



Quality Assurance in Minnesota 2007

Findings and Recommendations of the Legislatively-
Mandated Quality Assurance Panel

Laws of Minnesota 2005, First Special Session, Chapter 4, Article 7, Sec. 57

Final Report

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Executive Summary

Expansion of Medicaid financed Home and Community Based (“waiver”) Services (HCBS) and other community service options in Minnesota has dramatically increased the number of settings in which people receive services. This has brought enormous challenges in monitoring service quality and protecting the well-being of persons who receive those services. In recent years there have been persistent reminders in media and government investigations of the gap between assurances of basic monitoring that the state has made in its HCBS waiver applications and the practical capacities and accomplishments of its quality assurance programs to fulfill those assurances.

To consider approaches for addressing such challenges, in 2005 the Minnesota Legislature requested a study of local and regional quality assurance models that might be adopted statewide. Specifically, it requested that, “the Commissioner of human services shall arrange for a study, including recommendations for statewide development and implementation of regional or local quality assurance models for disability services. The study shall include a review of current projects and models; make findings regarding the best components, role, and function of such models within a statewide quality assurance system; and shall estimate the cost and sources of funding for regional and local quality assurance models on a statewide basis.”

In response, the Department of Human Services (DHS) established a Quality Assurance Panel of citizen experts representing a range of perspectives and charged it with responsibility to recommend an approach to quality assessment and management of HCBS and related disability programs. Expectations for the recommended approach include that it:

- 1) is applicable for all HCBS waiver recipients regardless of disability type or how and by whom their long-term services and supports are managed;
- 2) meets federal expectations;
- 3) reflects contemporary concepts of quality;
- 4) is outcome-based;
- 5) is valid and reliable in its assessments;
- 6) exhibits cost-effectiveness in yielding needed products;
- 7) is founded on previous experiences in Minnesota and elsewhere; and
- 8) is sufficiently well-funded to meet the substantially increased requirements placed on it.

The QA Panel’s work was guided by the expectations for quality assurance of the Centers for Medicare and Medicaid Services’ (CMS) as specified in the CMS Quality Framework. The Quality Framework provides states with substantial guidance regarding their responsibilities in managing HCBS programs. Specifically it establishes state responsibility for programs of assessment (discovery), remediation and improvement in seven focus areas, including access; person-centered services; provider capacity; participant safeguards; rights and responsibilities; outcomes and satisfaction; and system performance.

The QA Panel met monthly throughout 2006. During the year, it heard from national QA experts, received reports of interviews, focus groups and surveys, read case studies of

innovations in other states, regions and local communities, and participated in facilitated discussions. It then formulated and vetted its recommended model for Minnesota.

The QA Panel recommends adoption of five key components of a reformed statewide quality assurance program to respond Federal expectations and State responsibilities for quality assurance and improvement for supports and services. These integrated components include:

- 1) a State Quality Commission to provide the needed leadership, attention, commitment and public awareness of the strengths and limitations, the successes and challenges in the services provided to Minnesotans with disabilities and to promote specific guided efforts throughout the state to improve the ability of long-term services and supports to protect the health and safety and to contribute to the quality of life of Minnesotans with disabilities;
- 2) Regional Quality Councils to provide leadership, analyze the results of the various quality assurance activities, identify needed program improvement and design and implement program improvement initiatives through training, technical assistance and print and electronic publications within six state regions to respond to regional and statewide priorities for establishing and maintaining high quality and continuously improving community services and supports;
- 3) An annual independent statewide survey of a sample of service recipients to determine and report the outcomes of services and supports provided to individuals with disabilities in Minnesota, with attention to services used, individual characteristics, and residential, employment and other circumstances associated with service and lifestyle outcomes to establish the effectiveness of service system performance and to set and monitor the goals for system improvement. The Quality Assurance Panel recommends that the Legislature commit in this biennium to developing, field-testing and fielding a consumer interview survey that meets the cross-disability needs of Minnesota;
- 4) An outcome-based quality assessment program for service quality monitoring, including both licensed and unlicensed services, based on outcome-based interviews of a sufficient sample of individuals and caregivers supported by an organization to determine organizational performance with sufficient reliability to determine the level of service quality, issue program licenses as called for, recommend remedial activities, and inform the need for general and specific training, technical assistance, consumer education, and other service improvement activities;
- 5) An effective program of incident reporting, investigation and analysis that provides necessary protections, assures timely and appropriate response, and gathers and analyzes data to guide quality improvement initiatives;

