Quality Management in HCBS 2011:

The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services

Disability Services Division

February 2011

Minnesota Department of **Human Services**

Legislative Report

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Executive Summary

This report is prepared for the Minnesota Legislature in accordance with Minnesota Statutes §256B.096, Subd. 5, which requires the Minnesota Department of Human Services (DHS) to submit a biennial report on the development and activities of the quality management, assurance and improvement system for Minnesotans receiving services through the Medicaid home and community-based services (HCBS) waiver programs for persons with disabilities. These programs include the Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Developmental Disabilities (DD), and Traumatic Brain Injury (TBI) waivers.

Minnesota's four Medicaid HCBS waiver programs for persons with disabilities allow the state to use Medicaid funds in providing creative, cost-effective supports and services to individuals in their homes and communities as alternatives to institutional services. Assuring and improving the quality of supports and services for waiver participants is the purpose of quality management in these programs.

Approximately 35,000 people participate in the state's four disability waivers programs, at an annual cost of approximately $1.65 billion. Roughly half of this amount (approximately $825 million) is federally funded, contingent upon the periodic approval of Minnesota's waiver applications and ongoing compliance with waiver program requirements. To sustain federal approval of its waiver programs, Minnesota must design and implement quality management activities that provide assurance to the Centers for Medicare & Medicaid Services (CMS) that waiver requirements are being met.

The 2007 Legislature enacted law (Minn. Stat. §256B.096) to establish a quality management system for Minnesotans receiving disability services. The purpose of this system is (a) to improve the quality of services provided to individuals, and (b) to meet federal HCBS waiver program requirements. To meet these purposes, DHS has undertaken a number of significant system improvement initiatives in the last several years. Among these are:

Projects to meet federal compliance

- **Provider Enrollment and Provider Standards Initiative** (2009 – present), to comply with federal requirements to:
  - Eliminate the use of "lead agency" (county or tribal) contracts with providers and replace the contracts with statewide provider agreements, and
  - Build upon the statewide provider enrollment process with consistent and equitable waiver services standards, and improved processes to verify compliance with those standards.

- **Rate Setting Methodologies Initiative** (2009 - present), to comply with federal requirements to:
  - Create statewide, uniform rate determination methods and standards that apply to each waiver service
  - Ensure payments across all areas of the state are equitable, and
  - Ensure any differences in rates are based on factors specified in the statewide methodology based on concrete indices (e.g., difficulty of care or geographic factors).

- **Quality Essentials Team** (an internal DHS workgroup; 2008 – present) to comply with federal requirements to:
  - Identify and monitor system-wide measures of compliance with federal waiver program requirements.

Projects to meet state Legislative requirements

- **Participant Experience Survey – Minnesota version** development project (2008 – 2009), to provide a tool for:
  - Supporting federal waiver compliance with measurements of service quality, and
  - Evaluating participants' experience of service quality and the impact of those services in peoples' lives.
    - Survey was implemented statewide in 2010, which included the onsite interviews of 826 randomly selected individuals receiving CAC, CADI, DD and TBI waiver services as well as persons receiving home care (PCA) services.

- Establish a **centralized "Common Entry Point"** for the intake of reports of suspected maltreatment of vulnerable adults through both a statewide toll-free telephone number and a Web site-based reporting system.

- **Residential Support Services and Quality Outcome Standards** provider standards development project (2010 – present), to:
  - Establish provider standards for corporate foster care services that integrate service standards and the residential setting under one license, and
  - Develop a single set of "quality outcome standards" governing services for people with disabilities under the CAC, CADI, DD and TBI waiver programs.
  - To avoid duplication or divergence between standards resulting from these interconnected mandates, DHS will submit statutory language and a unified implementation plan for all new standards developed under this project to the 2012 Legislature.[1]

Other DHS Quality Management Initiatives for HCBS

- **DHS Priority for HCBS** – developing **Provider Performance Measures** and an **HCBS Report Card** (2007 – present) to:
  - Educate consumers about differences among HCBS services, service providers, and costs
  - Contribute to DHS' response to federal waiver program assurances regarding service access, choice, and system improvement, and
  - Support HCBS providers in targeting improvements in their services.

[1] Pursuant to Minnesota Statutes §245A.11, Subd. 8, this report includes draft language for residential setting licensing requirements for residential support services (see Appendix B). This will be integrated with the Quality Outcome Standards and presented, as statutory language, to the Legislature in January 2012.

- **Quality Commission** (2009 – present, currently on hold), a committee of home and community-based services stakeholders convened to assist DHS in identifying quality indicators and measures that:
  - Allow DHS to better capture, evaluate, describe and respond to what is learned about the level of quality in Minnesota's waiver services programs, and
  - Will be used to meet state and federal quality management reporting requirements, as well as in reports on program quality to the public.

In addition, the integration of many of these projects with the **Minnesota CHOICES** (MnCHOICES) comprehensive assessment project will enable DHS to achieve greater consistency and accountability in the quality management of services to all populations with disabilities in Minnesota and older Minnesotans.

Cost projections for continuing or implementing the products of these projects:

Limited Costs

- The **Quality Essentials Team** and **Quality Commission** will continue to be staffed by DHS within existing staff resources.

More Substantial Costs/Investments

- Statewide implementation of the **Participant Experience Survey – Minnesota version** – $230,000 annually
  - Allows for sampling sufficient to support valid federal waiver compliance reporting, and HCBS waiver and home care program quality management purposes.

- **Centralization of Common Entry Point** function and Web-based reporting of maltreatment of vulnerable adults:
  - Development – $3.5 million (first year)
  - Continuing operation – $2 million annually

- Information technology (IT) data integration systems and Web-based reporting applications for **HCBS Report Card**:
  - Development and roll-out – $224,000 (first year)
  - Continuing operation – $218,000 annually

Costs to be determined

- In 2009, the Legislature appropriated funds to develop the various tools and processes required as outcomes of the **Rate Setting Methodologies Initiative**, **Provider Enrollment and Provider Standards Initiative**, and **Residential Support Services and Quality Outcome Standards** projects. Costs for the implementation and ongoing operation of these tools and processes are still being determined.

I. Purpose of Report

This report was prepared for the Minnesota Legislature in accordance with Minnesota Statutes §256B.096, Subd. 5. The legislation requires the Minnesota Department of Human Services (DHS) to submit a biennial report on the development and activities of the quality management, assurance and improvement system designed to meet the federal requirements under the state's four home and community-based services (HCBS) waiver programs for persons with disabilities:

- Community Alternative Care (CAC)
- Community Alternatives for Disabled Individuals (CADI)
- Developmental Disabilities (DD)
- Traumatic Brain Injury (TBI)

DHS understands the intended outcomes of the quality management system for persons receiving disability services to be:

- Establishment and maintenance of substantial compliance with federal requirements in Minnesota's HCBS waiver programs, and
- Improvement in the quality and value of services provided to individuals participating in these programs.

Activities to achieve these outcomes are described within this report.

This report also includes draft language for residential setting licensing requirements for residential support services, pursuant to Minnesota Statutes §245A.11, Subd. 8.[2]

II. Background

A. Minnesota's Medicaid HCBS Waiver Programs

Minnesota's Medicaid HCBS waivers[3] allow the state to use Medicaid funds to provide creative and cost-effective supports to Medicaid-eligible persons in their homes and communities, instead of placing them in institutional settings.[4] HCBS waivers allow states to put together various service options that are not available under regular state plan Medical Assistance (MA). These service options are available to persons in addition to services covered by MA. Generally, these services are targeted to people with specific needs or diagnoses.

Today, approximately 35,000 people participate in the state's four disability waiver programs, at an annual cost of approximately $1.65 billion. Minnesota is able to make waiver services available because of federal financial participation (FFP), which currently matches the state nearly dollar for

[2] See Appendix B. As explained below (pp. 16-17), this language will be integrated with the Quality Outcome Standards and presented, as statutory language, to the Legislature in January 2012.
[3] Including the Elderly Waiver (EW), for persons 65 and older.
[4] Hospitals, nursing homes, and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD).

dollar (about $825 million annually) for program costs. To obtain FFP, Minnesota submits waiver plans that must be approved by the Centers for Medicare & Medicaid Services (CMS).

B. Federal Requirements for Quality Management in HCBS Waiver Programs

In order to operate an HCBS waiver program, a state must submit a waiver application to CMS that describes the waiver's design and quality management processes. The application "must include sufficient information to permit CMS to determine that the waiver meets applicable statutory and regulatory requirements, especially the assurances specified in 42 CFR §441.302."[5] A state must continually demonstrate – and CMS must determine – that waiver assurances and other federal requirements are "satisfactorily met" in order to continue operation of its waiver program(s).

Since 2003, when the U.S. General Accounting Office (GAO) released a report[6] critical of federal oversight of states' HCBS waiver programs, CMS has dedicated increasing effort to holding states accountable for:

- Establishing an effective quality management system within their waiver programs, and
- Providing quantifiable and valid evidence that the waiver assurances are being met.

Currently, CMS requires states to develop and operate a formal quality management system for waiver programs, consisting of three primary elements:

- ***Discovery*** (collecting waiver program performance data)
- ***Remediation*** (taking corrective action in *all* instances where system performance is measured as less than 100%) and
- ***Continuous improvement*** (basing decisions for program improvement on the collected program performance data).

As proof of having an appropriate quality management system, states must identify and commit to using suitable waiver performance measures to monitor compliance with federal waiver requirements. All measures must be waiver-specific and statistically reliable and valid, at or better than a 95% ±5% level of confidence. In all cases where a state does not have suitable performance measures, the state must commit to develop appropriate monitoring activities and corresponding measures before a waiver approval or renewal is granted.

C. DHS Waiver Quality Management Activities

Waiver compliance ensures FFP in Minnesota's waiver programs. In addition to the loss of federal funding, a failure to meet waiver requirements and maintain federal approval would impair Minnesota's ability to conform to the U.S. Supreme Court's *Olmstead v. L.C.* decision and the

[5] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (page 6). See Appendix D for a list of the federal statutory assurances.

[6] *Long-Term Care: Federal Oversight of growing Medicaid Home and Community-Based Waivers Should Be Strengthened*. United States General Accounting Office, 2003.

"integration mandate" (Title II) of the Americans with Disabilities Act.[7] To ensure compliance with waiver program and legislative requirements, to better serve people participating in these programs, and to meet Minnesota public policy, DHS has undertaken a number of significant system improvement initiatives in the last several years. Among these are:

- Projects to meet federal compliance
  - **Provider Enrollment and Provider Standards Initiative**
  - **Rate Setting Methodologies Initiative** (RSMI)
  - **Quality Essentials Team** (QET), to develop waiver performance measures for federal compliance
- Projects to meet state Legislative requirements
  - **Participant Experience Survey – Minnesota version** (MN PES) development project
  - Establishing a **centralized Common Entry Point**
  - **Residential Support Services and Quality Outcome Standards** project (RSS-QOS)
- Other DHS Quality Management Initiatives for HCBS
  - **DHS Priority for HCBS –** development of **Provider Performance Measures and HCBS Report Card**
  - **Quality Commission**

Each of these projects and initiatives – along with their purposes and products – are described below, in the following sections of this report.

i. Integration with Minnesota CHOICES (MnCHOICES)

DHS is poised to operationalize administrative systems and tools to support significant legislative reform in the management and delivery of its disability and aging programs. Foremost among these reforms is a new streamlined customer-centric approach to assessing need and formulating service plans, being developed under the Minnesota CHOICES Project (MnCHOICES).[8] The 2009 Legislature approved funding for DHS to implement MnCHOICES beginning January 2011. MnCHOICES includes developed standards and protocols to assess the needs of persons for long-term care services, a common data collection tool and reflects stakeholder recommendations. DHS will use MnCHOICES across the Medical Assistance State Plan long-term care services and home and community-based waiver programs

MnCHOICES uses a person-centered planning approach to:

- Allow for timely consideration of support options beyond what is reimbursed through Medical Assistance long-term care programs
- Combine long-term care assessment processes
- Simplify and standardize face-to-face assessments, and
- Provide additional data to evaluate outcomes

[7] "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." 28 CFR Section 35.130(d).
[8] MnCHOICES was formerly known as MN Comprehensive Assessment, MNCOMPASS, the Comprehensive or Universal Assessment.

When implemented, MnCHOICES' assessment, support planning, and data gathering capabilities will affect and support a variety of quality management functions described within this report, including:

- **Provider Enrollment and Provider Standards Initiative**
  - MnCHOICES' support planning function lists qualified, enrolled providers that offer services for which a person qualifies
- **Rate Setting Methodologies Initiative**
  - MnCHOICES provides the ability to calculate a rate for waiver services for which a person qualifies, based on specific factors unique to the person's situation
  - MnCHOICES also provides a rate range for a given type of service to provide flexibility (within guidelines) to lead agency budget staff as they allocate funds for waiver services
- **Quality Essential Team**
  - MnCHOICES data will enable the development of simplified and improved measures to monitor compliance with federal waiver program requirements
- **Provider Performance Measures and HCBS Report Card**
  - MnCHOICES includes a select number of questions from the **Participant Experience Survey – Minnesota version**, enabling near-100% annual sampling of disability services participants regarding their experience with services and service providers. Provider-specific feedback will be used to populate and directly influence provider performance measures used in an HCBS Report Card.

