

# **Minnesota Quality Assurance Panel Interviews with Counties Final Report**

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## Overview

The Quality Assurance Panel met throughout 2006 to consider various models of quality assurance, enhancement and improvement. During those discussions members requested information about what counties and other local entities in Minnesota were currently doing to address their quality assurance, enhancement and improvement needs. To respond to that request, project staff conducted interviews and site visits with key stakeholders on current practices, new initiatives and feasibilities of alternatives in conducting and using quality assessments to monitor and improve services in local and regional areas in Minnesota. This report summarizes the results of interviews with county officials in Minnesota regarding their quality assurance efforts. These interviews addressed both current practices as well as recommendations for improvements to the quality assurance infrastructure at the local, regional and state levels.

## Methodology

Interviews were conducted in October and November 2006 with a total of 30 officials from 14 counties regarding the current status and effectiveness of licensing practices in Minnesota as a basis of quality assurance. Participants represented 4 metropolitan Twin Cities counties (Hennepin, Ramsey, Anoka and Dakota) and 10 counties in greater Minnesota (Nicollet, Itasca, Benton, Kanabec, Mower, Goodhue, Lake of the Woods, Crow Wing, Morrison, Goodhue). Counties and respondents were selected by DHS Quality Assurance Staff with support from the Regional Resource Specialists. All of the nominated metro counties were interviewed as were all but two of the nominated greater Minnesota counties. Interviews were conducted both face-to-face and telephone interviews. The interview protocol is included at the end of this report.

We gathered information about current county practices regarding quality assurance for people of all ages with physical, cognitive, and chronic health conditions determined to have a disability who receive Medicaid funded supports, including:

- people with developmental disabilities, mental retardation or related conditions
- people with disabilities using home care or PCA services
- people with traumatic or acquired brain injury
- people with physical disabilities or chronic medical condition
- people on CAC, CADI, TBI, MR/RC waivers

Questions focused on several topics including:

- current county quality assurance activities in the development, discovery, remediation and quality improvement;
- technology supports;
- current systems for managing licensing, vulnerable adults and maltreatment of minors act complaints and processes;
- variations in quality assurance (QA) activities across populations receiving community supports;
- observations regarding how managed care for seniors has impacted quality assurance efforts;
- areas of strength and challenge faced by counties in implementing quality assurance programs;

- comments and recommendations about changes needed to address the Centers for Medicaid and Medicare Services' Quality Framework critical components and desired outcomes for quality; and
- recommendations for improving Minnesota's quality assurance system at the local and regional level.

## **Results**

**County Quality Assurance Activities.** Interviewees described a variety of county discovery, remediation and improvement activities for persons with disabilities receiving community supports including:

### **Discovery**

- Consumer satisfaction surveys were used in some but not all counties, some but not all populations (DD and MH more commonly), and some but not all service types (rarely in assisted living, PCA and CCT funded services).
- Various configurations of county staff members comprise teams that meet to evaluate quality outcomes.
- Licensing and contracting practices ranged from very informal to comprehensive and structured practices.
- Limited work in measuring individual outcomes in most of the counties.
- Counties assume providers holding 245B licenses are qualified by virtue of the license. Few counties have additional mechanisms to monitor qualifications. For county contracted providers, qualifications are reviewed during the contracting process.
- County staff (particularly case managers and public health nurses), providers and service recipients are reportedly the primary sources of information about the quality of services
- "Usually we discover problems due to consumer satisfaction complaints with services."
- Some counties report using performance based contracts to improve accountability for outcomes.
- Direct consumer interviews (such as the consumer experience surveys) are used in only a few of the interviewed counties)
- Counties reported using the standard MMIS, SSIS, MAXIS, Health Match and other state data bases. Most focused on very basic analyses of service data.
- The larger counties had specialized staff designated for planning and analyzing quality assurance data. In the smaller counties, this function was more likely to be one of several tasks of a manager or supervisor who had other duties. Resources and expertise in data analysis and synthesis were reported to vary across the counties.
- Most counties reported using basic spreadsheets and data bases for managing information gathered about quality outcomes. Relatively few reported using even basic statistical analysis packages. Some said they did not track or analyze any quality data on a systematic basis. Others reported having relatively sophisticated reporting and analyses processes through their planning offices.
- Asked about technology some counties said "what technology" or "pencil and paper" while others described fairly sophisticated business intelligence systems, data sharing programs, and relational data bases.