The QA Panel recognizes that these programs will require time to be fully developed and urges haste in beginning the process. Without substantial progress, Minnesota's Medicaid HCBS applications are in jeopardy of rejection, and Minnesota's citizens with disabilities are at risk of receiving services and supports that are of poorer quality than they have the right to expect. Therefore, the Panel strongly recommends that the State Quality Commission, the six Regional Quality Councils and the statewide survey be funded and implemented in the next biennium. The QA Panel also recommends that reports based on the current incident reporting, investigation and analysis system be provided to the State Quality Commission and Regional

Quality Councils and that an implementation design for revisions to this system be funded in this biennium. The recommended reforms to create an outcome-based quality review program should likewise be undertaken with urgency.

The QA Panel recommends that changes to the QA system be phased in over time beginning with all HCBS Waiver Services for all persons with disabilities except for those whose services are funded by the “Elderly Waiver”. As experience with these reforms is obtained, this new system could be expanded to services for all persons with disabilities funded under other programs including other state and county funded services and for persons in the “Elderly Waiver” program.

The cost of the State Quality Commission is estimated to be \$240,000 in the first year and \$224,000 in the second year of this biennium. The cost of the Regional Quality Councils is estimated to be \$2.9 million in the first year and \$3.1 million in the second year (the year 1 costs will be substantially lower if the Regional Quality Councils are not implemented on July 1, 2007). The costs of the annual statewide survey and analysis is estimated to be \$242,600 in the first year as the survey is finalized and pilot tested, and \$506,480 in the second year as the final survey is fielded for the first time with a sample of 3,400 service users. The cost of the recommended incident reporting, investigation and analysis system reforms is estimated to be \$100,000 in each of the next two years. The costs of the outcome-based service quality review have not been determined and funding is not requested for that activity at this time, but the Panel recognizes the importance of Department of Human Services working with diligence in moving from a system that has been regulation based to one that focuses on individual needs and service outcomes.

As a fundamental aspect of managing services in accordance with CMS requirements that states establish an effective infrastructure to support quality assurance and improvement, the cost of the new quality assurance and improvement infrastructure would be cost-shared by the Federal government at the Medicaid administrative rate (50% federal funds for an effective rate of 40% once non-Medicaid services are included). Additional details and anticipated costs of these reforms are described in the full report of the Quality Assurance Panel.

The “proposed legislation for implementation of a statewide system of quality assurance” called for in the Legislature mandate that established the QA Panel and further details regarding the Panel’s recommendations are included in the full version of this report available from the project’s website at www.qapanel.org.

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Project Overview

Mandate

In 2005 the Minnesota Legislature mandated a study and recommendations on statewide development of regional or local quality assurance models.

In 2005, the Minnesota Legislature mandated a study and recommendations on statewide development of regional or local quality assurance models for disability services.* Specifically the mandate was that, “ The commissioner of human services shall arrange for a study, including recommendations for statewide development and implementation of regional or local quality assurance models for disability services. The study shall include a review of current projects or models; make findings regarding the best components, role, and function of such models within a statewide quality assurance system; and shall estimate the cost and sources of funding for regional and local quality assurance models on a statewide basis. The study shall be done in consultation with counties, consumers of service, providers, and representatives of the Quality Assurance Commission under Minnesota Statutes, section 256B.0951, subdivision 1. The study shall be submitted to the chairs of the legislative committees with jurisdiction over health and human services with recommendations on implementation of a statewide system of quality assurance and licensing by July 1, 2006. The commissioner shall submit proposed legislation for implementation of a statewide system of quality assurance to the chairs of the legislative committees with jurisdiction over health and human services by December 15, 2006.”

*In preparing this report disability services has been defined to include the Medicaid Mental Retardation and Related Conditions (MR/RC), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), and Traumatic Brain Injury (TBI) HCBS waivers; Personal Care Attendant services; Home Care; Family Support Grant services; Consumer Support Grant services; and Supervised Independent Living services. The people impacted include all persons with disabilities receiving services through the auspices of Disability Services Division (DSD).

Quality Assurance Panel

“...in December 2005 the Commissioners of the Department of Human services appointed a Quality Assurance Panel to conduct is study and make requested recommendations.”