The combined effect from these efforts, once successfully implemented, will achieve greater consistency and accountability in the quality management of services to all populations with disabilities in Minnesota and older Minnesotans.

ii. Domains of a Meaningful Life – Guiding Quality Management Activities

Within the Department's Disability Services Division (DSD), the desired outcomes of all quality assurance and program improvement activities are reflected in the "CHOICE Life Domains." Part road map, part yardstick, these domains allow DSD to gauge the success of programs and services by measuring how well their outcomes reflect participant achievement in the following areas:

- **C**ommunity membership that is grounded in both participation and actual group membership.
- **H**ealth, wellness and safety, with an emphasis on features of communication, relationships and trust.
- **O**wn place to live, where people choose both the place and whoever else lives or provides support in their home – roommate and direct support staff.
- **I**mportant long-term relationships that are reciprocal and provide for safety.
- **C**ontrol over supports, including control over the funding for personal supports, housing and transportation.
- **E**mployment earnings and stable income through typical jobs, self-employment, or stable income from public and private sources.

III. Quality Management System Improvement Projects and Initiatives

A. Projects to Meet Federal Compliance

In 2008 and 2009 reviews of DHS waiver programs, CMS has raised concerns about state quality management and oversight for the waiver programs, which DHS is in the process of addressing. In particular, CMS questioned:

- *The adequacy of monitoring of non-licensed providers*
- *The role of the counties in contracting with providers, instead of direct contracts between the state and providers, and*
- *The role of counties in setting provider reimbursement rates, rather than a statewide methodology for rate setting.*

In order to create greater consistency in contracting and rate-setting, DHS is currently developing [enhanced] statewide provider standards and enrollment processes, as well as statewide rate-setting methodologies.[9]

i. Provider Enrollment and Provider Standards Initiative

In response to the CAC Waiver renewal submitted in 2007, CMS stated that Minnesota's use of lead agency (i.e., county and tribal) contracts as the mechanism for establishing and monitoring waiver provider qualifications and service standards does not assure that waiver participants have the ability to choose from among all qualified providers to receive waiver services. CMS informed DHS that the state must have a uniform provider enrollment process across all waiver services (including CADI, DD and TBI) with provider standards and verification methods that are consistent across the state and will meet federal waiver requirements.

The Provider Enrollment and Provider Standards Initiative is underway to develop an enhanced provider enrollment business process across home care and waiver services, with provider standards and verification processes that respond to the need for transitioning from lead agency contracts with waiver service providers to a consistent statewide approach for monitoring provider qualifications and compliance, as well as participant access to these services. The development of a statewide approach will:

- Build upon the statewide provider enrollment process with consistent and equitable waiver services standards and improved processes to verify provider compliance
- Enhance provider standards, when necessary, to improve the delivery of services
- Increase recipient access to and choice of qualified providers
- Eliminate the use of lead agency contracts with providers and replace the contracts with a statewide provider agreement
- Develop statewide methods for lead agencies to monitor providers, which will assist DHS in determining whether to enroll or continue to enroll a provider

[9] Excerpt from *Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System*. Thomson Reuters, 2009 (pp. 64).

- Integrate existing provider quality assurance and oversight mechanisms – including the evidence of provider qualifications and performance these mechanisms generate – into DHS' provider enrollment system, and
- Align provider standards between the disability waivers and the Elderly Waiver and Alternative Care programs, where appropriate.

Following preparatory work on enrollment and service standards developed in cooperation with local government, service provider and participant advocacy stakeholders in two workgroups,[10] DHS is currently engaged with a workgroup of lead agency and state waiver program staff to:

- Refine standards by developing a process for providers that are not currently enrolled, and enhancing standards for unlicensed providers
- Review existing lead agency contract language to determine new policies for the statewide provider enrollment process
- Establish monitoring protocols with lead agencies
- Design mechanisms to collect provider monitoring and oversight data
- Develop provider performance standards in the form of a performance framework, and
- Evaluate the current provider verification, monitoring and enrollment systems, and make necessary changes.

The expected outcomes of this initiative are to:

- Bring DHS into compliance with federal requirements for the renewal of the HCBS disability waiver programs
- Ensure that recipients will receive services from qualified providers based on standards that impact their health and safety
- Provide recipients with increased access to providers and choice of providers
- Develop a streamlined and consistent enrollment process for providers of waiver and home care services, and
- Allow lead agencies to focus on provider performance monitoring activities.

ii. Rate Setting Methodologies Initiative (RSMI)

In response to the CAC Waiver renewal submitted in 2007, CMS stated that Minnesota's current rate setting methodology for all waiver services (including CADI, DD and TBI) does not assure that payments for these services are consistent with efficiency, economy and quality of care as stated in section 1902(a)(30)(A) of the Social Security Act. CMS informed DHS that a state must have uniform rate determination methods that apply to each waiver service. This is to ensure:

- Payments across all areas of the state are equitable, and
- Any differences in rates are based on factors specified in the methodology or formula based on concrete indices (e.g., difficulty of care or geographic factors).

[10] This preparatory work is described in the Department's *Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities*. DHS Disability Services Division, 2010 (pp. 12-15).

CMS proposed that DHS create a uniformly applied statewide rate-setting methodology that allows rate variations to capture the individualized nature of services.

The Rate Setting Methodologies Initiative (RSMI) has been undertaken to establish statewide rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities, which includes all services provided under the CAC, CADI, DD and TBI waivers. The rate-setting methodologies for these services must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

This initiative will:

- Bring DHS into federal compliance for the renewal of federal financial participation in the disability waiver programs
- Identify components of each waiver service
- Determine standardized pricing for each service component, and
- Create rate methodologies based on service components and individual needs.

In order to develop standardized rate setting methodologies, DHS engaged other local government, service provider and participant advocacy stakeholders to participate in the development of rate frameworks. Since July of 2009, DHS and involved stakeholders have:

- Reviewed information regarding current and previous rate setting research and methodologies
- Interviewed subject matter experts on rate development and service provision
- Created rate setting methodologies for disability waiver services
- Defined service components to be included in rates for disability services
- Created rate calculations specific to each service which define how service components relate to one another to determine rates
- Determined data sources and gathered data that will be used to populate the rate frameworks
- Begun a comprehensive data collection and analysis process, and
- Completed rate frameworks.

In order to implement the Rate Setting Methodologies Initiative, the Department will:

- Finish determining data to populate rate frameworks
- Create rate ranges based on assessment information
- Connect rate customizations to assessment information
- Conduct impact analysis
- Develop web based technology
- Connect technology to billing systems
- Develop legislative language
- Coordinate stakeholder training and communication
- Manage discovery and remediation issues, and
- Conduct program evaluation

iii. Quality Essentials Team (QET)

CMS's current quality management requirements for HCBS waiver programs were issued in January 2008.[11] The following month, DSD and Aging and Adult Services Division (AASD) staff responsible for waiver program quality assurance policy began meeting to formulate the Department's strategy to meet the increased performance measurement requirements. Eventually, this internal DHS workgroup was established as the Quality Essentials Team (QET), with a responsibility to identify data sources and measures that – when monitored and successfully acted upon – will ensure ongoing compliance with federal waiver requirements.

Over the next two years, the QET examined existing data sources used to measure waiver program performance to:

- Identify common system performance measures that could be used across all five HCBS waiver programs
- Identify the strongest and fewest possible number of measures needed to effectively demonstrate the state's level of compliance with federal waiver requirements, and
- Eliminate redundant or ineffective measures from the Department's waiver compliance evidence submissions.

In the few instances where gaps were noted in this developing suite of performance measures, efforts were made to identify where new data sources and measures could be developed within existing DHS program initiatives, such as the Participant Experience Survey (MN PES), Provider Enrollment and Provider Standards Initiative, and the Minnesota Comprehensive Assessment (now MnCHOICES) project. As a result, any gaps or areas of potential weakness in Minnesota's waiver performance measures will be addressed with measures being developed in these ongoing quality improvement projects.

In September 2010, CMS granted a renewal of Minnesota's CADI Waiver based in part upon the Department's first submission of the waiver performance measures identified by the QET. In the renewed waiver's "Quality Improvement Strategy," the QET itself is assigned responsibility for ongoing analysis of program performance, and for recommending improvements in the state's waiver performance measures.[12]

B. Projects to Meet State Legislative Requirements

i. Participant Experience Survey – Minnesota version (MN PES)

Minnesota Statutes §256B.096, Subd. 3 required DHS to develop and test an annual survey of service recipients to determine the effectiveness and quality of disability services. In its 2009

[11] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare & Medicaid Services, 2008.

[12] For Minnesota's approved CADI waiver quality management measures and Quality Improvement Strategy, see Appendix E.

report to the legislature on HCBS quality management,[13] DHS described work underway to adapt CMS' Participant Experience Survey (PES) to meet Minnesota's various quality management needs as identified by the legislature, DHS and disability services stakeholders.[14] Subsequent to that report, survey development and testing continued, and the final survey instruments and associated research products were delivered to DHS in June 2009.[15]

During survey development, it was determined that separate versions would be developed for adults and children, so that nuances in how services differ according to a person's age are reflected within the survey instruments. It was also decided that the surveys would be modular in form, meaning separate sections (corresponding with various *domains* of service and quality) can be included or omitted, depending on the specific services an individual receives. This allows DHS to capture targeted feedback on people's *experience* with disability services and the impact these services have on their lives. The MN PES survey "domains" include:

- Case management & service plan development
- Own home (adult version only)
- Experience with congregate housing (adult version only)
- Self-direction
- Experience with direct care staff
- Daily activities/employment (adult version only)
- Health, welfare and safety
- Community membership (adult version only)
- Important long-term relationships
- Quality of life

With the finalized MN PES instruments in hand, DSD began exploring options to implement the survey. Identified goals for using the survey and resultant data include:

- Supporting federal waiver compliance by including MN PES data as performance measures within waiver quality management evidence submissions
- Establishing baseline data, and evaluating the person-level impact of future changes to the waiver and PCA programs
- Evaluating participants' *experience* of service quality and the impact of those services in peoples' lives, and
- Providing a participant-based "check and balance" on existing administrative data measures.

It is important to emphasize these last two points; MN PES is not meant to obtain verifiably objective information, but the *participant's experience* of the supports and services they receive. Instances where participant feedback fails to support conclusions drawn from administrative

[13] *Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services*. DHS Disability Services Division, 2009.
[14] Stakeholders including self-advocates, advocacy organizations, citizen experts, service provider organizations, local and state government representatives.
[15] *Final Report: Development and Testing of the Participant Experience Survey, Minnesota Version*. Thomson Reuters, 2009. For final survey instruments, see Appendix G (adult version) and Appendix H (minor version).

data sources may indicate that the intended effects or outcomes of services being measured aren't translating into the effects or outcomes people actually experience. Then, steps can be taken to identify and address the gap in system performance between *intent* and *outcome*.

Considering their potential to support waiver performance monitoring, it was decided to include a few MN PES measures within the performance measures package submitted as part of the CADI Waiver renewal. Although the legislation specifies using a *percentage* sample (between five and ten percent of service recipients) for implementing the MN PES, CMS currently endorses the use of *representative* samples for states' waiver quality management strategies. For resultant MN PES data to be suitable for federal reporting and waiver compliance purposes, a sample to yield a 95% ±5% confidence level is necessary. In the case of the CADI Waiver, a sample of just under 400 individuals is needed to meet this requirement – far less than 5% (or approximately 850 people) of total CADI Waiver participants.

In late 2009, using funds from the CMS Medicaid Infrastructure Grant to prepare the MN PES for wider use, DHS had the survey instruments translated into Spanish, Hmong and Somali language versions. Community reviews were conducted with people fluent in those languages to ensure the meaning and intent of the survey questions were understandable. Then, early in 2010, an RFP was issued to find a vendor to coordinate and conduct 800 MN PES interviews across the state; 400 surveys with CADI Waiver participants (for statistical significance, as explained above), and a total of 400 surveys between participants in five other MA programs (MA-EPD[16], CAC, DD, TBI, and PCA[17]). Again using Medicaid Infrastructure Grant funds, DHS contracted with Vital Research, LLC[18] to conduct these surveys during calendar year 2010.

This first round of MN PES implementation has concluded, with 826 survey interviews completed. All interviews were conducted at the respondent's location of choice – ranging from people's own homes to their places of employment, from public libraries to fast food restaurants. The survey data files were delivered from the vendor to DHS at the end of 2010; data analysis and a report of findings will be completed in early 2011.

ii. Centralized Common Entry Point

In its 2009 HCBS quality management report,[19] DHS reported concerns raised by disability services stakeholders about problems and inconsistencies between Minnesota's 87 counties in how reports of suspected maltreatment involving vulnerable adults are taken and handled by each county's common entry point (CEP).[20] DHS recommended examining the pros and cons of centralizing the common entry point function into a single, state-operated system, with the capability to receive reports both by telephone and through a Web-based reporting application.