- Challenges reported by counties included:
  - Lack of time for monitoring activities (contract compliance);
  - Three counties specifically reported having limited time to focus on individual outcomes or that they only did so for a particular population or when they had an intern who could collect and analyze data;
  - Some counties said they don't get negative feedback on satisfaction surveys so stopped using them or that they stopped because of poor response rates; and
  - Informal system does not allow tracking trends.

### **Remediation**

- Counties expressed frustration with common entry point system. Significant time delays in processing VA reports on the state side sometimes frustrate local efforts to ensure that health and safety concerns are adequately addressed.
- Due process was viewed as a necessary and positive process by most counties. It was used to identify avoidable issues and train county staff to prevent from reoccurrence.
- Providers are monitored through contracts and licenses. Counties will stop new referrals to providers who are not responding to remediation or will move clients in serious situations but only those who are under county case management.
- Counties had different perspectives about who is responsible for licensing activities (state staff versus county staff).
- "We have to license those even if they are bad because of state procedures. We just make certain we don't use them." [regarding foster care licenses].
- Remediation practices vary in formality.
- Remediation is a challenge when there are no alternatives available to choose and "folks don't get along or can't handle a person".
- Complaint resolution mechanisms are available and used.
- Some counties send complaints to the Ombudsman Office for follow up.
- Complaint resolution often involves working through a county case manager or team.
- County remediation efforts include increased county supervision of programs, bringing in consultants or trainers to help providers, problem solving and addressing specific situations, planning to address larger needs, revising service plans, contract amendments, using plans of correction, bringing in other resources (law enforcement, adult or child protection, mental health supports) as needed, working with the Ombudsman office to negotiate solutions, and service plan revisions.

### **Improvement**

- Some counties described well developed systems including using formal gaps analysis for identifying unmet needs and developing new services. Other counties reported they had all the providers they need, that they sent people to other counties because it was difficult to develop services for just one person, or that political pressures limited their opportunities to expand services.
- County efforts to increase knowledge of effective practices varied from sending out newsletters or holding annual provider meetings, to holding weekly meetings involving case consultations and cross trainings to increase the skills of case managers.

- Some counties reported being confident their staff members were well trained and up to date on best practices. Others volunteered that they were far behind. One person said “I can’t pass on knowledge I don’t have.”
- Some counties offered many training opportunities for families, individuals and providers while others specifically said they did not feel it was their responsibility to train those groups on best practices.

### **County QA Strengths**

- The smaller counties reported their strength was that they knew the providers and the people supported well which facilitated good communication, quick responses when problems came up, less bureaucracy and greater opportunity for consumer input.
- Several counties reported strength in well structured management, planning, evaluation or quality teams who had worked together for a long period of time.
- Several counties remarked that they were very responsive when concerns were raised and that issues were quickly and thoroughly addressed.

### **County QA Challenges**

- Almost every county mentioned that quality assurance for the CAC, CADI and TBI waiver programs were more limited than for the MR/RC program because those waivers are newer, they have relatively fewer resources dedicated to them, and because caseloads are increasing in those areas.
- Services where monitoring was considered especially difficult or problematic included assisted living (especially in the metro counties where people from several counties and managed care entities received supports from a single vendor), personal care attendant services, home health services and other services for persons who do not have county case managers, consumer directed community supports, ARMHS, and CTCS.
- Coordination challenges were noted in counties that used both county and contracted case managers. Informal systems for monitoring quality that depended on county case managers to report problems were being reworked as more contract case managers were used.
- County budget cuts and turnover of county staff were noted as problems for some counties.
- Several counties both metro and greater Minnesota noted difficulties related to monitoring services across county lines.

### **Critical Incident Reporting System**

- Some counties reported that the common entry point system was working reasonably well for them particularly at the local level.
- Most counties commented that the turnaround time at the state level was too slow and that communication about what happened with particular complaints was inadequate.
- Some noted that complaints were not taken seriously by the state which then discouraged further reporting.
- Many counties noted that communication between various parts of the system was not working well. Some talked about silos. Others talked about a lack of follow up, others mentioned the need to file multiple copies of reports.