As mandated, in December 2005, the Commissioner of the Department of Human services appointed a Quality Assurance Panel to conduct this study and make the requested recommendations. The Panel consisted of state employees representing DHS Disability Services Division and Department of Licensing; Department of Health; county officials; service providers; advocacy group members; family members; consumer representatives; and members of the Region 10 Quality Assurance Commission. Pursuant to the legislation, the Commissioner submitted an interim report of initial Panel deliberations and findings to the chairs of the legislative committees with jurisdiction over health and human services in July 2006. This final report of findings and recommendations concludes the work of the Quality Assurance Panel as charged by the Legislature (Laws of Minnesota, First Special Session, Chapter 4, Article 7, Sec. 57).

The DHS Quality Assurance Panel was appointed by the Commissioner of Human Services to represent major constituencies with vested interests in the design, implementation and effectiveness of quality assurance practices in Minnesota. During the entirety of 2006 the Panel met monthly for periods of 4-6 hours, with additional sub-group meetings conducted periodically as needed. Panel members received and responded to materials sent to them between meetings. (Panel members are identified in Appendix A).

In its meetings, the QA Panel:

- Adopted definitions, goals and objectives of quality assurance;
- Established means of evaluating achievement of the consensus goals and objectives;
- Evaluated quality assurance components and options for their ability to achieve the established goals and objectives;
- Considered the implications and costs of various components and options;
- Developed recommendations and proposed legislation for a quality assurance model that reflects and promotes the goals and purposes held for home and community supports for Minnesotan's with disabilities.

In May 2006 the Department of Human Services contracted with the University of Minnesota...to provide technical support, research, advice and facilitation of the Panel's work

In May 2006 the Department of Human Services contracted with the University of Minnesota and its subcontractor Human Services Research Institute support the Panel's work. Their role was to:

- Coordinate, support, and record meetings of the Panel, and work with Panel members to achieve and confirm consensus;
- Serve as a resource to the Panel by analyzing and sharing information from research and experience on promising approaches to quality assurance;
- Conduct interviews, surveys, site visits, and focus groups with key stakeholders on current practices, new initiatives, and feasibility of alternative approaches to quality assessment and improvement;
- Provide resource and cost-benefit analyses to the Panel on different quality assurance and improvement approaches;
- Draft and provide reports for the panel to review on the context, challenges, benefits, and costs of various approaches to quality assurance and the recommendations of the Panel.

Necessity of Quality Assurance Reform

Minnesota's current process for assuring the basic quality of Medicaid home and community-based services is inadequate and must be reformed. Existing monitoring practices in Minnesota reflect outmoded, rule-based compliance

Minnesota's current process for assuring basic quality of Medicaid Home and Community-Based Services is inadequate and must be reformed. It has contributed to high degrees of criticism regarding quality assurance in Minnesota.

models. The resources allocated to the operation of these practices and systems leaves them increasingly limited in their ability to establish even the most basic protections. Despite skilled and committed personnel, the failure to adopt contemporary outcome-based quality assessment and improvement practices and support the agencies responsible for service quality monitoring has contributed to high degrees of criticism regarding the relevance and reach of quality assurance in Minnesota. Perhaps even more compelling for policy-makers is the clear expectation of the Centers for Medicare and Medicaid Services (CMS) that Medicaid Home and Community-Based Services must operate with quality assessment and improvement systems that are much more focused on the achievement of an individual's desired outcomes and the organizational performance in delivering those outcomes than are currently being implemented in Minnesota. Minnesota must respond to these new expectations of CMS that states develop and implement comprehensive systems of quality assessment and improvement to maintain its federal HCBS program approval and funding.

....consistent with this mandated report and recommendations the Department of Human Services recently created an internal workgroup of subject matter experts and external stakeholders...to create a comprehensive quality system for HCBS.

DHS Quality System Architecture Initiative

In an effort consistent with this mandated report and recommendations, the Department of Human Services recently created a workgroup of internal subject matter experts and external stakeholders. The work of this group is to create a comprehensive quality system for HCBS, to establish a structure which assures timely and pertinent data collection to assess performance of and improve the quality of service delivery. This Quality System Architecture Initiative requires and demands coordination of the many businesses that collectively work to create, enhance and maintain individual community-based services.

This Quality System Architecture Initiative is expected to subsume the findings and recommendations of this study into its planning.

As expected, initial findings of the Initiative show that improvement is needed. Initial findings of the Quality System Architecture Initiative group are consistent with those of the QA Panel and recommendations in this report. Both have recognized the disconnection among service providing businesses, data system gaps, business practices resulting in delays in service, assessment systems that lack measurable outcomes, quality assurance/monitoring systems that have not expanded commensurately with the growth of programs that now serve more than 31,000 of Minnesota's most vulnerable citizens.