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[16] Medical Assistance for Employed Persons with Disabilities (MA-EPD)
[17] Personal Care Assistance (PCA)
[18] Since 2005, Vital Research has also conducted annual measurements of resident satisfaction in 400 nursing home facilities in Minnesota. Resultant data is used as part of the Minnesota Nursing Home Report Card.
[19] *Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services*. DHS Disability Services Division, 2009 (pp. 20-21)
[20] Reporting of Maltreatment of Vulnerable Adults (Minnesota Statutes §626.557, Subd. 9)

The 2009 Legislature directed the department to "seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557 [Vulnerable Adults Act]. The purpose of the federal grant is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult."[21] Since that time, DHS has been monitoring developments in federal legislation and funding opportunities for this purpose.

In March 2010, the Elder Justice Act (EJA) was passed by Congress and signed into law. The legislation, which coordinates efforts to prevent elder abuse on a federal level, authorizes funding over four years for a number of elder abuse prevention and protective services purposes, including $100 million annually for state grants to enhance the provision of adult protective services. All funds received under these grants may only be used for adult protective services, and may not supplant other federal, state, and local public funds already being spent to provide adult protective services in a state. It is estimated that Minnesota's share, if awarded, would be approximately $1.57 million annually through the term of the grant. As of this writing, no money has been appropriated for the EJA, although it appears funding may be available beginning in 2012. Once available, the Department is prepared to seek these funds.

It appears likely this EJA funding (if and when appropriated) could be used to develop and operate a centralized, statewide common entry point function. However, based on prior estimates[22], the grant funds alone would not fully cover the costs involved in the development ($3.5 million in the first year) or continuing operation costs ($2 million annually) of such a system. The remaining costs would need to be covered by the state.

iii. Residential Support Services and Quality Outcome Standards (RSS-QOS) provider standards development project

In addition to the work underway to develop basic provider standards for all waiver services providers (see *Provider Enrollment and Provider Standards Initiative*, above), DHS is involved in updating licensing standards for waiver providers licensed directly by the Department, or by county social service agencies as delegated under Minnesota Statutes §245A.16 . The primary function of current licensing standards is to protect the health, safety and rights of people receiving services by requiring providers to meet minimum standards of care and physical environment requirements.

Minnesota spends a substantial share of its waiver budget on corporate foster care – the current trend cannot be sustained. Recognizing this, the Legislature placed a moratorium on new corporate foster care development in 2009. To establish a mechanism for managing statewide corporate foster care capacity into the future, legislation was passed[23] requiring a new service type ("Residential Support Services") for existing corporate foster care services to be created.

[21] Minnesota Statutes, §245A.655 (a)
[22] *Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services*. DHS Disability Services Division, 2009 (pp. 27).
[23] Minnesota Statutes §245A.11, Subd. 8; Minnesota Statutes §256B.092, Subd. 11; and Minnesota Statutes §256B.49, Subd. 22.

Where several sets of laws and rules exist for licensing of corporate foster care programs, a single license ("Community Residential Setting") and set of standards must be established.

The 2009 Legislature also passed a law requiring the development of a "single set of standards" for disability waiver service providers by January 2012. The 2010 Legislature amended this law to refer to the new standards as "quality outcome standards."[24] The essence of this requirement is that provider monitoring and credentialing become more focused upon supports for and the achievement of individual outcomes, and less upon paperwork and process compliance. "Quality outcomes" and their establishment within provider standards and monitoring/credentialing are to be addressed under the requirements of this legislation.

Because these two mandates intersect with regard to waiver services provided in corporate foster care settings, and to avoid either duplication or divergence between the resulting standards, DHS combined and is addressing them both under a sequential, two-part process:

- Phase One – establish environmental *setting* standards for Residential Support Services (RSS) facilities, to be applied under the Community Residential Setting license.
- Phase Two – develop a common set of "quality outcome standards" (QOS) governing *services* (including RSS) across all four HCBS disability waiver programs.

The Department issued an RFP in June 2010 for a vendor to research outcome-based provider standards and licensing models, and to facilitate the development of the required standards with stakeholder cooperation. A contract was awarded to STAR Services for this purpose. Then, in September 2010, a workgroup of stakeholders with a direct interest in corporate foster care services[25] was convened to develop a set of recommended RSS facility standards – standards specific to the physical plant and service environment for RSS. The Phase One portion of the work was concluded in December 2010; the resultant set of recommended standards is included in Appendix B to this report.

In Phase Two, the stakeholder workgroup has been expanded to include additional service provider and advocacy organizations, reflecting the larger set of services and constituencies that will be affected by the single, cross-waiver set of service standards. The Department intends to submit statutory language for these standards, and a unified implementation plan for all new standards developed under this project, to the 2012 Legislature.

C. Other DHS Quality Management Initiatives for HCBS

i. DHS Priority for HCBS – Provider Performance Measures and HCBS Report Card

DHS has identified seven priorities to guide department planning efforts. One of these is to improve home and community-based services by establishing and using measures of service provider performance:

[24] *Laws of Minnesota 2010, Chapter 352, Article 1, Section 24.*
[25] See Appendix C for a list of RSS-QOS stakeholder workgroup participants.

> ***"Improve home and community-based services for the elderly and people with disabilities.*** *The department will improve the performance data it collects for home and community-based services so that consumers and government can make informed purchasing decisions. As a result, services will be more efficient, effective and appropriate in meeting the needs of consumers."*

The Minnesota Nursing Home Report Card has been successful in informing and supporting consumer choice, and in creating incentives for service improvement among providers. As the number of people receiving long-term care in the community continues to grow, it makes sense to develop similar mechanisms, to serve similar purposes, for home and community-based services. Including more and better information about HCBS services and providers will help individuals and families make better choices, including choices based on comparative information about HCBS costs that can affect their ability to use and extend private resources.

The use of provider performance measures in the format of an "HCBS Report Card" could:

- Educate consumers about differences among HCBS services, service providers, and costs. Good and timely information can facilitate better decision making.
- Contribute to DHS' response to federal waiver program assurances regarding access, choice, and system improvement.
- Support HCBS providers in targeting improvements in their services.

Strategies related to managing growth in publicly-funded HCBS and sustaining the availability of cost-effective HCBS requires that:

- Private pay consumers have better information about service options and better information about HCBS costs to help them extend their personal resources, including informal caregiving.
- Public purchasers have tools available to better match "the right service at the right time, for the right person, at the right cost."

As a first step in this process, DHS contracted with Thomson Reuters to propose a limited candidate list of cross-cutting measures for assessing and comparing individual providers, as well as an assessment of the feasibility of implementing these measures for an initial subset of HCBS provider types. The Provider Performance Measures task is one component of a grant Minnesota received from the U.S. Centers for Medicare & Medicaid Services to develop a State Profile Tool.

The Home and Community-Based Services Expert Panel (Expert Panel) provided ongoing review and feedback on project activities. The Expert Panel is a stakeholder group created under the State Profile Grant to assist in developing the state profile and to identify and discuss strategies to improve HCBS in Minnesota. It comprises stakeholders from across the state representing consumers, providers, the public sector, and associations knowledgeable and active in HCBS issues. Contractor staff participated in all the bi-monthly meetings of the Expert Panel to update members on project activities and to obtain feedback on project findings and deliverables.[26]

[26] Excerpt from *Assessing HCBS Providers' Performance: Candidate Measures for MN DHS – Final Report*. Thomson Reuters, 2009.

The resulting list of proposed provider performance measures[27] includes:

- Substantiated findings of maltreatment
- Conditional licensure
- Retention of staff employed at least six months
- Participant satisfaction
- Respectful treatment
- Safety with provider
- Substantiated violation of participant's rights
- Accuracy of MNHelp.info profile
- Activities meet preferences in day programs (specific to Adult Day Care and Day Training & Habilitation providers)
- Adequate employment support for current job (specific to Supported Employment Services providers), and
- Ability to make choices at home (specific to Adult Foster Care and Assisted Living providers).

ii. Quality Commission

In 2005, the Minnesota Legislature mandated a study and recommendations for implementing a statewide system of quality assurance for HCBS and related disability programs. DHS convened a Quality Assurance Panel (QA Panel) of citizen experts and local and state agency representatives to fulfill this requirement. The QA Panel's report[28], submitted to the legislature in February 2007, recommended the adoption of five components as part of a comprehensive quality management system:

1. A State Quality Commission
2. Six Regional Quality Councils
3. An annual statewide survey of a sample of service participants
4. An outcome-based quality assessment program for service monitoring
5. An effective program of incident reporting, investigation and analysis.

Of these five components, the development of (a) the statewide "quality" survey and (b) recommendations for improvements to the state's incident reporting and follow-up systems were passed into law, and subsequently addressed with the cooperation of a stakeholder advisory group between November 2007 and June 2009 (as described in section III., subsections B.i. and B.ii., above).

[27] *Assessing HCBS Providers' Performance: Candidate Measures for MN DHS – Final Report*. Thomson Reuters, 2009 (pp. 6-9).
[28] *Quality Assurance in Minnesota 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel*. Minnesota Quality Assurance Panel, 2007.

Although not nearly as expansive in its scope as what was proposed by the QA Panel in 2007[29], a Quality Commission of disability services stakeholders was convened in September 2009 to assist DHS in identifying quality indicators and measures that:

- Allow DHS to better capture, evaluate, describe and respond to what is learned about the level of quality in Minnesota's Home Care (PCA) and Waiver services programs, and
- Will be used to meet state and federal quality management reporting requirements, as well as in reports on program quality to the public.

Between September 2009 and June 2010, the Quality Commission considered and recommended quality indicators to measure the effects and impact of various HCBS program changes coming out of the 2009 Legislative session[30]. These included:

- Personal Care Assistance (PCA) reform[31]
- Corporate foster care license moratorium[32]
- "Quality Outcomes" for the Single Set of Standards/Quality Outcome Standards[33] and Residential Support Services[34], and
- Statewide priority list for disability waiver waiting lists[35].

Given the volume and magnitude of current activities within DSD focused upon meeting federal waiver program and State legislative requirements, staff resources for the Quality Commission are limited. However, the Quality Commission met again in November 2010 to update members on quality measurement tools under development, and DSD envisions being able to reconvene the commission again in mid-2011 for additional updates.

[29] *Quality Assurance in Minnesota 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel*. Minnesota Quality Assurance Panel, 2007 (pp. 9-12).
[30] See Appendix F.
[31] *Laws of Minnesota 2009, Chapter 173, Article 1, Section 25*; and *Laws of Minnesota 2009, Chapter 79, Article 8, Sections 7, 18-28, 31, 74, 75, 77, 80*.
[32] *Laws of Minnesota 2009, Chapter 79, Article 8, Section 8*.
[33] *Laws of Minnesota 2009, Chapter 79, Article 8, Section 81*.
[34] *Laws of Minnesota 2009, Chapter 79, Article 8, Section 9*.
[35] *Laws of Minnesota 2009, Chapter 79, Article 8, Sections 50, 54, 64*.

IV. Conclusion and Looking Ahead

The quality assurance, management and improvement activities described herein represent the Department's ongoing efforts in establishing a system to (a) meet the requirements of the federally-approved HCBS waivers, and (b) improve the quality of services provided to Minnesotans with disabilities. Already, a few of these activities have been developed and implemented since the Department's last Quality Management report in 2009:

- The Department's internal **Quality Essentials Team** (QET) workgroup is established and will continue to monitor compliance with federal HCBS waiver requirements using the program quality and performance measures approved by CMS in Minnesota's waiver plans. As more effective data collection tools are established through the "federal compliance" (PEPSI and RSMI) and MnCHOICES comprehensive assessment projects, the QET is poised to refine or replace existing measures and propose new ones that speak more directly – and simply – to the quality of the state's waiver programs.
- The **Participant Experience Survey** (MN PES) was fielded on a statewide scale in 2010, at a cost of $230,000. DHS continues to explore funding and implementation options to continue gathering systematic input and feedback from program participants on the quality of services they receive using this vital tool.
- The **Quality Commission** stakeholder group, though on hiatus at the time of this writing, has an established membership drawn from a broad and highly engaged community of disability services stakeholders. DHS looks forward to re-engaging with the Quality Commission in 2011 to obtain stakeholder input and feedback on the Department's quality management strategy for home and community-based services.

Over the next two years, additional quality management projects will be set for implementation. Specifically:

- The **Provider Enrollment and Provider Standards Initiative**, **Rate Setting Methodologies Initiative** (RSMI), and **Residential Support Services-Quality Outcome Standards** (RSS-QOS) provider standards development project are all well underway. The projected implementation date for the new standards and monitoring and rate setting tools resulting from these projects is January 1, 2013.

Although implementation timelines are yet to be established, DHS intends to continue development of the remaining quality management projects so they may be ready to implement upon completion:

- Collecting and publishing **Provider Performance Measures** in the format of an online **HCBS Report Card** remains a priority for DHS. At present, the Department's preferred venue to make this information available is through MinnesotaHelp.info, a website easily found by the public at www.minnesotahelp.info. The website has information on services for older adults, people with disabilities, veterans, caregivers, families and children. Within the website there is an award-winning interactive tool called "The Long Term Care Choice Navigator" which allows individuals and their caregivers to create custom plans that help consumers remain in their own home. Including more and better information about HCBS services and providers would help families and individuals make better choices, including

choices based on better and comparative information about HCBS costs that can affect their ability to use and extend private resources.