- Some commented about conflicting recommendations coming from various parts of the system

### **Managed Care**

Counties were asked to comment on how their quality assurance efforts had been impacted by the introduction of managed care for certain groups of persons with disabilities receiving community supports. There was a great deal of uncertainty about ongoing quality assurance roles and responsibilities. Examples included statements such as

- “We are ‘Off the hook’ for monitoring quality but not I am not sure who is responsible for making sure that individual providers are doing their job since multiple entities have people receiving services at each unlicensed location.”
- “Who is responsible for QA for long term care for people in managed care? Who will have a quorum of information about how the provider is doing in providing services to people from six different HMO vendors? Anytime services are operating across counties or across payers, QA is a challenge. How does the primary county know to do quality?”
- “The scope of what the county is to do is not clear. When MSHO is using services, we don’t have knowledge and feedback. We don’t know gaps about services in MSHO.”
- “We just don’t know where to go to get our questions answered. If we have a problem it is so multileveled. If we have a problem with MA or services and need a policy ruling do we go to DHS, DHS managed care, or the health plan. . . . It was rolled out very poorly. We still get different answers.”
- Many comments focused on the confusion of the transition to a new system and difficulties figuring out how to get basic needs met under a new set of rules.

### **County Recommendations for Quality Assurance Improvements**

In response to requests for suggestions for the state’s new focus on quality several recommendations were offered including:

- Counties recommended that consumers and families should be more involved in quality assurance activities. Some suggested that regionalizing quality assurance activities would facilitate this.
- Counties wanted more information about quality definitions, designs and expectations, or requested more tools to do their quality assurance work.
- Counties requested improved training on new initiatives prior to implementation. The requested consistent, clear expectations and directives, training to carry out those expectations and rewards or recognition for a job well done. They were interested in video conferencing and in person training as well as technical support. They specifically requested that bulletins contain accurate information the first time, and that each bulletin be comprehensive without the need to refer back to previous bulletins for key points.
- Counties noted their appreciation that DHS was noticing the good work they were doing. They noted the importance of timeliness, clarity and specificity of information provided to counties especially about major changes in quality assurance, and a more integrated relationship with activities and expectations emerging within DHS.
- Many counties requested assistance with survey and interviewing tools and strategies for assessing individual and provider outcomes. Many noted that they did not have internal

resources to develop good instruments. Several were interested in more standard instruments that could be used across counties.

- Counties recommended that DHS, satisfaction and consumer outcome data be translated into meaningful reports they can use to make decisions. For example:
  - “We need better data systems across the state. Data elements. Better way to get information back. Screening documents characteristics of people, allocations, authorized, paid services, units by providers, what providers are having issues, who are providers serving, documentation of specializations, licensing complaints and appeals, VA and MOMA reports and findings, due process reports and findings. What other services people use other than what our county funds.”
- Counties requested additional resources for quality assurance activities, and to address specific quality challenges such as staff turnover, people whose needs were particularly expensive, or for incentives to provide increased choices for consumers.
- Counties recommended standardizing various components of the system such as universal care plans, satisfaction surveys, provider contracts, establishing foster care rates, service menus, assessments, and quality standards used across waiver groups and populations.

## **Discussion**

The sophistication of local and regional quality assurance efforts in Minnesota varied throughout the state. Some counties had made extensive efforts to create a program of quality assurance to monitor and remediate quality for many types of community services and supports provided to Minnesotans with disabilities. Hennepin County, for example, had developed a consumer survey process across the disability populations to gather information about service quality and outcomes. However, other counties described very rudimentary quality assurance systems with virtually no ongoing systemic efforts to improve quality outcomes for citizens with disabilities. Even the counties that had invested considerable local tax resources into creating quality infrastructures described challenges. The smaller counties had fewer resources and less expertise available to them for all phases of quality assurance (discovery, remediation, and improvement). Counties identified many challenges ranging from lack of clarity regarding who was responsible for monitoring certain program types to lack of coordination between counties, the state and managed care entities, to inadequate resources and infrastructure to monitor, remediate and improve quality in newer types of community based supports such as the CAC, CADI and TBI waivers, and for basic MA services such as personal attendant supports.

The purpose of these interviews was to identify local or regional quality assurance efforts that could be considered model programs to emulate statewide. None of the counties had programs of quality assurance that were as comprehensive as the Region 10 quality initiative (described in the QA Panel report) or the regional models that had been developed in other states. The Hennepin County program that surveyed consumers across disability types was described separately to QA Panel members. From these county interviews it was clear a more coordinated system of quality assurance and enhancement supports that provided training and assistance to counties on consumer outcome surveys and quality improvement could be very helpful. Counties also were very supportive of a quality enhancement system that involved individuals with disabilities much more directly.

