Minnesota’s quality management needs. However, developing an entirely new annual survey of service recipients would likely be an expensive option in terms of time spent in development and field testing, and involve a greater potential for not meeting the statute’s expectation of field testing the survey in 2008. It would also limit future opportunity to directly compare service outcomes in Minnesota with those in other states.

Because of the impact any survey instrument and discovery process will have upon Minnesota’s HCBS quality management strategy, and ultimately upon the effectiveness and quality of services delivered to service recipients, DHS and the Advisory Group understand the need to carefully consider our survey options. At the same time, we also recognize the need to proceed with diligence toward choosing a survey and beginning the field testing process in accordance with our statutory charge. The Advisory Group will continue to meet on a monthly basis throughout 2008, working with DHS on a course for timely development and field testing of the annual quality survey. Factors such as cost, sustainability, and applicability to Minnesota’s own quality management expectations will continue to guide this process.

## **V. Appropriations Necessary to Implement an Annual Survey of Service Recipients**

In early 2007, both the QA Panel and DHS established similar preliminary cost estimates for the development, field testing, and implementation of an annual quality survey. With slight modification to those original DHS figures, minus the funding already appropriated for survey development and field testing, we propose the following cost estimates for implementation of the annual survey across ten percent of participants in Minnesota’s four HCBS disability waiver programs:

10% Sample – approximately 3,400 surveys in year one (estimated yearly increase: 4%)

<b>Statewide Survey and Analysis</b>	Annual FTE/Rate	Year 1	Year 2	Year 3
Survey Support (interviewer training, data collection and editing, data management, analysis, summaries, and regional reports)	2 FTE	\$200,000	\$180,000	\$180,000
Survey printing/Computer software	Number of surveys x \$1.50	\$5,100	\$5,304	\$5,516
Contract Interviewers (10% sample)	\$75 x number of surveys	\$255,000	\$265,200	\$275,808
<b>Total*</b>		\$460,100	\$450,504	\$461,324
<b>Net State Costs</b>	After 40% Federal reimbursement	\$276,060	\$270,303	\$276,795

\*40% of costs would be reimbursed by the Federal government as a Medicaid administrative expense based on the proportion of program recipients who are Medicaid beneficiaries.

While not specifically indicated in this estimate, the cost of survey support and contract interviews may trend upward over time, due in large part to two variables:

1. Survey support. In comparison with other current statewide surveys, the need for special training, accommodation, and/or assistance for both interviewers with disabilities and interviewers without prior experience in effective, reciprocal communication with persons with disabilities could require more funding per interviewer.
2. Contract interviewers. By virtue of the widely varying abilities of service recipients to communicate and respond to a survey instrument, interviewers will likely need to conduct face-to-face interviews with the majority of persons sampled. This will require a greater amount of time and miles traveled on a per-survey basis in comparison, for example, with the annual Nursing Home Report Card Resident Satisfaction Survey, where costs associated with scheduling, time and travel are mitigated by the fact that the overall sample of residents interviewed live in fewer and more concentrated settings. Recipients of home and community-based services – by the very promise and nature of those services – live more widely scattered throughout the state in their own homes or other small community-based service facilities, typically of four residents or less.

A more precise estimate of survey implementation costs will be possible once a survey instrument and methodology is chosen, and there is further study of the potential costs involved in recruiting, training, and support of interviewers, including the potential efficiencies of contracting for interviewers who reside in communities dispersed across the state.

## **VI. Recommendations for Improvements in the Incident Reporting System**

The Advisory Group has been reviewing current projects meant to enhance access to and sharing of critical incident information between DHS, the Department of Health, and local (county and tribal) lead agencies. Chief among these is the expansion of Minnesota’s Social Services Information System (SSIS) to include

information on reports of alleged maltreatment, deaths, and serious injuries made to county Common Entry Point and adult protection units. This will provide a quick, automated way to share information regarding critical incident reports and investigations within and among local and state agencies responsible for discovery and remediation. Sharing this data electronically will dramatically reduce the need to communicate such information through the use of paper reports and files.