- DHS is prepared to pursue federal funding, as it becomes available, to support the development of a statewide, **centralized Common Entry Point** for the intake and referral of reports alleging maltreatment of vulnerable adults.

Cost Projections

Limited Costs

- The **Quality Commission** (for limited activities) and the **Quality Essentials Team** will continue to be staffed by the Department within existing staff resources.

More Substantial Costs/Investments

- Statewide implementation of the **Participant Experience Survey**, Minnesota version (MN PES):
  - Annual sample size of 800 completed surveys (for statistically valid and reliable results across the disability waiver and home care programs) – $230,000 annually[36]

- **Centralization of Common Entry Point** function and Web-based maltreatment reporting:
  - Development – estimated $3.5 million (first year)
  - Continuing operation – estimated $2 million annually[37]

- Information technology (IT) data integration systems and Web-based reporting applications for **HCBS Report Card** within MinnesotaHelp.info:
  - Development and roll-out – estimated $224,000 (first year)
  - Continuing operation – estimated $218,000 annually

Costs to be determined

- The 2009 Legislature appropriated funds to develop the various tools and processes required as outcomes of the **Rate Setting Methodologies Initiative** (RSMI), **Provider Enrollment and Provider Standards Initiative**, and **Residential Support Services – Quality Outcome Standards** (RSS-QOS) projects. Costs for the implementation and ongoing operation of these tools and processes are still being determined.

[36] Based on actual MN PES 2010 statewide implementation costs.
[37] Source: *Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services*. DHS Disability Services Division, 2009 (pp. 27).

Appendices

Appendix A: Minnesota Statutes §256B.096

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall 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. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow-up for disability services.

The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, 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. By January 15, 2008, the commissioner shall provide a

preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

History: *2007 c 147 art 7 s 18*

Appendix B: Draft Language for Community Residential Setting License and Residential Support Services Standards

Purpose.

To establish provider standards for residential support services that integrate service standards and the residential setting under one license.

Scope.

The licensing standards in this section as well as quality outcome standards must be met to obtain and maintain a community residential setting license to provide residential support services. For the purposes of this section, residential support services must meet the following criteria:
(1) providers of residential support services must own or control the residential site;
(2) the residential site must not be the primary residence of the license holder;
(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;
(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's community support plan; and
(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

Residential Support Services refers to the services defined in 256B.092. Subd. 11

Adult foster care license holders providing residential support services under their foster care license on [*INSERT DATE HERE*], shall be permitted to continue providing these services with no additional requirements until their adult foster care license is due for renewal. At the time of relicensure, an adult foster care license holder will transition to provide residential support services upon demonstration of compliance with this section.

License holders providing residential support services for children are required to hold a child foster care license as well as meet the quality outcome standards and are exempt from [*INSERT SECTIONS HERE OF RSS*].

Adult foster care variances issued prior to [*INSERT DATE HERE*] are grandfathered in as variances to Community Residential Setting License standards.

Definitions.

For the purposes of this section, the terms defined in this subdivision have the following meanings unless otherwise provided for by text.

Adult. "Adult" means a person at least 18 years of age.

Applicant. "Applicant" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 3

Building Official. "Building official" means a person appointed in accordance with Minnesota Statutes, section 326B.133, to administer the state building code or the building official's authorized representative.

Commissioner. "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Communicable Disease "Communicable Disease" means a contagious or infectious disease or condition as specified in Minnesota Administrative Rules Chapter 4605 parts 4605.7000 to 4605.7800.

Department. "Department" means the Minnesota Department of Human Services.

Dwelling Unit. "Dwelling unit" means a single unit providing complete living facilities for one or more persons, including permanent provisions for living, sleeping, eating, cooking and sanitation as defined in the MN State Fire Code.

Fire Marshal. "Fire marshal" means the person designated by Minnesota Statutes section 299F.011, to administer and enforce the Minnesota State Fire Code or the fire marshal's authorized representative.

Health Authority. "Health Authority" means the designated representative of the board of health as defined in Minnesota Statutes, section 145A.02 subdivision 2, to enforce public health codes.

Legal Representative. "Legal representative" means a person appointed by the court as a guardian or conservator of an adult under Minnesota Statutes, sections 525.539 to 525.6198 or chapter 252A, or a health care agent appointed by a principal in a health care power of attorney to make health care decisions as provided in Minnesota Statutes, chapter 145C.

License**.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner.

Licensed health care professional. "Licensed health care professional" means a medical doctor, physician's assistant, or nurse practitioner.

Local agency. "Local agency" means the county or multicounty social service agency governed by the county board or multicounty human services board of the county in which the Residential Support Services home is located.

Licensed Capacity. "Licensed capacity" means the maximum number of persons receiving services who may receive residential support services in the home at any one time.

License Holder. "License holder" means that which is defined in 245A.02 Subd. 9

Medication. "Medication" means a prescription or over the counter substance taken internally, applied externally, or injected to prevent or treat a condition or disease, heal or relieve pain.

Minnesota State Building Code. “Minnesota State Building Code” means those codes and regulations adopted by the commissioner of administration under chapter 1300 and Minnesota Statutes section 326B.101.

Minnesota State Fire Code. “Minnesota State Fire Code” means those codes and regulations adopted by the fire marshal under Minnesota Statutes, section 299F.011 and chapter 7511.

Person receiving services. “Person receiving services” means an individual residing in a community residential setting licensed home and receiving services.

Pets. “Pets” means a domesticated animal living in the home or on the property where residential support services are provided.

Primary Emergency Contact. “Primary Emergency Contact” means the person that should be notified immediately in case of an emergency. This person could include but is not limited to the legal representative of the person receiving services.

Residence. (Home) “Residence” means the single dwelling unit in which Residential Support Services is provided with complete, independent living facilities for one or more persons. As defined in section 405 of the Minnesota State Building Code, the residence has permanent provisions for living, sleeping, cooking, eating and sanitation.

Roomer. "Roomer" means a household member who is not a person receiving services, caregiver, or person(s) related to a caregiver.

Supervision. "Supervision" means: a) oversight by a caregiver as specified in the community support plan/individual service plan and daily awareness of a person's needs and activities; and b) the presence of a caregiver in the residence during normal sleeping hours or the presence of alternative overnight supervision through the compliance of 245A. 11 subdivision 7, 7a, and 7b.

Variance. “Variance” means written permission by the commissioner for an applicant or license holder to depart from the provisions of parts *NEW NUMBERS TO BE ASSIGNED*

Weapons. “Weapons” means firearms and other instruments or devices designed for and capable of producing bodily harm.

Applicable state and local code compliance.
The home must comply with applicable state and local fire, health, building, and zoning codes. Any condition cited by a fire marshal, building official or health authority as hazardous or creating an immediate danger of fire or threat to health and safety must be corrected before a license is issued or renewed by the department.

The home must be in compliance with applicable fire safety standards. The residence must be inspected by a fire marshal or their delegate within 12 months before initial licensure to verify that the residence is a dwelling unit within a residential occupancy as defined in the Minnesota State Fire Code and that the

residence complies with the fire safety standards for that residential occupancy contained in the Minnesota State Fire Code.

A home safety checklist, approved by the commissioner, must be completed by the license holder and the commissioner before licensure each year a fire marshal inspection is not made. If the commissioner has reasonable cause to believe that a potentially hazardous condition may be present, the commissioner shall request a subsequent inspection and written report by a fire marshal to verify the absence of hazard.

Community Residential Setting Licensed Homes are permitted single family use homes. After a license has been issued the commissioner shall notify the local municipality where the residence is located of the approved license.

The residence must meet the definition of a dwelling unit in a residential occupancy and be free of any plumbing, electrical, ventilation, mechanical or structural hazard that would threaten the health or safety of a person receiving services.

Notification to local agency.
The license holder must notify the local agency within 24 hours of the onset of changes in a home resulting from construction, remodeling, or damages requiring repairs that require a building permit and/or may affect a licensing requirement in this chapter.

Capacity.
Except as provided in Minnesota Statutes, section 245A.11, subd. 2a, a maximum of four people receiving services may live in the Community Residential Setting Licensed home at one time.

Physical Examination of a person receiving services.
In order to promote a healthy environment for all who live in the home the license holder must have documentation of the examination of a person receiving services by a licensed health care professional 365 days prior to or within 30 days after admission to determine if the person has a communicable disease named in parts 4605.7000 to 4605.7800 or a health condition that would pose a risk to others within the home.

Emergencies.
The license holder shall be prepared for emergencies and ensure that:

- a non-coin-operated landline telephone that is not cordless, an operable battery operated radio, and an operable flashlight are located within the residence;
- the phone numbers of each person receiving services' primary emergency contact representative, primary medical professional, emergency mental health provider, if applicable, and dentist are readily available for emergency personnel;
- the universal emergency phone number 911 and the home's address is posted by the telephone;
- each person receiving services is informed of a designated area where they can take shelter during severe storms or tornadoes and a drill is conducted annually;
- fire drills are conducted at least once every three months;
- a written fire escape plan and a log of quarterly fire drills are on file in the residence;
- the fire escape plan is initially reviewed by the fire marshal and includes the following on the floor plan: occupancy assembly point, exits, primary evacuation routes, secondary evacuation

routes, enclosed exit stairs (if any), accessible egress routes (if any), areas of refuge (if any), manual fire alarm boxes (if any), portable fire extinguishers, smoke detectors, fire alarm enunciators and controls (if any). Fire escape plans are readily available for staff and persons receiving services;

- the house number is located on the outside of the house, in a prominent location that is visible from the street, to ensure that emergency vehicles will be able to easily locate the home in case of an emergency.

The license holder shall ensure that the residence is equipped with accessible first aid supplies including bandages, sterile compresses, scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, gloves, and first aid manual.

Common area requirements.
Each person receiving services must have use of and free access to common areas in the home, unless it is documented as contraindicated for that person. The dining area is furnished to accommodate meals shared by all people receiving services. The living area shall be provided with an adequate number of furnishings for the usual functions of daily living and social activities. These furnishing shall be in good repair and functional to meet the daily needs of the people receiving services in the home.

The license holder shall maintain the interior and exterior of the building in a sanitary and safe condition. The residence must be clean and free from accumulations of dirt, grease, garbage, peeling paint, vermin, and insects.

Chemicals, detergents, and other toxic substances must not be stored with food products or in any way that poses a hazard to person(s) receiving services.

Medications.
The home will have a locked storage area available to store medications as identified in the person's Risk Management Plan. Schedule II controlled substances in the residence that are named in Minnesota Statutes, section 152.02, subdivision 3, must be stored in a locked storage area permitting access only by person receiving services and staff authorized to administer the medication.

Medications will be disposed in such a manner that is in compliance with Environmental Protection Agency recommendations.

Goods provided by the license holder.
The license holder will provide for persons receiving services, towels, wash cloths, and clean bed linen appropriate for the season and the person's comfort.

Usual or customary goods for the operation of a home which are communally used by all person receiving services living in the home will be provided by the license holder including: household items for meal preparation, cleaning supplies to maintain the cleanliness of the home, window coverings on windows for privacy, toilet paper, and hand soap.

Water.
Potable water from privately owned wells must be tested annually by a Minnesota Health Department certified laboratory for coliform bacteria and nitrate nitrogens to verify safety. Retesting and corrective

measures may be required by the health authority if results exceed state water standards in Minnesota Rules, chapter 4720 or in the event of a flooding or incident which may put the well at risk of contamination.

To prevent scalding, the water temperature at faucets shall not exceed 120 degrees Fahrenheit.

Food.
Food served must meet special dietary needs of a person receiving services as prescribed by the person receiving service's physician or dietitian. Three nutritionally balanced meals a day must be served or made available to a person receiving services, and nutritious snacks must be available between meals.

Food must be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to the health of a person receiving services.

Bedrooms.
People receiving services must mutually consent, in writing, to sharing a bedroom with one another. No more than two people receiving services may share one bedroom.

Bedrooms occupied by people receiving services must meet the following criteria:

- A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling.

Bedrooms must be separated from halls, corridors, and other habitable rooms by floor to ceiling walls containing no openings except doorways and must not serve as a corridor to another room used in daily living.

The person receiving services must have an identified space for clothing and personal possessions with cabinets, dresser, closets, shelves, or hanging space sufficient to accommodate clothing and personal possessions.

Each person receiving services shall be provided with a separate bed of proper size and height for the convenience and comfort of the person with a clean mattress in good repair.

Personal possessions.
The person receiving services must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available in the Community Residential Setting Licensed home. The person receiving services must be allowed to accumulate possessions to the extent the home is able to accommodate them, unless doing so would interfere with safety precautions, use of the bedroom, or violate a building or fire code.

Personal possessions and items for the person's own use are the only items permitted to be stored in the bedroom of a person receiving services.

Pets and service animals.
Pets and service animals must be immunized and maintained as required by local ordinances and state law.

Weapons.
Weapons and ammunition must be stored separately in locked areas that are inaccessible to a person receiving services.

Variances.

The commissioner may grant a variance to any of the requirements in this section if the conditions in section 245A.04, subdivision 9, are met.