**DHS Quality Assurance Panel  
Minnesota Key Informant Phone Interview Protocol  
September/October 2006**

**County:**

**Date:**

**Person(s) Interviewed:**

**Title:**

**Contact Info:**

In 2005, the Minnesota Legislature requested a study of local and regional quality assurance models that might be adopted statewide. The Department of Human Services (DHS) established a Quality Assurance Panel and charged it with responsibility to recommend an approach to quality assessment of all publicly funded programs within a community setting at the local or regional level. The University of Minnesota was selected to support the work of the Panel. As part of that work, we are gathering information about current county practices regarding quality assurance for people of all ages with physical, cognitive, and chronic health conditions determined to have a disability who receive Medicaid funded supports, including:

- people with developmental disabilities, mental retardation or related conditions
- people with disabilities using home care or PCA services
- people with traumatic or acquired brain injury
- people with physical disabilities or chronic medical condition
- people on CAC, CADI, TBI, MR/RC waivers

We are particularly interested in the activities that local and regional entities particularly counties are doing.

1. Please describe the primary quality assurance activities at the county level **for the populations you serve** in the following areas:
  - a. Discovery
    - i. Licensing
    - ii. Contracting
    - iii. Provider qualifications
    - iv. Monitoring individual outcomes (e.g., satisfaction surveys, ISP reviews, consumer experience interviews)
    - v. Due process
    - vi. Data you collect or track
    - vii. Critical incident reporting
    - viii. Vulnerable adult and maltreatment of minors
    - ix. Other
  - b. Remediation
    - i. Plans of correction
    - ii. Service plan revisions
    - iii. Other
  - c. Quality improvement



- i. Providing training to providers, families and individuals on best practices or new techniques
  - ii. Development of new services
  - iii. Other
- 2. Thinking about your CURRENT quality assurance activities, please answer the following questions.
  - a. How do your quality assurance and protection processes differ for each disability/waiver group? How could it be improved?
  - b. What kinds of technological support does your county have for quality assurance (e.g., what databases do you use)?

**PROBE:** Is what you described the same across the different populations of interest (see list below)? If not, can you please describe the differences? If not, who else should I speak with?

- people with developmental disabilities who meet the definition of mental retardation or related condition
  - people with disabilities using PCA or home care services
  - people with traumatic or acquired brain injury
  - people with physical disabilities or chronic medical condition
  - people on CAC, CADI, TBI, MR/RC waivers
- 3. Do you have any model practices that may be applied to only one disability group in practice but that could be generalized to other groups as well? If so, please describe.
- 4. How are managed care models for seniors (e.g., MSHO) or other groups affecting your quality assurance activities?
- 5. What are the strengths or best practices in your county's current quality assurance activities?
- 6. What is not working well about your county's current quality assurance activities? What improvements could be made?
- 7. The Centers for Medicaid and Medicare Services Quality Framework have identified the following critical components and desired outcomes for quality:
  - **Participation Access:** access to community supports; information and referral; timely intake and eligibility determination; reasonable promptness
  - **Person-Centered Service Planning and Delivery:** individually-oriented needs assessment and service plans; implementation and monitoring and service as planned; responses to changing needs/choices and to participant direction
  - **Provider Capacity:** organizational licensure and certification; sufficient providers (agencies and staff); sufficient staff training; provider monitoring

- **Participant Safeguards**: incident reporting/response; risk assessment/balance with choice; monitoring of behavioral/pharmacological interventions; medication administration; emergency/disaster preparation/response; health monitoring
- **Rights and Responsibilities**: protection of rights and decision-making authority; due process and grievance procedures
- **Outcomes and Satisfaction**: surveys show satisfaction with quality of services and service outcomes, as well as quality of life; data is used to find and respond to dissatisfaction and unmet goals
- **System Performance**: systematic gathering and analysis of performance data; community participation in designing and appraising system performance and improvement activities; financial accountability; system strives to improve quality

If Minnesota is to be successful at supporting local and regional quality assurance efforts in accomplishing these outcomes what do we need to change or do differently?

8. How well do you think the current system for managing incoming complaints (both licensing complaints and VA and MOMA complaints) is working? What improvements would you recommend be made in this system?
9. How effective are you at getting information about innovations and best practices to county staff (including case managers) and to providers, families and consumers?
10. **RECOMMENDATIONS:** What are your top recommendations for improving Minnesota's quality assurance system at the local or regional level?