Another development to aid discovery, remediation and improvement activities is the Data Mart project. Data Mart will allow the capture and incorporation of data from various state agencies with a role in critical incident investigations and monitoring into a single, commonly-accessible data warehouse. While this data currently exists in various formats and has long been available for review and analysis, the Data Mart database structure will provide a new opportunity for more complete and complex reporting and analysis on systemic conditions and trends. Much like SSIS, Data Mart promises to reduce reliance upon cross-divisional and cross-departmental sharing of information through paper reports and files, and also greatly reduce the need for duplicative data entry into multiple, disparate data bases. When this data is centrally compiled in a common database, the department will assign specific staff to perform skillful analysis of the data and distribute the results.

With this information, and building upon the QA Panel's recommendations for the development of essential characteristics and processes within Minnesota's incident reporting, investigation, and analysis system, the Advisory Group will continue to meet on a monthly basis throughout 2008, working with DHS to (a) identify further information, data, and technology needs and (b) incorporate those needs into a set of recommendations for system-wide analysis and improvement.

## **VII. Plan for Incorporating Regional Quality Assurance Efforts into the Statewide System**

Within DHS, plans for the development of infrastructure and processes to support future regional quality management efforts involve a number of projects currently underway. Examples include:

- The HCBS Waiver Review Project. Through formal on-site reviews of county lead agency implementation of quality management practices corresponding to the HCBS Quality Framework, this process is yielding information on local and regional strengths and opportunities for improvement in meeting state and federal requirements for quality in home and community-based services.
- The Collaborative Action Network Developing Opportunities (CAN DO) Initiative. This has been established to create and maintain regional and statewide networks of people and organizations to design, implement, and evaluate innovative approaches to supports and opportunities that result in improved outcomes for people with disabilities. In 2007, eight regional

action conferences, attended by approximately 550 stakeholders, were held to foster the establishment of regional collaborative workgroups and develop local plans for action.

- The State Long-Term Care Profile Project. DHS recently received notice of funding from CMS to support a project to create a statewide profile of home and community-based services for persons with disabilities. Among the products of this project will be a comprehensive description of the long-term care system in Minnesota, an identification of strengths and gaps in services across the state for different disability groups, comparisons of Minnesota with other states, and the identification of measures of value to persons in assisting them to evaluate and choose among long-term services and service providers.

Through these and similar efforts, DHS plans to gather and use information and feedback being provided by regional, county, and local groups of stakeholders to inform our understanding of: (a) what's important on a local basis; (b) what are viable and actionable next steps in building and advancing regional quality management efforts; and (c) what it will take to assure these regional efforts support and function within an overall, statewide quality management strategy.

In 2008, the Advisory Group will discuss and recommend ways in which the quality survey information can be reported to regional and county quality management entities and to home and community-based service providers to assist them in planning and measuring the impact of their own quality improvement activities. Matters of data classification, the protection of private information, and participant access to information obtained through the quality survey process will also need to be addressed by DHS and the Advisory Group over the next year. These activities will help to assure the overall quality survey process is designed with an eye toward compatibility with anticipated regional and local components of quality assurance and improvement as they are developed and implemented within the statewide system of quality management.

## **VIII. CONCLUSION**

The federal HCBS Quality Framework and corresponding requirements for incorporating formal activities of discovery, remediation, and continuous improvement into a state's quality management strategy are intended to set ever-increasing standards for quality assurance and improvement for state Medicaid waiver programs. These quality management standards also place great emphasis upon achieving the desired outcomes of service recipients. With this guidance in mind, the work of DHS and the Advisory Group toward the development and implementation of the quality management components and legislative reporting requirements set forth in section 256B.096 will continue throughout the coming year. Further report of progress and recommendations to the legislature will be made in January 2009.

**Quality Assurance Stakeholder Advisory Group**

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**Organizations/Stakeholders Represented**

DHS Special Needs Purchasing  
 Minnesota Developmental Achievement Center Association  
 Arc of Minnesota  
 Minnesota Home Care Association  
 Otter Tail County Human Services  
 DHS Disability Services Division – Manager  
 Medica  
 DHS Disability Services Division – Quality Assurance  
 Minnesota Association of County Social Service Administrators  
 Association of Residential Resources in Minnesota  
 Family Representative/Advocate  
 Local Public Health Association of Minnesota  
 Advocating Change Together  
 DHS Licensing Division – Director  
 Brain Injury Association of Minnesota  
 DHS Aging and Adult Services Division – Quality Assurance  
 Minnesota Association of County Social Service Administrators  
 DHS Survey Research Coordinator  
 University of Minnesota  
 Arc of Minnesota  
 Minnesota Department of Health – Licensing & Certification  
 Minnesota Habilitation Coalition  
 Ombudsman for Mental Health & Developmental Disabilities  
 Lutheran Social Services  
 Minnesota Disability Law Center  
 DHS Aging and Adult Services Division – Adult Protection  
 Family Representative/Advocate (Autism Society of Minnesota)  
 AXIS Healthcare  
 Hennepin County Human Services & Public Health Department  
 Self Advocate  
 Region 10 Quality Assurance Commission