Appendix C: Residential Support Services and Quality Outcome Standards (RSS-QOS) Stakeholder Workgroup Participants

Phase One: Residential Support Services (September 2010 – December 2010)

Workgroup participants	Organizations/Stakeholders represented
Jim Arneson	Minnesota Association of County Social Service Administrators (MACSSA)
Deborah Beske Brown	DHS – Child Safety & Permanency
Mary Cahill	Minnesota Department of Health – Compliance Monitoring Division
John Flanders	Minnesota Region 10 Quality Assurance
Jason Flint	DHS – Disability Services (Project Officer)
Joyce Hagen	Lutheran Social Service of Minnesota (LSS)
Barb Jacobson	Association of Residential Resources in Minnesota (ARRM)
Mike Kalpiers	Minnesota Association of County Social Service Administrators (MACSSA)
Mary Kelsey	DHS – Licensing
Jerry Kerber	DHS – Licensing
Steve Larson	The Arc of Minnesota
Wade Majewski	TBI Advisory Committee
Phil Manz	Care Providers of Minnesota
Jennifer McNertney	Aging Services of Minnesota
Chris Michel	Office of the Ombudsman for Mental Health and Developmental Disabilities
Sherilyn Moe	Office of the Ombudsman for Long-Term Care
Peggy Peterson	Direct Support Professional Association of Minnesota
Sheri Peterson	Minnesota Adult Foster Care Workers Association
Bud Rosenfield	Minnesota Disability Law Center
Darlene Schroeder	DHS – Aging and Adult Services
Jill Tilbury	Brain Injury Association of Minnesota

Phase Two: Quality Outcome Standards (January 2011 – present)

Additional participants	Organizations/Stakeholders represented
Elisabeth (Buff) Hennessey	The Arc of Minnesota (replacing Steve Larson)
Quentin Johnson	Advocate
Ryan Marshall	Local Public Health Association of Minnesota (LPHA)
Ruth Moser	DHS – Adult Mental Health
Bonnie Peplinski	Health Counseling Services
Dan Rietz	Minnesota Habilitation Coalition
Shelley Robinson	MnDACA
Jolene Thibedeau Boyd	MNAPSE
Mary Youle	Aging Services of Minnesota (replacing Jennifer McNertney)

Project Staff

Angie Hart	STAR Services
Laurie Tazelaar-Williams	STAR Services
Mark Winters	STAR Services

Appendix D: 1915(c) Federal HCBS Waiver Assurances

Level of Care (LOC)

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver.
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

Service Plan

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
- The state monitors service plan development in accordance with its policies and procedures.
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
- Participants are afforded choice:
  - Between waiver services and institutional care;
  - Between/among waiver services and providers.

Qualified Providers

- The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Health and Welfare

- The state, on an on-going basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Administrative Authority

- The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Financial Accountability

- State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Appendix E: Quality management measures and Quality Improvement Strategy – CADI Waiver (effective 10/1/2010)

Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Performance Measure:
Percent of administrative waiver requirement compliance deficiencies resolved, over the most recent three calendar years. Numerator: Number of waiver requirement corrective actions resolved, per Lead Agency follow-up review. Denominator: Number of waiver requirement corrective actions issued, per initial Lead Agency Review.

Performance Measure:
Percent of waiver requirement compliance deficiencies resolved, per three-year Triennial Compliance Assessment cycle. Numerator: Number of waiver requirement compliance deficiencies resolved, per mid-cycle follow-up review. Denominator: Number of waiver requirement corrective actions issued, per Triennial Compliance Assessment.

Level of Care

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measure:
Number and percent of completed assessments that include a level of care determination, per calendar year. Numerator: Number of completed assessments that include a level of care determination, per calendar year. Denominator: Number of assessments completed, per calendar year.

Performance Measure:
Number and percent of people who receive a level of care determination within required timelines, per calendar year. Numerator: Number of requested assessments completed within required timelines, per calendar year. Denominator: Number of requested assessments, per calendar year.

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measure:
Number and percent of reassessments that occur within required timeframes, per calendar year. Numerator: Number of reassessments that occur within required timelines (i.e., within 366 days), per calendar year. Denominator: Number of reassessments completed, per calendar year.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measure:
Percent of case files reviewed over the most recent 3 years in which the screening document in the case files matches all the data found on the screening document in MMIS.

Performance Measure:
For managed care enrollees, percent of audited community support plans in which complete LTCC results are present, per calendar year. Numerator: Number of audited CADI waiver community support plans in which complete LTCC results are present, per calendar year. Denominator: Number of audited CADI waiver community support plans, per calendar year.

Qualified Providers

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measure:
Percent of total CADI waiver claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI waiver claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI waiver claims paid, per calendar year.

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

Performance Measure:
Percent of total CADI waiver claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI waiver claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI waiver claims paid, per calendar year.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

Performance Measure:
Percent of total CADI waiver claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI waiver claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI waiver claims paid, per calendar year.

Service Plan

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measure:
Percent of case files reviewed over the most recent 3 calendar years in which all assessed needs are documented in the community support plan. Numerator: Number of case files reviewed over the most

recent three calendar years in which all assessed needs are addressed in the community support plan. Denominator: Total number of case files reviewed over the most recent three calendar years.

Performance Measure:
% of case files reviewed over 3 years in which services to address all assessed needs are documented in the community support plan. Numerator: Number of cases files reviewed over three years in which services to address all assessed needs are documented in the community support plan. Denominator: Total number of case files reviewed over three years.

Performance Measure:
Percent of audited CADI waiver care plans in which assessed needs and concerns are identified and addressed, per calendar year. Numerator: Number of audited CADI waiver care plans in which assessed needs and concerns are identified and addressed, per calendar year. Denominator: Number of audited CADI waiver care plans, per calendar year.

Performance Measure:
Percent of audited care plans per calendar year in which the plan includes the type of provider furnishing each service. Numerator: Number of audited care plans in which the plan includes the type of provider furnishing each service. Denominator: Number of audited care plans, per calendar year.

Performance Measure:
Percent of survey respondents who report being able to express personal wants/desires in annual community support planning, per survey cycle. Numerator: Number of participants who answer "yes" to MN PES questions 3, 4a, and 4b, or 3a, per survey cycle. Denominator: Number of participants who respond to questions 3, 4a, and 4b, or 3a, per survey cycle.

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measure:
Percent of case files reviewed over 3 years in which community support plans were completed within 15 calendar days of assessment/ reassessment. Numerator: Number of case files reviewed over 3 years in which community support plans were completed within 15 calendar days of assessment/reassessment. Denominator: Number of case files reviewed over 3 years.

Performance Measure:
% of case files reviewed over 3 years in which the community support plan is signed and dated by all relevant parties. Numerator: Number of case files reviewed over the most recent three calendar years in which the community support plan is signed and dated by all relevant parties. Denominator: Number of CADI waiver case files reviewed over the most recent three calendar years.

Performance Measure:
% of case files reviewed over the most recent three calendar years in which assessed health and safety issues are documented in the community support plan. Numerator: Number of case files reviewed over the 3 years in which assessed health and safety issues are documented in the community support plan. Denominator: Number of case files reviewed over the most recent 3 years.

Performance Measure:

Percent of CADI waiver case files reviewed over the most recent three calendar years that include a complete back-up plan. Numerator: Number of CADI waiver case files reviewed over the most recent three calendar years that include a complete back-up plan. Denominator: Number of CADI waiver case files reviewed over the most recent three calendar years.

Performance Measure:
Percent of CADI waiver case files reviewed over the most recent three calendar years that include complete emergency contact information. Numerator: Number of CADI waiver case files reviewed over the most recent three calendar years that include complete emergency contact information. Denominator: Number of CADI waiver case files reviewed over the most recent three calendar years.

Performance Measure:
% of audited care plans that were developed and completed within 60 calendar days of enrollment and incorporates all elements of the Community Support Plan, per CY. Numerator: # of audited care plans that were developed and completed within 60 calendar days of enrollment and incorporate all elements of the Community Support Plan, per calendar year. Denominator: # of audited plans, per CY.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measure:
% of case files reviewed that include a community support plan that has been updated within the past 366 days, over the most recent 3 CYs. Numerator: # of case files reviewed over 3 CYs that include a community support plan that has been updated within the past 366 days. Denominator: Number of CADI waiver case files reviewed over the most recent three calendar years.

Performance Measure:
Percent of survey respondents who report participant-initiated changes in services being made, per survey cycle. Numerator: # of participants who answer "yes" to MN PES questions 11 and 12 (adult version) or 10 and 11 (minor version), per survey cycle. Denominator: # of participants who respond to questions 11 and 12 (adult version) or 10 and 11 (minor version), per survey cycle.

Performance Measure:
% of audited care plans per CY in which include evidence of regular monitoring of level of care and adjustments made to the care plan as determined necessary. Num: # of audited care plans per CY in which include evidence of regular monitoring of level of care and adjustments made as necessary due to new situations, events, or conditions. Den: Number of audited care plans, per CY.

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measure:
% difference between the dollar amount encumbered for CADI waiver services compared to the dollar amount claimed for CADI waiver services provided, per calendar year. Numerator: Dollar amount encumbered for CADI waiver services, per calendar year. Denominator: Dollar amount claimed for CADI waiver services provided, per calendar year.

Performance Measure:

% of survey respondents who report receiving services in accordance with their community support plan, per survey cycle. Numerator: Number participants who answer "yes" to MN PES question 6 (adult version) or 5 (minor version), per survey cycle. Denominator: Number of CADI waiver participants who respond to question 6 (adult version) or 5 (minor version), per survey cycle.

Performance Measure:
% of audited care plans per calendar year in which documentation is present for monitoring progress toward goals, interventions, and services. Numerator: # of audited CADI waiver care plans per calendar year in which documentation is present for monitoring progress toward goals, interventions, and services. Denominator: # of audited CADI waiver care plans, per calendar year.

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measure:
% of case files reviewed over the most recent 3 CYs that include documentation of choice of (a) institutional care and of (b) waiver services and providers was afforded to the participant. Num: # of case files reviewed over 3 CYs that include documentation of choice. Den: Total # of case files reviewed over 3 CYs.

Performance Measure:
% of audited care plans per CY in which documentation is present indicating (a) an enrollee was given a choice between HCBS and institutional services, and (b) enrollee was given information to enable the enrollee to choose among providers. Num: # audited care plans per CY in which documentation is present indicating participant was given a choice. Den: Number of audited care plans, per CY.

Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measure:
Percent of CADI waiver participants per calendar year who are victims of substantiated maltreatment. Numerator: Number of CADI waiver participants per calendar year who are victims of substantiated maltreatment while on the CADI waiver. Denominator: Number of CADI waiver participants per calendar year.

Performance Measure:
Percent of CADI waiver survey respondents per survey cycle who report possible maltreatment. Num: # of participants per survey cycle who answer "yes" to MN PES questions 86, 89, 92 or 95 (adult version) or 46, 49 or 52 (minor version). Den: Number of CADI waiver participants per survey cycle who respond to questions 86, 89, 92 or 95 (adult version) or 46, 49 or 52 (minor version).

Performance Measure:
Percent of CADI waiver survey respondents per survey cycle who indicate lack of knowledge of how to report instances of possible maltreatment. Numerator: # of participants per survey cycle who answer "I

don't know" to question 98 (adult version) or 55 (minor version). Denominator: # of participants per survey cycle who respond to question 98 (adult version) or 55 (minor version).

Performance Measure:
% of survey respondents per survey cycle who report they do not feel safe because paid caregivers are not with them when they're supposed to be. Num: # of participants per survey cycle who answer "yes" to question 99 (adult version) or 45 (minor version). Den: # of participants per survey cycle who respond to question 99 (adult version) or 45 (minor version).

Performance Measure:
Percent of CADI waiver survey respondents per survey cycle who report they do not feel safe at home. Numerator: Number of adult CADI waiver participants per survey cycle who answer "no" to question 100 (adult version). Denominator: Number of adult CADI waiver participants per survey cycle who respond to question 100 (adult version).

Performance Measure:
Percent of CADI waiver survey respondents per survey cycle who report they do not feel safe when they leave their home. Numerator: Number of adult CADI waiver participants per survey cycle who answer "no" to question 101 (adult version). Denominator: Number of adult CADI waiver participants per survey cycle who respond to question 101 (adult version).

Performance Measure:
% of case files reviewed over the most recent three CYs in which a participant's assessed health and safety issues are documented in the community support plan. Num: # of case files reviewed over the most recent 3 CYs in which a participant's assessed health and safety issues are documented in the community support plan. Den: Total # of case files reviewed over the most recent 3 CYs.

Performance Measure:
Percent of case files reviewed over the most recent three calendar years in which a participant's case file includes an emergency back-up plan. Numerator: Number of case files reviewed over the most recent three calendar years in which a participant's case file includes an emergency back-up plan. Denominator: Total number of case files reviewed over the most recent three calendar years.

Performance Measure:
% of case files reviewed over the most recent 3 CYs in which emergency contact information is included in the community support plan. Num: # of case files reviewed over the most recent three calendar years in which emergency contact information is included in the community support plan. Den: Total # of case files reviewed over the most recent three calendar years.

Performance Measure:
% of audited care plans per CY year in which identified health and safety risks and what to do in the event of an emergency are documented. Numerator: Number of audited CADI waiver care plans per calendar year in which identified health and safety risks and what to do in the event of an emergency are documented. Denominator: Number of audited CADI waiver care plans, per calendar year.