Specific Federal Mandate

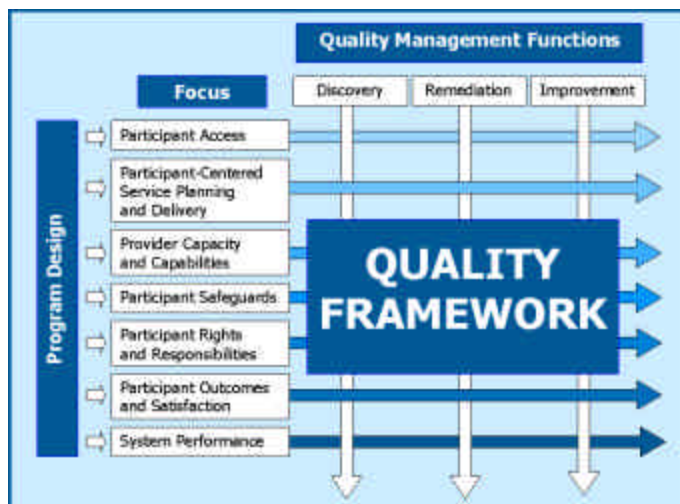
Expectations for quality assessment and improvement in HCBS programs have been conveyed in the CMS Quality Framework.

Minnesota is not alone in facing the challenge of designing and implementing a more effective model of quality assurance and improvement. Much more rigorous and comprehensive expectations for quality assessment and improvement in HCBS programs have been conveyed to the states through the CMS Quality Framework. The CMS Quality Framework recognizes that the realm of quality assurance includes dimensions of quality of life, individual rights, choice, and satisfaction in addition to protection of health, safety and well-being.

The CMS Quality Framework represents a firm commitment on the part of CMS to operate at a new level of engagement in defining, expecting, monitoring and improving quality.

According to the CMS Quality Framework, contemporary quality assurance systems are not only expected to operate with more sophisticated concepts of quality, they are asked to make a difference in improving quality. The Quality Framework represents firm commitment on the part of CMS to operate at a new level of engagement in defining, accessing and improving quality.

Chart 1. The CMS Quality Framework



Because of its central role in establishing CMS expectations for state models of quality assurance, the QA Panel recognized that the CMS Quality Framework must serve as the guide to the analysis and recommended reform of quality assurance and improvement efforts in Minnesota. To do otherwise was viewed by Panel members as imprudent, given CMS’s position that the Framework provides the needed specificity to states about their administrative responsibilities, the assurances that they are expected to integrate into the new HCBS application and reporting requirements, and the promise of expanded CMS oversight of states’ fulfillment of these assurances.

As shown in Chart 1, The CMS Quality Framework is made up of seven focus areas of program design and three quality management functions. The seven focus areas of quality and components of each are:

- 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); adequate staff training; provider monitoring
- Participant Safeguards: incident reporting and response; risk assessment/balance with choice; monitoring of behavioral and pharmacological interventions; medication administration; emergency and disaster preparation/response; health monitoring;

- Rights and Responsibilities: protection of rights and decision-making authority; due process and grievance procedures;
- Outcomes and Satisfaction: surveys that show outcomes of and satisfaction with services provided; data used to identify and respond to dissatisfaction and poor performance generally and for specific subgroups;
- System Performance: systematic gathering and analysis of performance data; community participation in designing and appraising system performance and improvement activities; financial accountability; a system that strives to improve quality.

The Quality Framework requires quality assurance systems that not only gather quality-relevant data, but also that use the data they gather in ways that contribute to the quality of services.

With CMS’s adoption of the Quality Framework, Minnesota’s HCBS programs will be held accountable for monitoring specified “desired outcomes” in each of these areas. The Quality Framework not only requires quality assurance systems to gather quality-relevant data, but also that the data be used to improve the quality of services. This is to be accomplished through three specified quality management functions:

- Discovery: knowing what outcomes are being accomplished, identifying problems, determining opportunities for improvement, and finding sources of effective practice;
- Remediation: responding to problems on a individual, agency and system-wide basis;
- Improvement: using information about HCBS programs and those persons enrolled in them, knowledge of effective practices and information and knowledge dissemination to improve the quality of services and supports, and elevate the expectations of and demand for higher quality by service recipients and their advocates.

There is, of course, an implied fourth management function, quality system program design, in which an infrastructure must be created and sustained to support the other management functions.

QA Panel Criteria for Minnesota’s Approach

The QA Panel established specific criteria to guide its analyses of options and recommendations for future design of Minnesota’s approach to quality assurance and improvement.