\* denotes QA Panel member

## GLOSSARY OF SELECTED TERMS

Centers for Medicare and Medicaid Services (CMS) – the federal agency, within the U.S. Department of Health & Human Services, responsible for approval and oversight of all state Medicaid Home and Community-Based Services waiver programs.

Common Entry Point – the entity, designated by each county, that is responsible for receiving reports regarding alleged maltreatment (i.e., abuse, neglect, financial exploitation).

Data Mart – a specific location or “room” in the DHS Data Warehouse where DHS can store, organize, table, and query data that has been extracted, transformed, and loaded from other source data bases.

Data Warehouse – a data collection and analysis support system that facilitates timely and flexible analysis by providing direct access to single sources of data or to data across systems. Designed to assist decision making throughout DHS by copying source system data and optimizing it for reporting.

Home and Community-Based Services (HCBS) – services offered to states as an alternative to institutionalization so that persons with disabilities can receive individualized and flexible services in their own homes or communities. Home and community-based waiver programs available to persons with disabilities who meet eligibility criteria include:

- Community Alternative Care (CAC) wavier, for chronically ill and medically fragile persons who need the level of care provided in a hospital;
- Community Alternatives for Disabled Individuals (CADI) wavier, for people with disabilities who require the level of care provided in a nursing facility;
- Developmental Disability (DD) wavier, for persons with developmental disabilities who require the level of care provided in an Intermediate Care Facility for persons with Mental Retardation or related conditions (ICF/MR); and
- Traumatic Brain Injury (TBI) wavier, for persons with traumatic or acquired brain injuries who need the level of care provided in: (a) a nursing facility that provides specialized service for persons with TBI; or (b) a neurobehavioral hospital.

HCBS Quality Framework – developed by CMS, it is a uniform national format that enables states to describe the key components of *discovery*, *remediation*, and *continuous improvement* in their quality management strategies across seven domains of HCBS program design:

- Participant Access;
- Person-Centered Service Planning and Delivery;
- Provider Capacity and Capabilities;

- Participant Safeguards;
- Participant Rights and Responsibilities;
- Participant Outcomes and Satisfaction; and
- System Performance.

Quality – the degree to which services and supports for individuals and populations increase the likelihood for desired health and quality of life outcomes and are consistent with current professional knowledge.

Quality Assurance – the systematic monitoring and after-the-fact evaluation of the various aspects of a project, service, or facility to ensure that minimum thresholds of acceptable quality are met.

Quality Improvement – the desired result of programs and systems designed and organized to support the best possible outcome (i.e., maximization of quality of life, functional independence, health, and well being of the population served).

Quality Management – a multi-faceted strategy for organizing, tracking, and improving HCBS programs to deliver quality outcomes. Encompasses the three functions of:

- Discovery – collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement;
- Remediation – taking action to remedy specific problems or concerns that arise; and
- Continuous Improvement – utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Quality Assurance Stakeholder Advisory Group (Advisory Group) – the 2007-2009 legislatively directed work group responsible to develop and make recommendations to the Commissioner of DHS on: (a) the development of a survey tool to determine the effectiveness of and quality of disability services; and (b) information, data sources, and technology needed to improve the system of incident reporting.