Performance Measure:
Percent of audited CADI waiver care plans per calendar year in which identified environmental and personal safety concerns are addressed. Numerator: Number of audited CADI waiver care plans per

calendar year in which identified environmental and personal safety concerns are addressed. Denominator: Number of audited CADI waiver care plans, per calendar year.

Performance Measure:
% of audited care plans per CY year in which a service back-up plan is in place in the event that regularly scheduled care cannot be provided for a specified amount of time considered critical to the enrollee. Num: # of audited care plans per CY in which a service back-up plan is in place. Den: # of audited care plans, per CY.

Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measure:
Percent of CADI waiver claims paid for which there is corresponding prior authorization, per calendar year. Numerator: Dollar amount paid for CADI waiver claims with a corresponding prior authorization, per calendar year. Denominator: Dollar amount of all paid CADI waiver claims, per calendar year.

Performance Measure:
% of MCO enrollees for whom the adjusted amount for services is paid based on the eligibility for services identified in the screening document, per CY. Num: # of enrollees for whom the adjusted amount for services is paid based on the eligibility for services identified in the screening document, per CY. Den: # of enrollees for whom the adjusted amount for services is paid, per CY.

Appendix H: Quality Improvement Strategy

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process

The DHS Continuing Care Administration's Quality Essentials Team (QET) will meet twice a year to review and analyze collected performance measure and remediation data ("monitoring data") according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the Policy Review Team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
Performance Measure and Remediation (monitoring) data

Analysis (QET)
1. Is there a problem (single instance or trend) indicated by the monitoring data?
    If yes – test data (step 2).
    If no – return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?

If yes – Identify what type of problem is indicated (i.e., policy, process, and/or "bad actor").
If no – return to monitoring.

3. Do existing remediation processes address the identified problem?
If yes – remediate and return to monitoring.
If no – enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (Policy Review Team & QET)
Policy Analysis Realm

1. Can the problem's cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven policy alternatives.
If no – develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select "best" policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm

1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven internal process alternatives.
If no – develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven external process alternatives.
If no – develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select "best" process alternative.
5. Enact new process(es) and return to monitoring.

System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the Policy Review Team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:

- a web-based performance measure dashboard (to be developed);
- annually providing information to DHS-CCA quality management-related stakeholder bodies; and
- mandated legislative reports.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS-CCA leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix F: Quality Commission's proposed indicators to measure effects/impact of 2009 legislative changes

PCA program (January 2010 meeting)

- Number/percent of people with a change of status (eligible/not eligible, change to other program/service).
- Number/percent of people who moved to a more/less restrictive environment.
- Number/percent of people with referrals to other services.
- Number of appeals and their outcomes.
- Number/percent with a Qualified Professional
  - Better measures would address the reasons for QP requirement:
    - Vulnerable persons are receiving appropriate services
    - Their health and safety are being protected
    - Services were actually provided
    - The caregivers delivered satisfactory care
- Number/percent of people using multiple PCAs, providers, and/or services.
  - Consider alternate measures, like:
    - What's the impact of the 275 hr. maximum?
    - Is there coordination, if more than one PCA serving a person?

Foster Care license moratorium (February 2010 meeting)

- Number/percent of people living where they don't want to live
  - Better info may be gathered from case managers/local lead agency staff:
    - How have they dealt with the moratorium, what have they done?
    - Measure change in county share of institutional (NF, RTC, etc.) costs?
- Change in corporate foster care vacancy rate
- Change in number/percent of people who control their housing
- Change in rate of use of other services (e.g., crisis respite, in-home supports, etc.).
- Number/percent of people who moved to a more/less restrictive setting
- Change in rate of hospitalizations/falls/other health & safety indicators

"Quality Outcomes" for Single Set of Standards & Residential Support Services (April 2010 meeting)

- Participants have control of their lives
  - Demonstrate informed choice of:
    - where they live
    - not to work, retire if they want to
    - who they live with
    - who they socialize with
    - what activities they do
    - scheduling flexibility
    - plan and provider
  - Control money
  - Exercise rights
- Coordinated service delivery based on needs
- Participants achieve what they want

- Cost-effectiveness
- Improved quality of life
- Employment: earn a wage
- Safety
- Contribute value to community

Statewide waiver waiting list priorities (May 2010 meeting)

- Track by case mix
- Track by priority list (i.e., 1s vs. 2s vs. 3s...)
- How long on the waiting list?
- Services received while waiting (current services)
- Track by demographics (disability type, gender, etc.)
- Why people go off waiting list (e.g., death, enter institutional setting)

Appendix G: Participant Experience Survey – Minnesota version (MN PES) Adult Survey

Instructions

Text in **bold** is the questions (and sometimes responses) to be read aloud to the respondent.

Text in ***bold italics*** is the transitions between sections that should be read aloud.

Text in all CAPS is instructions to the interviewer and should not be read.

Plain text is use for coding.

Introductory Script

Thank you for agreeing to talk with me, I really appreciate your willingness to help.

It is your choice whether or not to answer these questions, and we can take a break or stop whenever you want. There are no right and wrong answers; I am only interested in your experience. Sometimes people have difficulty remembering if something happened in the past. It is OK to tell me you don't remember or don't know as your answer.

Nothing you tell me will change the help you receive. I also cannot help you get any new services you might want, but I can give you information about who to call with any questions or problems.

I will keep the things you tell me private, and won't share them with any of the people paid to help you. You should know, however, that I am a mandated reporter, and if I see something or learn something that makes me concerned about your health or safety, I am required by law to let Adult Protection know so they can help you.

You may notice me writing down or typing some of the things you say. This is to help me remember your comments – it does not mean I think anything you say is "good" or "bad."

Do you have any questions? Are you ready to begin?

I. Case management and Service Plan Development – "***This first set of questions has to do with your case manager (sometimes called a social worker or Public Health Nurse), the person assigned to help you get the services you need, and to develop your service plan***."

As you know, there is a person called your case manager, social worker or Public Health Nurse who is responsible for working with you to make sure you get the services and supports you need to stay in your home. Our records indicate that your current case manager is _____.

1) Is this information correct?

Yes (skip to #3)
No
I don't know/not sure
Unclear response
No response

2) Do you know who your case manager is?

Yes
No
I don't know/not sure
Unclear response
No response

3) Every year a group of people, including your case manager, meet to talk about your services and plan for the next year. Did you attend your annual planning meeting?

Yes
No (skip to #5)
I don't remember (skip to #5)
Unclear response (skip to #5)
No response (skip to #5)

4) During this planning meeting:

a. Did someone explain why it was important that you talk about the services you want?

- Yes
- No
- I don't remember
- Unclear response
- No response

b. During this planning meeting were you able to say what you wanted?

- Yes
- No
- I don't remember
- Unclear response
- No response

c. During this planning meeting were you given useful information about providers you could choose from?

Yes
No
I don't remember
Unclear response
No response

(IF NON-CDCS, ASK d, IF CDCS, ASK e)

d. During this planning meeting, were you told about other services and programs that were not on your plan, such as the option to manage your own services or hire your own staff?

Yes (skip to #5)
No (skip to #5)
I don't remember (skip to #5)
Unclear response (skip to #5)
No response (skip to #5)

e. During this planning meeting, were you told about other services and programs that were not on your plan?

Yes
No
I don't remember
Unclear response
No response

5) Who decides what is on your plan? Would you say you do, you work with other people, or someone else does?

I do
I work with others to make this choice
Someone else does
I don't remember
Unclear response
No response

6) Do the things included in your plan happen? (PROBE IF NECESSARY): **Do you get all the services and supports your plan says you should get?**

Yes
No
I don't remember
Unclear response
No response

7) **Who would you talk to if you disagree with or want to change your plan?** (CHECK ALL THAT APPLY)
- Family member or friend
- Direct care staff
- Case Manager
- Other (_____)
- I don't know
- Unclear response
- No response

8) **Are you able to get in touch with your case manager as often as you need to?**
- Yes
- No
- Unsure
- N/A – does not know who current CM is (skip to #15)
- Unclear response
- No response

9) **Does your case manager treat you respectfully?**
- Yes
- No
- Unclear response
- No response

10) Do you think your case manager would help you if you had a problem?
- Yes
- No
- I don't know/not sure
- Unclear response
- No response

11) Have you ever asked your case manager for changes to your services or supports?
- Yes
- No (skip to #14)
- I don't remember (skip to #14)
- Unclear response (skip to #14)
- No response (skip to #14)

12) Did s/he make the changes you asked for?
- Yes (skip to #14)
- No
- In process (skip to #14)
- I don't know/not sure (skip to #14)
- Unclear response (skip to #14)
- No response (skip to #14)

13) Do you know how to appeal if services or supports you ask for are denied?
- Yes
- No
- Unsure

Unclear response
No response

14) Overall, are you generally happy with your case manager?

Yes
No
Unsure
Unclear response
No response

15) Do you know you have the ability to change case managers if you want?

Yes
No
I don't know/not sure
Unclear response
No response

II. Own Home – "***Now I'd like to ask you a bit about where you live."***

16) Who decided you should live where you do now? Would you say you did, you worked with other people to make this choice, or someone else did?

I did
I worked with others to make this choice
Someone else chose it
I don't remember
Unclear response
No response

I understand you live _____.

17) If you could choose again, would you rather keep things as they are, live alone, live with your family, or live with friends or other people?

live alone
live with your family
live with friends/others
keep things as they are
No response

18) Who decided which people you should live with (or who decided you should live by yourself)? Would you say you did, you worked with other people to make this choice, or someone else did?

I did
I worked with others to make this choice
Someone else chose it
I don't remember
Not applicable – lives with family
Unclear response
No response

III. Experience with Congregate Housing ***"I'd like to ask you some questions now about your experiences in the home you share with other people, including your privacy and ability to make choices."***

SKIP TO NEXT MODULE IF RESPONDENT LIVES WITH FAMILY OR IN HIS/HER OWN HOME

19) When you are at home, can you be by yourself when you want to?

Yes
Sometimes
No
Unclear response
No response

20) Can you use the phone without other people in your home listening to your conversation?

Yes
Sometimes
No
Not applicable – does not use phone
Not applicable – is not allowed to use phone
Unclear response
No response

21) Does anyone ever read your mail without asking you first?

Yes
No
I don't know/not sure
Unclear response
No response

22) Do other people come into your room when you don't want them to?

Yes
Sometimes
No
Unclear response
No response

23) **Can you be alone with another person when you would like to?**

Yes
Sometimes
No
Unclear response
No response

24) Who decides what you do each day, like when you get up, when you eat, or when you go to sleep? Would you say you do, you work with other people to make these choices, or someone else chooses?

I do
I work with others to make this choice
Someone else chooses it
I don't remember
Unclear response
No response

25) Who decides what you buy with your spending money? Would you say you do, you work with other people to make this choice, or someone else chooses?

I do
I work with others to make this choice
Someone else chooses it
I don't remember
N/A – doesn't have any spending money
Unclear response
No response

26) Do you have to go on group outings if you don't want to?

Yes
Sometimes
No
Unclear response
No response

27) Are you ever afraid of any of the people you live with?

Yes
No
Unclear response
No response

28) Overall, are you generally happy living here?

Yes
No
Unclear response
No response

<u>IVa. Self Direction</u> – "***Because you participate in Consumer Directed Community Supports – the program where you can hire your own staff - I'd like to ask you a few questions specific to this program.***

THIS SECTION IS FOR CDCS PARTICIPANTS ONLY, ALL ELSE SKIP TO IVb

29) Are all of your paid staff family members?

Yes (skip to #36)
No
Unclear response
No response

30) Do you receive enough information on how to:

a. **Hire your own workers?**

Yes
No
I don't know/not sure
N/A – did not ask for or need
Unclear response
No response

b. Do you receive enough information on how to train your workers?

Yes
No
I don't know/not sure
N/A – did not ask for or need
Unclear response
No response

c. Do you receive enough information on how to manage and supervise your workers?

Yes
No
I don't know/not sure
N/A – did not ask for or need
Unclear response
No response

d. Do you receive enough information on how to resolve problems with your workers?

Yes
No
I don't know/not sure
N/A – did not ask for or need
Unclear response
No response

31) **How did you locate your workers?** (LISTEN AND CHECK ALL THAT APPLY)

Newspaper/other advertisements
Family or friends recommended
Some workers are family members or friends
Employment service
Church or other community organization
On-line resources
Other (_____)
Unclear response
No response

32) **Do you ever have trouble finding people to hire?**

Yes
No (skip to #35)
Unclear response (skip to #35)
No response (skip to #35)

33) What is the longest time it has taken you to find and hire a worker?

One week or less
Two weeks or less
One month or less
More than one month
I don't remember
Unclear response
No response

34) **What did you do in the meantime?** (OPEN-ENDED RESPONSE)

35) **During the past year, did you find it difficult to keep workers?**

Yes
No
Unclear response
No response

THESE NEXT 3 QUESTIONS ARE FOR CAC WAIVER PARTICIPANTS ONLY, ALL ELSE SKIP TO #39

36) Do you receive enough information on how to find nurses to hire?