The QA Panel established specific criteria to guide its analyses of options and recommendations for a future design of Minnesota’s approach to quality assurance and improvement. These criteria derived from both the Legislative mandate to the Panel and from the Panel’s understanding of its responsibility under that mandate to the state and its citizens with disabilities. These criteria included:

- The quality assurance and improvement system must be consistent with the CMS Quality Framework;

- The quality assurance and improvement system must be adequately funded to achieve the substantial expectations of CMS for Minnesota’s quality assurance and improvement infrastructure;
- The quality assessment and improvement system should be applicable to all HCBS and other community support programs for persons with disabilities regardless of how and by whom their long-term supports and services are managed;
- Operational definitions of quality must derive primarily from service outcomes that people with disabilities and caregivers view as important;
- The quality assurance and improvement system must be designed, implemented, and evaluated for its ability to cause positive change in the lives of people with disabilities;
- The quality assurance and improvement system must support the interests and commitments of family members, friends and others to be engaged positively in the lives of Minnesotans with disabilities;
- The quality assurance and improvement system must provide for local or regional management and must include mechanisms to identify and respond to specific areas of needed assistance;
- Quality assessment and improvement system must provide for and support direct participation and advisory involvement of individuals with disabilities, family members, local government employees, service providers and other citizens;
- The quality assessment and improvement system must include effective procedures for reporting, investigating, and resolving incidents of potential abuse, neglect or exploitation; and to provide for regional analyses of incidents and responses to potentially related problems;
- The quality assurance and improvement system must attend appropriately to services with differing or no current licensing and certification requirements;
- Quality assessment and improvement system must integrate the activities, responsibilities and gathered information of all who have a role in monitoring individual well-being and the quality of support received by individuals;
- Advocacy and self-advocacy are important components of effective quality assurance and improvement systems and should be integrated into Minnesota’s quality assurance and improvement activities;
- The quality assessment and improvement system must fulfill its purposes in an efficient manner with appropriate consideration of resource use for individuals in different circumstances, with different vulnerabilities, and/or supported by organizations with different histories or alternative review programs;

- The outcomes of quality monitoring must be integrated into comprehensive quality improvement programs (e.g., training, technical assistance, consumer education) as indicated by quality assessment findings and stakeholder input; and
- Outcomes of quality assessments should be documented in public reports prepared by or under the auspices of the Department of Human Services and shared with federal authorities, the Legislature, the disability community, current and potential services users, and the public.

A Recommended Model for Minnesota

Primary Purpose and Rationale:

The Quality Assurance Panel recommends five core components of a comprehensive Minnesota-wide system of quality assurance and improvement to respond to the expectations of the federal government and the needs of Minnesotan's with disabilities. These components include:

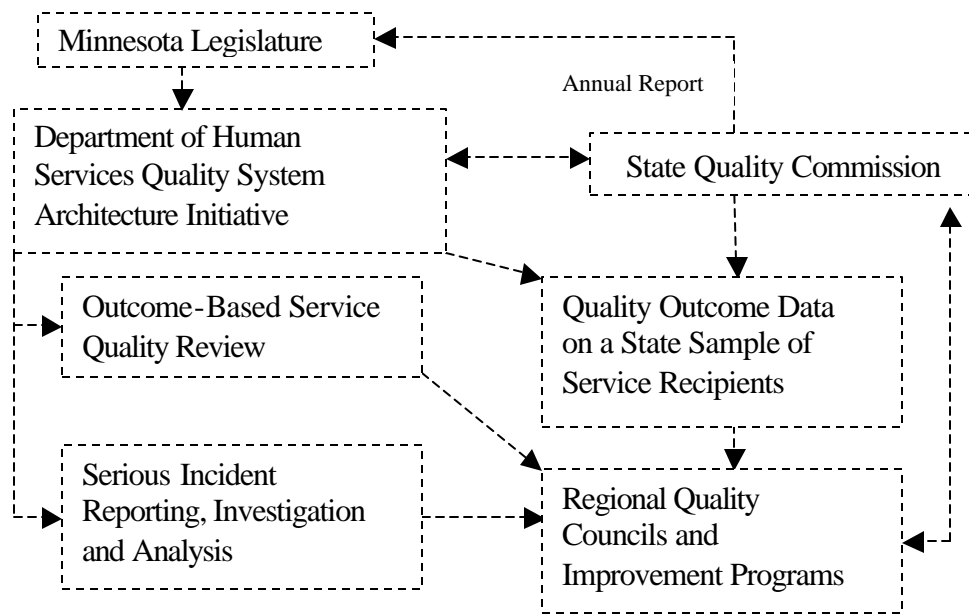
- A State Quality Commission that receives and analyzes results of outcome based quality assessments from statewide quality assessment activities including licensing reviews, reviews of unlicensed services, reviews of findings from the statewide sample survey of service recipients, analyses of critical incident reports and investigations, and reports and recommendations of Regional Quality Councils to issue an Annual Report that establishes state priorities for improvement activities. This report will be publicly available and will be posted on the Commission's public website.
- Regional Quality Councils that gather, analyze, synthesize and evaluate information on quality, contribute to statewide service outcome reporting and priority-setting, and provide programs of individual, family, and professional education, training, technical assistance, self-advocacy support, and activities to improve the quality of services in each of 6 regions of the state. The Regional Quality Councils will create an Annual Report summarizing their analysis of quality outcomes and the regional level, articulating their local and regional intervention priorities, and describing the results of quality improvement activities that will also contribute to the statewide annual public report on the quality of services for Minnesotan's with disabilities.
- An annual independent statewide sample of service recipients to determine and report the outcomes of supports provided to individuals with disabilities in Minnesota, with attention to the services used, individual characteristics, and the residential, employment and other circumstances associated with service and lifestyle outcomes. Annual statewide and regional reports of the results will be published and used to assist regions, counties and providers to plan and measure the impact of quality improvement activities.