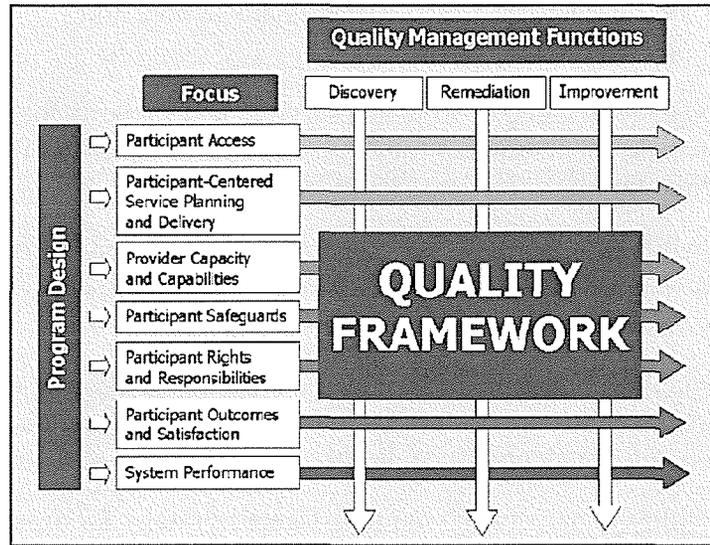
Quality Assurance Panel (QA Panel) – the 2005-2007 legislatively directed work group comprised of citizen experts responsible for making recommendations on approaches to quality management in HCBS and related disability programs. The QA Panel's final report to the legislature and related documents can be found at [www.qapanel.org](http://www.qapanel.org).

Social Services Information System (SSIS) – a software application for all 87 counties that provides a quick, automated way to refer cases of alleged maltreatment for investigation by preparing required alerts, notifications, and reports during – and as the result of – an investigation.

# HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).



Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	Individuals have access to home and community-based services and supports in their communities.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community
Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.



## HCBS QUALITY FRAMEWORK QUALITY FOCUS AREAS

### Focus I: Participant Access

*Desired Outcome: Individuals have access to home and community-based services and supports in their communities.*

#### I.A Information/Referral

*Desired Outcome: Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, offered a referral.*

#### I.B. Intake and Eligibility

##### I.B.1 User-Friendly Processes

*Desired Outcome: Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance available in applying for HCBS.*

##### I.B.2 Referral to Community Resources

*Desired outcome: Individuals who need services but are not eligible for HCBS are linked to other community resources.*

##### I.B.3 Individual Choice of HCBS

*Desired Outcome: Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.*

##### I.B.4 Prompt Initiation

*Desired Outcome: Services are initiated promptly when the individual is determined eligible and selects HCBS.*

### Focus II: Participant-Centered Service Planning and Delivery

*Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*

#### II.A Participant-Centered Service Planning

##### II.A.1 Assessment

*Desired Outcome: Comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan.*

##### II.A.2 Participant Decision Making

*Desired Outcome: Information and support is available to help participants make informed selections among service options.*

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**II.A.3 Free Choice of Providers**

*Desired Outcome: Information and support is available to assist participants to freely choose among qualified providers.*

**II.A.4 Service Plan**

*Desired Outcome: Each participant's plan comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.*

**II.A.5 Participant Direction**

*Desired Outcome: Participants have the authority and are supported to direct and manage their own services to the extent they wish.*

**II.B Service Delivery****II.B.1 Ongoing Service and Support Coordination**

*Desired Outcome: Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.*

**II.B.2 Service Provision**

*Desired Outcome: Services are furnished in accordance with the participant's plan.*

**II.B.3 Ongoing Monitoring**

*Desired Outcome: Regular, systematic and objective methods - including obtaining the participant's feedback - are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.*

**II.B.4 Responsiveness to Changing Needs**

*Desired Outcome: Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan.*

<b>Focus III: Provider Capacity and Capabilities</b>
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<i>Desired Outcome: There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.</i>
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**III.A Provider Networks and Availability**

*Desired Outcome: There are sufficient qualified agency and individual providers to meet the needs of participants in their communities.*

**III.B Provider Qualifications**

*Desired Outcome: All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively.*

**III.C Provider Performance**

*Desired Outcome: All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan.*

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**Focus IV: Participant Safeguards**

*Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*

**IV.A Risk and Safety Planning**

*Desired Outcome: Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant.*

**IV.B Critical Incident Management**

*Desired Outcome: There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.*

**IV.C Housing and Environment**

*Desired Outcome: The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.*

**IV.D Restrictive Interventions**

*Desired Outcome: Restrictive interventions - including chemical and physical restraints - are only used as a last resort and subject to rigorous oversight.*