Yes
No
Don't know/not sure
N/A – not on CAC waiver (skip to #39)
Unclear response
No response

37) What is the longest time it has taken you to find and hire a nurse?

One week or less
Two weeks or less
One month or less
More than one month
I don't remember
Unclear response
No response

38) **During the past year, did you find it difficult to keep nurses?**

Yes
No
Unclear response
No response

39) Do you receive enough information on how to develop your CDCS plan?

Yes
No
I don't know/not sure
Unclear response
No response

40) Have you ever been denied something you asked for in your CDCS plan?

Yes
No (skip to #42)
I don't know/not sure (skip to #42)
Unclear response (skip to #42)
No response (skip to #42)

41) What did you ask for? What did you do when it wasn't approved? (OPEN ENDED)

42) Do you know who your fiscal support entity, or third party payer, is?

Yes
No (skip to #44)
I don't know/not sure (skip to #44)
Unclear response (skip to #44)
No response (skip to #44)

43) **Does your fiscal support entity give you the support you need?**

Yes
No
Unclear response
No response

44) How does your experience with directing your own support compare to what you expected? Would you say harder than you expected, the same, or easier than you expected?

Harder than expected
Same as expected
Easier than expected
Don't know/unsure
Unclear response
No response

45) How does your experience with directing your own support compare to having a provider agency do this? Would you say harder, the same, or easier?

Harder than working with agency
Same as working with agency
Easier than working with agency
Don't know/unsure
N/A – have not worked with agency
Unclear response
No response

46) Overall, are you satisfied with your experience directing your own support?

Yes
No
Unclear response
No response

<u>IVb. Experience with Direct Care Staff</u> ***"The next questions are about the people who are paid to help you."***

THIS SECTION IS FOR NON-CDCS ONLY. SKIP TO SECTION V IF CDCS OR IF RESPONDENT HAS NO DIRECT CARE STAFF

47) Did you help pick the people who are paid to help you?

Yes (skip to # 49)
No
I don't remember (skip to # 49)
Unclear response (skip to # 49)
No response (skip to # 49)

48) Would you like to help pick the people who are paid to help you?

Yes
No
I don't know
Unclear response
No response

49) Do the people who help you at home have enough time to do all they need to do?

Yes
Sometimes
No
N/A – congregate housing (skip to #51)
Unclear response
No response

50) **Do they stay as long as they are supposed to?**

Yes
No
Unclear response
No response
Not applicable - congregate setting or shift staff

51) Do the people who are paid to help you do a good job?

Yes
No
I don't know
Unclear response
No response

52) **Do the people paid to help you where you live treat you respectfully?**

Yes
Sometimes
No
Unclear response
No response

53) **Can you understand the people who are paid to help you?**

Yes
Sometimes
No
Unclear response
No response

54) **Can they understand you?**

Yes
Sometimes
No
Unclear response
No response

55) Overall, are you generally happy with the people paid to help you in your home?

Yes
Sometimes
No
Unclear response
No response

<u>V. Daily Activities/Employment</u> – *"**Now I'd like to hear about the organized activities you do during the day outside of your home, things like work, school, and training."***

56) **What kinds of things do you do during the day? Do you (**READ EACH ITEM SEPARATELY AND CHECK ALL THAT APPLY)

Go to school?
Have a job where you earn money?
Do volunteer work?
Go to day program where you learn new things?
Other _____
Nothing else
I don't know
Unclear response
No response

57) Is this what you want to be doing during the day?

Yes
No
Unclear response
No response

58) **What else would you like to be doing during the day that you are not currently doing, or not doing as often as you would like?** (READ EACH AND CHECK ALL THAT APPLY)

School
Job where I can earn money
Volunteer work
Day program where I can learn new things
Other _____
Nothing else
I don't know
Unclear response
No response

59) How do you usually get to work, school or the other things you do during the day?

Van services or other special transportation
Public transportation, like a bus
Walk or ride a bike (skip to #61)
I drive myself (skip to #61)
Someone I know drives me
N/A –doesn't have a daily activity outside home (skip to #61)
Other (_____)
Unclear response (skip to #61)
No response (skip to #61)

60) **Can you count on this ride to come when you need it?**

Yes
No
Unclear response
No response

SKIP TO #63 IF RESPONDENT REPLIES YES TO PAID JOB IN #56

61) You mentioned before that you are not currently working at a paid job. Would you like to work?

Yes
No (skip to #73)
I don't know/not sure
Not applicable – has paid job (skip to #73)
Unclear response (skip to #73)
No response (skip to #73)

62) **Many people with disabilities would like to work, but feel that something is holding them back. Is this true for you? If so, what is holding you back from working?** (LISTEN AND CHECK ALL THAT APPLY)

Benefits (skip to #73)
Concerns about managing one's health condition, or restatement of one's diagnosis (skip to #73)
Don't know where the helping resources are (skip to #73)
Advice from others (skip to #73)
Training needs or concerns (skip to #73)
Looking, but can't find a job (skip to #73)
Issues with previous employer, or work setting. (skip to #73)
Transportation (skip to #73)
Other (_____)(skip to #73)
Unclear response (skip to #73)
No response (skip to #73)

63) You told me that you have a job where you earn money. About how many hours a week do you work?

_____ hours Don't Know No Response

64) If you want to, can you work more or fewer hours?

Yes
No
I don't know/not sure
Unclear response
No response

65) Do you have the chance to learn new things and get better at your work?

Yes
No
I don't know/not sure
Unclear response
No response

66) Do you receive Supported Employment Services to help you work?

Yes
No (skip to #73)
I don't know/not sure (skip to #73)
Unclear response (skip to #73)
No response (skip to #73)

67) Who chose the company that provides your Supported Employment Services? Would you say you did, you worked with other people to make this choice, or someone else chose?

I did
I worked with others to make this choice
Someone else chose it
I don't remember
Unclear response
No response

68) Do you have someone who is paid to support you while you are at your job?

Yes
No (skip to #72)
I don't know/not sure (skip to #72)
Unclear response (skip to #72)
No response (skip to #72)

69) Who chose the person or people who support you at work? Would you say you did, you worked with other people to make this choice, or someone else chose?

I did
I worked with others to make this choice
Someone else chose it
I don't remember
Unclear response
No response

70) Do the people paid to help you at work provide the supports you need?

Yes
No
Unclear response
No response

71) Do the people paid to help you at work treat you respectfully?

Yes
No
Unclear response
No response

72) Overall, are you generally happy with your Supported Employment Services?

Yes
No
Unclear response
No response

IF THE RESPONDENT DID NOT SAY "YES" TO DAY PROGRAM IN #56, SKIP TO #77

73) Who chose which day program you would attend? Would you say you did, you worked with other people to make this choice, or someone else chose?

I did
I worked with others to make this choice
Someone else chose it
I don't remember
N/A – does not attend a day program (skip to #77)
Unclear response
No response

74) **Do the people paid to help you at your day program treat you respectfully?**

Yes
No
Unclear response
No response

75) Do you have a chance to try new things at your day program?

Yes
No
I don't know/not sure
Unclear response
No response

76) Overall, are you generally happy with your day program?

Yes
No
Unclear response
No response

<u>VI. Health, Welfare and Safety</u> – ***"These questions have to do with the quality and adequacy of your supports, including your safety."***

77) **Do you need help or reminders from another person to do things like get dressed, take a bath, eat, or use the bathroom?**

Yes
No
Unclear response
No response

78) Are you ever unable to do any of these things when you need to?

Yes
No (skip to #81)
I don't remember (skip to #81)
Unclear response (skip to #81)
No response (skip to #81)

79) Is this because you do not have anyone to help you?

Yes
No (skip to #81)
I don't remember (skip to #81)
Unclear response (skip to #81)
No response (skip to #81)

80) Why isn't anyone there to help you?

staff did not show up
staff showed up late
no back up staff

staff refused to help
no informal support available
Other reason (_____)
I don't know
Unclear response
No response

81) Do you need help or reminders from another person to do things like cooking, laundry, using the telephone, shopping, or doing housework?

Yes
No
Unclear response
No response

82) Are you ever unable to do any of these things when you need to?

Yes
No (skip to #85)
I don't remember (skip to #85)
Unclear response (skip to #85)
No response (skip to #85)

83) Is this because you did not have anyone to help you?

Yes
No (skip to #85)
I don't remember (skip to #85)
Unclear response (skip to #85)
No response (skip to #85)

84) Why isn't anyone there to help you?

staff did not show up
staff showed up late
no back up staff
staff refused to help
no informal support available
Other reason (_____)
I don't know
Unclear response
No response

85) Do you ever go without a meal when you need one?

Yes
No
I don't remember
Unclear response
No response

I'm going to ask you some questions now about whether anyone ever hurts you or treats you badly. I am not asking these questions because I think anyone is abusing you – we ask them of everybody as

part of the state's responsibility to make sure people are safe. I want to remind you that I am a mandated reporter, and if I hear something that really concerns me about your safety, I will need to tell someone else about it, to make sure that you are safe.

86) Does anyone ever hit you or hurt your body?

Yes
No (skip to #89)
Unclear response (skip to #89)
No response (skip to #89)

87) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

88) **Who does this?** (CHECK ALL THAT APPLY)

Staff at home
Staff somewhere else
Family members
People you live with
Other (_____)
Unclear response
No response

89) Does anyone ever do mean things to you, such as yell at or intimidate you?

Yes
No (skip to #92)
Unclear response (skip to #92)
No response (skip to #92)

90) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

91) **Who does this?** (CHECK ALL THAT APPLY)

Staff at home
Staff somewhere else
Family members
People you live with
Other (_____)
Unclear response
No response

92) Does anyone ever steal or take your things or money without asking?

Yes
No (skip to #95)
Unclear response (skip to #95)
No response (skip to #95)

93) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

94) **Who does this?** (CHECK ALL THAT APPLY)
- Staff at home
- Staff somewhere else
- Family members
- People you live with
- Other (_____)
- Unclear response
- No response

95) Does anyone ever touch you now in a way you don't like?
- Yes
- No (skip to #98)
- Unclear response (skip to #98)
- No response (skip to #98)

96) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

97) **Who does this?** (CHECK ALL THAT APPLY)
- Staff at home
- Staff somewhere else
- Family members
- People you live with
- Other (_____)
- Unclear response
- No response

98) **Who would you talk to if someone did any of these things?** (CHECK ALL THAT APPLY)
- Family member or friend
- Direct care staff
- Case Manager
- Law enforcement
- Other (_____)
- I don't know
- Unclear response
- No response

Now I have some questions about how safe you feel everyday.

99) Do you ever feel unsafe because people who are paid to help you are not with you when they're supposed to be?
- Yes
- No
- N/A – no direct care staff
- Unclear response
- No response

100) Do you feel safe in your home?

Yes
No
Unclear response
No response

101) Do you feel safe when you leave your home?

Yes
No
Unclear response
No response

<u>VII. Community Membership</u> – "***Now I'd like to ask you about the things you do outside of your home and your experiences in your community*.**"

102) Are you able to vote if you want to?

Yes
No, not allowed to vote
Unsure/don't remember
N/A – not eligible to vote
N/A – not interested in voting
Unclear response
No response

103) Can you attend events in your community that are important to you?

Yes
Sometimes
No
Unclear response
No response

104) Can you go out in your community on your own when you want to?

Yes
Sometimes
No
Unclear response
No response

105) Are you part of a group where you feel you belong? PROBE: **Such as a church or synagogue, a class, a club, a group at work, or a sports team)?**

Yes
No
Unclear response
No response

106) Can you get together with people who are important to you when you want to?

Yes
No
I don't remember
Unclear response
No response

107) Do you always have a way to get to the places you need to go in your community, such as shopping, a friend's house or the doctor's office?

Yes
No
Unsure/don't remember
Unclear response
No response

VIII. Important Long-term Relationships – "***These next questions focus on your relationships with the people in your community."***

108) Do you have friends who are not family members or paid staff?

Yes
No
Unclear response
No response

109) Do you have a best friend, or someone you are really close to?

Yes
No
Unclear response
No response

110) Do you have family, friends or neighbors who help you with everyday activities without being paid?

Yes
No
Unclear response
No response

IX. Quality of Life

These last two questions have to do with the impact of services on your life.

111) **Thinking overall, would you say the help you receive has made your life better, about the same, or worse than before you were on this program**?

Better
About the same
Worse
Unclear response
No response

112) Has the paid support you receive helped you do a lot more for yourself, a little more for yourself or no more for yourself?

No more
A little more
A lot more
Unclear response
No response

Interviewer Comments and Proxy Information (TO BE COMPLETED AFTER THE INTERVIEW CONCLUDES)

Proxy interview?
Yes No

1) For non-proxy interviews, what amount of the questions did the program participant answer by him/herself?

All
Almost all
Most
About half
A few
None

2) Who else provided responses?

Spouse
Child
Parent
Sibling
Other relative or friend
Direct care staff
Case manager
Other

3) Is there something in the participant's physical environment that could compromise his/her health or safety? If yes, please describe:

4) Other comments and observations about the interview: For example, did the participant seemed confused or upset by any of the questions? Were responses forthcoming?

Appendix H: Participant Experience Survey – Minnesota version (MN PES) Minor Survey

Instructions

Text in **bold** is the questions (and sometimes responses) to be read aloud to the respondent.