- An outcome-based quality assessment program for service quality monitoring, including both licensed and unlicensed services, based on outcome-based interviews of a sufficient sample of individuals and caregivers supported by an organization to determine organizational performance with sufficient reliability to determine the level of service quality, issue program licenses as called for, recommend remedial activities, and inform the need for general and specific training, technical assistance, consumer education, and other service improvement activities at the Agency, County, Regional and State levels;
- An effective program of incident reporting, investigation and analysis that provides necessary protections, assures timely and appropriate response, and guides quality improvement initiatives;

A Diagram of the Recommended Model

The diagram below depicts the components of the regional quality assurance and quality improvement model recommended by the Quality Assurance Panel. A description of the components and their interaction follows.

Chart 2. Recommended Components of a Regionally-Based Program of Quality Assurance and Improvement in Minnesota



Key Program Components

The components depicted in Chart 2 are recommended for adoption as a new regionally-structured outcome-based program of quality assurance and quality improvement In Minnesota. This recommended program is consistent with

federal expectations and with the goals of the Department of Human Services' Quality Systems Architecture Initiative. Key aspects of these components are described below.

State Quality Commission:

Primary Purpose and Rationale: The primary purpose of the State Quality Commission is to assure that quality and quality improvement in services and supports for Minnesotans with disabilities are approached with seriousness, integrity, creativity and cost effectiveness in all parts of Minnesota. The State Quality Commission will reflect both a symbolic and truly new beginning for quality assurance and improvement in Minnesota. It will reflect a commitment to quality as defined in required procedures and represents a new vision of quality that derives from personal outcomes and a commitment to continuous quality improvement. The State Quality Commission will reflect in its name, mission and membership that quality is a serious public concern in Minnesota that involves citizens in and out of government. It will reflect a new understanding that quality is not achieved through inspection processes, but derives from careful collection of data on outcomes of importance, analysis of and response to those data, communication between stakeholders, and support for quality improvement not just for the worst performers, but all organizations and individuals supporting Minnesotan's with disabilities. The State Quality Commission will play a central role in creating a culture of quality in Minnesota's disability services.

The State Quality Commission will play a central role in creating a culture of quality in Minnesota's disability services.

Essential functions of the State Quality Commission: The essential functions of the State Quality commission include:

- The State Quality Commission will commit to a statewide process for implementing, monitoring and reviewing quality focused on individual outcomes. The Commission will be responsible for developing a minimum set of quality indicators that will be monitored through Regional Quality Councils;
- The State Quality Commission will articulate a vision about quality for Minnesota's disability services;
- The State Quality Commission will serve to guide and support Minnesota's efforts in defining, collecting, measuring, and analyzing data on quality to improving services to Minnesotans with disabilities;
- The State Quality Commission will oversee the development of a new outcome-based quality assurance program for services to people with disabilities in Minnesota that reflects contemporary visions and expectations for quality assurance, including personal outcomes as a primary foundation;
- The State Quality Commission will identify existing regulations that are essential to the well-being of people with disabilities and the efficient and

effective operation of service delivery and will request of the Legislature elimination or revision of rules that impede contemporary practices;