**IV.E Medication Management**

*Desired Outcome: Medications are managed effectively and appropriately.*

**IV.F Natural Disasters and Other Public Emergencies**

*Desired Outcome: There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.*

**Focus V: Participant Rights and Responsibilities**

*Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities.*

**V.A Civic and Human Rights**

*Desired Outcome: Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.*

**V.B Participant Decision Making Authority**

*Desired Outcome: Participants receive training and support to exercise and maintain their own decision-making authority.*

**V.C Due Process**

*Desired Outcome: Participants are informed of and supported to freely exercise their Medicaid due process rights.*

**V.D Grievances**

*Desired Outcome: Participants are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.*

Working Draft

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**Focus VI: Participant Outcomes and Satisfaction**

**Desired Outcome:** *Participants are satisfied with their services and achieve desired outcomes.*

**VI.A Participant Satisfaction**

**Desired Outcome:** *Participants and family members, as appropriate, express satisfaction with their services and supports.*

**VI.B Participant Outcomes**

**Desired Outcome:** *Services and supports lead to positive outcomes for each participant.*

**Focus VII: System Performance**

**Desired Outcome:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

**VII.A System Performance Appraisal**

**Desired Outcome:** *The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.*

**VII.B Quality Improvement**

**Desired Outcome:** *There is a systemic approach to the continuous improvement of quality in the provision of HCBS.*

**VII.C Cultural Competency**

**Desired Outcome:** *The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds.*

**VII.D Participant and Stakeholder Involvement**

**Desired Outcome:** *Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.*

**VII. E Financial Integrity**

**Desired Outcome:** *Financial accountability is assured and payments are made promptly in accordance with program requirements.*

\*\* The following statement expresses the opinion of one member of the Quality Assurance Stakeholder Advisory Group. This statement neither expresses nor reflects the position of the Department of Human Services or the Quality Assurance Stakeholder Advisory Group as a whole.

There is at least one stakeholder of the advisory committee that disagrees with how the survey is being developed for the following reasons:

1. The statutory charge was to *“develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework”* (underline emphasis added).

It is this stakeholder’s opinion that the elements of the HCBS Quality Framework (system performance expectations) are intended to measure aggregate system performance; whereas it seems this advisory committee intends to measure an individual’s satisfaction with services delivered. Subdivision 3 of the legislation states *“The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities”*. Regions, counties, and providers should not have access to an individual’s level of satisfaction with services as it compromises the integrity of anonymity; and “quality improvement activities” are system, not individual, actions. Also, what is curiously missing from this sentence, and not found elsewhere in the legislation, is the directive to make the results useful to service recipients or measure their satisfaction. In the same subdivision it states *“The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of service, in different settings, with different costs”*. Again, the focus is on “service, setting, and costs” not on individual satisfaction.

Acknowledging that measuring individual satisfaction of services provided is a worthy activity, this stakeholder feels it is best left to a “person-centered planning” system and is well beyond the statutory charge of this legislation.

2. Implementing the survey being developed by this advisory group will be both onerous to all system stakeholders and very expensive. More to the point, it is redundant in that a critical role of the case management function should be to facilitate person-centered planning and evaluate the client’s satisfaction with

services provided. It seems that one of the fundamental purposes of the state funded – county administered service delivery model used in Minnesota is to provide the “independent” service planning and evaluation by a case manager. Case managers are required to meet with each recipient at least twice per year and this face-to-face interaction should be used to evaluate services and gather input from the individual’s network already gathered for the meeting. Survey satisfaction responses from these meetings could then be entered into a data system to report results by provider, county, region, and state. In state fiscal year ’05, this case management function cost \$96M (\$6M CAC; \$14M CADI; \$58M DD; \$3M TBI; \$25M Other). Therefore, it seems that any focus on service outcomes should be specified in standardizing case management responsibilities.

3. The legislation requires these activities be done for “*Minnesotans receiving disability services*” and goes on to define disability services “*for persons with developmental disabilities*”. DHS has interpreted this to include recipients of the CADI, CAC, and TBI waivers. If correct, this will certainly add to the complexity and cost of developing a survey system.

In conclusion, this stakeholder recommends that the legislature clarify to DHS that the statutory charge was to only develop a survey that met the federal requirements of “system performance”, stipulate the population to be surveyed, and specify if the five to ten percent sample was for a calendar or biennium time period.

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Mr. Barker is the MnDACA representative to the Quality Assurance Stakeholder Advisory Group.



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