Text in ***bold italics*** is the transitions between sections that should be read aloud.

Text in all CAPS is instructions to the interviewer and should not be read.

Plain text is use for coding.

Introductory Script

Thank you for agreeing to talk with me, I really appreciate your willingness to help.

It is your choice whether or not to answer these questions, and we can take a break or stop whenever you want. There are no right and wrong answers; I am only interested in your child's experience. Sometimes people have difficulty remembering if something happened in the past. It is OK to tell me you don't remember or don't know as your answer.

Nothing you tell me will change the help your child receives. I also cannot help you get any new services you might want for your child, but I can give you information about who to call with any questions or problems.

I will keep the things you tell me private, and won't share them with any of the people paid to help your family. You should know, however, that I am a mandated reporter, and if I see something or learn something that makes me concerned about your child's health or safety, I am required by law to let Child Protection know so they can help your child.

You may notice me writing down or typing some of the things you say. This is to help me remember your comments – it does not mean I think anything you say is "good" or "bad."

Do you have any questions? Are you ready to begin?

I. Case management and Services Planning – "***This first set of questions has to do with your child's case manager (sometimes called a social worker or Public Health Nurse), the person assigned to help you get the services s/he needs, and to develop your child's service plan*.**"

As you know, there is a person called your case manager, social worker or Public Health Nurse who is responsible for working with you to make sure your child gets the services and supports s/he needs to stay at home. Our records indicate that your child's current case manager is _____.

1) Is this information correct?

Yes (skip to #3)
No
I don't know/not sure
Unclear response
No response

2) If no, do you know who your child's case manager is?

Yes
No
I don't know/not sure
Unclear response
No response

3) Every year there is a meeting with your child's case manager to talk about your child's services and plan for the next year.

a. During this planning meeting were you able to say what you wanted about your child's needs?

- Yes
- No
- I don't remember
- N/A – proxy is neither parent nor guardian (skip to #5)
- Unclear response
- No response

b. During this planning meeting, were you given useful information about providers in your community you could choose from?

- Yes
- No
- I don't remember
- Unclear response
- No response

(IF NON-CDCS, ASK c, IF CDCS, ASK d)

c. During this planning meeting, were you told about other services and programs for your child that were not on his or her plan, such as the option to manage your child's services or hire your own staff?

- Yes (skip to #4)
- No (skip to #4)
- I don't remember (skip to #4)
- N/A – CDCS (go to 3d)

• Unclear response (skip to #4)
• No response (skip to #4)

d. During this planning meeting, were you told about other services and programs for your child that were not on his or her plan?
• Yes
• No
• I don't remember
• Unclear response
• No response

4) Do you have enough say on what is included on your child's plan?
Yes
No
I don't remember
Unclear response
No response

5) Do the things included in your child's plan happen? (PROBE IF NECESSARY): **Does your child get all the services and supports the plan says s/he should get?**
Yes
No
I don't remember
Unclear response
No response

6) **Who would you talk to if you disagree with or want to change your child's plan?** (CHECK ALL THAT APPLY)
Family member or friend
Direct care staff
Case Manager
Other (_____)
I don't know
Unclear response
No response

7) Are you able to get in touch with your child's case manager as often as you need to?
Yes
No
Unsure
N/A – does not know who current case manager is (skip to #14)
Unclear response
No response

8) Does your child's case manager treat you and your child respectfully?
Yes
No
Unclear response

No response

9) Do you think your child's case manager would help you if you had a problem?

Yes
No
I don't know/not sure
Unclear response
No response

10) Have you ever asked your child's case manager for changes to your child's services or supports?

Yes
No (skip to #13)
I don't remember (skip to #13)
Unclear response (skip to #13)
No response (skip to #13)

11) Did s/he make the changes you asked for?

Yes
No
In process
I don't know/not sure
Unclear response
No response

12) **Do you know how to appeal if services or supports you ask for are denied?**

Yes
No
Unsure
Unclear response
No response

13) Overall, are you generally happy with your child's case manager?

Yes
No
Unsure
Unclear response
No response

14) Do you know you have the ability to change your child's case manager if you want?

Yes
No
I don't know/not sure
Unclear response
No response

<u>IIa . Self Direction</u> – "***Because your child participates in Consumer Directed Community Supports – the program where you can hire your child's workers directly - I'd like to ask a few questions specific to this program. I am interested in the supports you get, such as assistance with your child's individual budget or in finding, training, and paying your child's workers.***"

THIS SECTION IS FOR CDCS PARTICIPANTS ONLY, ALL ELSE SKIP TO IIb

15) Are all of your child's paid helpers family members?

Yes (skip to #22)
No
Unclear response
No response

16) Do you receive enough information on how to:

a. **Hire your child's workers?**

Yes
No
I don't know/not sure
N/A – did not ask for/need
Unclear response
No response

b. Do you receive enough information on how to train your child's workers?

Yes
No
I don't know/not sure
N/A – did not ask for/need
Unclear response
No response

c. Do you receive enough information on how to manage and supervise your child's workers?

Yes
No
I don't know/not sure
N/A – did not ask for/need
Unclear response
No response

d. Do you receive enough information on how to resolve problems with your child's workers?

Yes
No
I don't know/not sure
N/A – did not ask for/need
Unclear response
No response

17) **How did you locate your child's workers?** (LISTEN AND CHECK ALL THAT APPLY)

Newspaper/other advertisements
Family or friends recommended
Some workers are family members or friends
Employment service
Church or other community organization
On-line resources
Other (_____)
Unclear response
No response

18) Do you have trouble finding people to hire?

Yes
Sometimes
No (skip to #21)
Unclear response (skip to #21)
No response (skip to #21)

19) What is the longest time it has taken you to find and hire a worker?

One week or less
Two weeks or less
One month or less
More than one month
I don't remember
Unclear response
No response

20) **What did you do in the meantime?** (OPEN-ENDED RESPONSE)

21) During the past year, did you find it difficult to keep workers?

Yes
No
Unclear response
No response

THESE NEXT 3 QUESTIONS ARE FOR CAC WAIVER PARTICIPANTS ONLY, ALL ELSE SKIP TO #25

22) Do you receive enough information on how to find nurses to hire?

Yes
No
Don't know/not sure
N/A – not on CAC waiver (skip to #25)
Unclear response
No response

23) What is the longest time it has taken you to find and hire a nurse?

One week or less
Two weeks or less
One month or less
More than one month
I don't remember
Unclear response
No response

24) **During the past year, did you find it difficult to keep nurses?**

Yes
No
Unclear response
No response

25) Do you receive enough information on how to develop your child's CDCS plan?

Yes
No
I don't know/not sure
Unclear response
No response

26) Have you ever been denied something you asked for in your child's CDCS plan?

Yes
No (skip to #28)
I don't know/not sure (skip to #28)
Unclear response (skip to #28)
No response (skip to #28)

27) What did you ask for? What did you do when it wasn't approved? (OPEN ENDED)

28) Do you know who your child's fiscal support entity, or third party payer, is?

Yes
No (skip to #30)
I don't know/not sure (skip to #30)
Unclear response (skip to #30)
No response (skip to #30)

29) Does your child's fiscal support entity provide you the support you need?

Yes
No
Unclear response
No response

30) How does your experience with directing your child's support compare to what you expected? Would you say harder than you expected, the same, or easier than you expected?

Harder than expected
Same as expected

Easier than expected
Don't know/unsure
Unclear response
No response

31) How does your experience with directing your child's support yourself compare to having a provider agency do this? Would you say harder, the same, or easier?

Harder than working with agency
Same as working with agency
Easier than working with agency
Don't know/unsure
N/A – have not worked with agency
Unclear response
No response

32) Overall, are you satisfied with your experience directing your child's support?

Yes
No
Unclear response
No response

IIb. Experience with Direct Care Staff – "***The next questions are about the people who are paid to help your child."***

THIS SECTION IS FOR NON-CDCS ONLY, SKIP TO SECTION III IF CDCS OR IF CHILD HAS NO DIRECT CARE STAFF

33) Did you help pick the people who are paid to help your child?

Yes (skip to #35)
No
I don't remember (skip to #35)
Unclear response (skip to #35)
No response (skip to #35)

34) Would you like to help pick the people who are paid to help your child?

Yes
No
I don't know
Unclear response
No response

35) Do the people who help your child at home have enough time to do all they need to do?

Yes
No
N/A – schedule still under development
Unclear response
No response

36) Do they stay as long as they are supposed to?

Yes
No
Unclear response
No response

37) Do the people who are paid to help your child do a good job?

Yes
No
I don't know
Unclear response
No response

38) Do the people paid to help your child treat your child respectfully?

Yes
No
Unclear response
No response

39) Can you understand the people who are paid to help your child?

Yes
Sometimes
Never
Unclear response
No response

40) Can they understand you and your child?

Yes
Sometimes
No
Unclear response
No response

41) Overall, are you generally happy with the people paid to help your child?

Yes
Sometimes
No
Unclear response
No response

III. <u>Health, Welfare and Safety</u> – ***I'd like to ask you now about your child's needs for assistance from other people. Sometimes children need assistance due to their disability, sometimes due to their age. Please let me know if your child needs help with any of these tasks, for any reason. We ask these questions of everyone, because some older children do spend time away from their parents with only staff present.***

42) **Does your child need help or reminders from another person to do things like get dressed, take a bath, eat, or use the bathroom?**

Yes
No
Unclear response
No response

43) Think about the people who are paid to help your child with these everyday activities such as help with eating, dressing, bathing, toileting. Is your child ever unable to do any of these everyday things because she or he doesn't have anyone to help?

Yes
No (skip to #45)
I don't remember (skip to #45)
N/A – child is never alone (skip to #45)
Unclear response (skip to #45)
No response (skip to #45)

44) Why isn't anyone there to help your child?

staff did not show up
staff showed up late
no back up staff
staff refused to help
no informal support available
Other reason (_____)
I don't know
Unclear response
No response

45) Do you ever feel your child is unsafe because people who are paid to help are not with your child when they're supposed to be?

Yes
No
N/A – no direct care staff
N/A – parents always present
Unclear response
No response

I'm going to ask you some questions now about whether anyone ever hurts your child or treats him or her badly. I am not asking these questions because I think your child is being abused – they are asked of everyone. The Department of Human Services takes every opportunity to make sure that children receiving services are safe. I do want to remind you that I am a mandated reporter, and if I hear something that really concerns me about your child's safety, I will need to tell someone else about it, to make sure that your child is safe.

46) Does anyone ever hit your child or hurt his or her body?

Yes
No (skip to #49)
Unclear response (skip to #49)
No response (skip to #49)

47) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

48) **Who does this?** (CHECK ALL THAT APPLY)

Staff at home
Staff somewhere else
Family members
People you live with
Other (_____)
Unclear response
No response

49) Does anyone ever do mean things to your child, such as insult or intimidate him or her?

Yes
No (skip to #52)
Unclear response (skip to #52)
No response (skip to #52)

50) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

51) **Who does this?** (CHECK ALL THAT APPLY)

Staff at home
Staff somewhere else
Family members
People you live with
Other (_____)
Unclear response
No response

52) Does anyone ever touch your child now in a way s/he doesn't like?

Yes
No (skip to #55)
Unclear response (skip to #55)
No response (skip to #55)

53) **What happens? When did this happen? Did you tell anyone about this?** (OPEN RESPONSE)

54) **Who does this?** (CHECK ALL THAT APPLY)

Staff at home
Staff somewhere else
Family members
People you live with
Other (_____)

Unclear response
No response

55) **Who would you talk to if someone did any of these things?** (CHECK ALL THAT APPLY)
Family member or friend
Direct care staff
Case Manager
Law enforcement
Other (_____)
I don't know
Unclear response
No response

IV. Important Long-term Relationships – "***These next questions focus on your child's relationships with the people in your community."***

56) Does your child have friends who are not family members or paid staff?
Yes
No
Unclear response
No response

57) Does your child have a best friend, or someone s/he is really close to?
Yes
No
N/A – child is very young
Unclear response
No response

58) Do you have other family, friends or neighbors who help your child with everyday activities without being paid?
Yes
No
Unclear response
No response

V. Quality of Life

These last three questions have to do with the impact of your child's disability on your family and the effect of services on your child's life.

59) **Because of your child's health, did anyone in your family ever:** (READ EACH AND CHECK ALL THAT APPLY)
Quit a job or retire early
Change jobs
Change or reduce work hours
Not take a job in order to care for your child
Turn down a better job or promotion

None of the above
Unclear response
No response

60) **Thinking overall, would you say the help your child receives has made his or her life better, about the same, or worse than before she or he was on this program?**

Better
About the same
Worse
Unclear response
No response

61) Has the paid support your child receives helped your child do a lot more his or herself, a little more or no more?

No more
A little more
A lot more
Unclear response
No response

Interviewer Comments and Proxy Information (TO BE COMPLETED AFTER THE INTERVIEW CONCLUDES)

Proxy: Parent Guardian Other _____

1) Is there something in the participant's physical environment that could compromise his/her health or safety? If yes, please describe:

2) Other comments and observations about the interview: For example, did any of the questions seem confusing or upsetting to the respondent? Were answers forthcoming?