- The State Quality Commission will have long-term responsibility for evaluation and improvement of the effectiveness of Minnesota's quality assurance system(s) whether operated by the state or by regional entities;
- The State Quality Commission will establish and administer rules and required program elements to guide regional entities in: a) developing regional quality assurance and quality improvement programs, or b) becoming the administrative entity for the new state quality assurance program within their region;
- The State Quality Commission will receive, review and respond to data on the quality of services provided to persons with disabilities in Minnesota from outcome-based quality assurance reviews, incident reports and investigations and from state samples of service recipients, and will issue an annual public report to the Legislature and the people of Minnesota on the quality of services for Minnesotans with disabilities in print and electronic formats available on the Commission's website;
- Based on an annual review of outcome data, the State Quality Commission will select 2-3 quality improvement priorities to address through statewide quality improvement initiatives and provide the rationale and outcomes of these initiatives within its annual report;
- The State Quality Commission will through its employees and/or contracted entities establish and operate a State Quality Support System Program that identifies, develops and disseminates via website, publications and presentations of information to support achievement of quality as defined in the new quality assurance program and the statewide priorities;
- The State Quality Commission will identify regional best practices and provide public recognition of exemplars of the highest quality through its annual report, other publications, its website, referrals, and other means of dissemination;
- The State Quality Commission will use educational and public relations strategies to publicize Minnesota's success in achieving service quality goals to the Department of Human Services, various stakeholder groups, the Legislature, and the general public;
- The State Quality Commission will establish criteria for and select Regional Quality Council members and will participate in developing the programs of Regional Quality Councils.

Composition: The State Quality Commission will be appointed by the Commissioner of the Department of Human Services. The Panel recommends that a Legislator be invited to participate on the Commission. Members will include representatives of state agencies engaged in quality assurance and improvement roles (e.g., the Department of Human Services Assistant

Commissioner, the Disability Services Division (DSD) Director, the DSD QA Policy Lead, Director of Licensing or designee, and the Ombudsman. Other appointments could be from departments such as Aging, Health, Area Agencies on Aging, and the Governor's Council on Developmental Disabilities). Citizen Commissioners elected by members of each Regional Quality Council will participate in the State Quality Commission. Commissioners will include well-informed representatives from disability service receiving, providing, administering and advocacy organizations, and county officials (e.g., advocates, self-advocates, families, service providers, health care plan representatives). Employees of the Department shall have permanent membership on the Commission.

Support: The State Quality Commission may be staffed by either state or contracted employees. At different times, the Commission will benefit from individuals with specific expertise. Access to such individuals will be on an as needed basis. Special support will be built in to assure that commission members with disabilities are comfortable with their role and the material being reviewed. A mentorship model will be used to support individuals who request assistance. Mentors will be available to meet with the individual prior to meetings, assist the person during meetings and review material covered after meetings.

Structure: The State Quality Commission will meet at least quarterly. Minutes of meetings shall be maintained. Orientation sessions will be conducted when the Commission is established and when new members are appointed.

Roles and Responsibilities: The State Quality Commission will be appointed by the Commissioner of Human Services with appropriate input from the Commissioner of Health. The Commission will work closely with appropriate state agencies to fulfill shared goals and expectations regarding continuous quality improvement in services and supports for Minnesotan's with disabilities. A citizen Chairperson and Vice Chairperson will guide the work of the State Quality Commission in cooperation with staff from the relevant State Departments.

The Commission shall be responsible for Essential Functions mentioned above. The State Quality Commission will periodically review current aggregate reports generated through the Outcome-Based Service Quality Review process, the Serious Incident Reporting, Investigation and Analysis process, and other sources of quality-relevant information. It will collect and analyze periodic Quality Outcome Data based on statewide interviews with a substantial sample of service recipients. Recommendations of the State Quality Commission will guide quality improvement activities of the Regional Quality Councils. The Department of Human Services and other relevant departments will support the work of the State Quality Commission by providing summaries of quality-related service outcomes. The State Quality Commission will review the annual reports submitted by each Regional Quality Council along with information about service quality in the state as a whole. It will develop an annual public report on the quality of services and supports in Minnesota, trends in service quality, changes in law or rule needed to address quality assurance or quality improvement gaps, and the activities of the

State Quality Commission and Regional Quality Councils during the preceding year. This report will be distributed to the Legislature, relevant state departments and key stakeholder groups and will be posted on the Commission’s public website. It will be provided in alternative formats as requested.

Regional Quality Councils:

Regional Quality Councils will represent a new vision of quality that derives from personal outcomes....

Primary Purpose and Rationale: The Panel recommends that Regional Quality Councils be established in 6 regions to build capacity and support for improved quality assurance and quality improvement on the regional level. Like the State Quality Commission, Regional Quality Councils will provide clear and focused attention to quality and quality improvement of services and supports to Minnesotans with disabilities. Like the State Quality Commission, Regional Quality Councils will represent a new vision of quality that derives from personal outcomes and will monitor, report, and initiate activities to improve outcomes of services and supports in their region.

The Regional Quality Councils will be on the frontline of transforming Minnesota from a vision of quality as adherence to rules to a contemporary vision of quality deriving from clear outcome goals, careful collection of data related to desired outcomes, analysis and response to those data, data-based program modifications, and support of systematic efforts to “build quality in” to programs, services and supports for Minnesotans with disabilities. Such approaches to quality are not new; they are the basic mode of operation in modern, successful businesses, including a growing number of human services enterprises in the U.S. and beyond.

Regional Designations: The Quality Assurance Panel recommends that the six designated regions be designated. The current boundaries of the existing Area Agencies on Aging (AAA; see Appendix B) provide guidance as to how the regions could be defined. Boundaries could be modified in instances in which existing county cooperative efforts would be impeded by rigid adherence the AAA regions. The AAA regions are generally congruent with the regions served by Minnesota’s Centers for Independent Living (CIL), although there are currently 8 CIL regions. Active chapters of The Arc are also located in each of the AAA regions. Creating the Regional Quality Council regions based on these generally established boundaries would allow for the maximum integration of existing federally-supported, regionalized programs of information and assistance to persons with disabilities into the work of the Regional Quality Councils. Although the purposes of the AAA, CIL and The Arc programs are not directly linked to support of state managed services, integration of the services they offer will contribute substantially to the ability of Regional Quality Councils to assist Minnesotans with disabilities to better understand their rights and opportunities and to more effectively use disability services programs. Ultimately, the Panel recommends that the Commissioner establish the final regional boundaries based

on such considerations in consultation with the Association of Minnesota Counties and other stakeholder groups.

Essential Functions of the Regional Quality Councils:

- Regional Quality Councils will provide direction, oversight, and support for quality assessment, analysis and improvement within the Regions;
- Regional Quality Councils will design and implement regional quality improvement initiatives based on the analysis of service quality assessment data from both licensed and unlicensed programs, incident reporting and surveys of consumers and will include training, technical assistance, and the dissemination of materials targeted for use by consumers, providers, county officials and case managers, and to the general public;
- The Regional Quality Councils will assure appropriate evaluation and modification of quality improvement initiatives offered within the Region;
- Based on analysis of service quality data from quality assessments, incident reporting and surveys of consumers and other consumer input, Regional Quality Councils will submit an annual report to the State Quality Commission on “Service Quality, Quality Enhancement Activities and Quality Improvement within the Region.” This report will contain summaries of quality outcome data from service quality assessment activities for both licensed and unlicensed providers, incident reporting and surveys of consumers, quality improvement activities undertaken, areas of continuing needed focus, priorities for regional quality improvement activities, and recommendations for state initiatives;
- Regional Quality Councils will participate with the State Quality Commission in monitoring the extent to which regional quality assurance and improvement efforts faithfully and successfully adhere to all criteria of agreements with the State Quality Commission regarding their management of quality assurance and improvement efforts;
- Regional quality improvement activities will be funded from a pool managed by the State Quality Commission based on specification of priority projects each year. The distribution of funds for these activities will also take into account the number of individuals with disabilities served in a region and the size of the catchments area covered;
- Regional Quality Councils will develop or select and purchase quality improvement information, materials and programs as needed from local, regional and state resource providers. In doing so they will adhere to general guidelines established by the State Quality Commission. Those guidelines will include, at minimum, the capacity to provide useful, valid contemporary information consistent with the areas and functions of the Quality Framework, the objectives for persons with disabilities in Minnesota, the statewide and/or regional priorities for quality improvement;

- Regional Quality Councils will be responsible for materials identification, development, dissemination and direct presentation as needed for meeting the priorities of the Regional Quality Council and the statewide priorities of the State Quality Commission;
- Regional Quality Councils will develop materials and information that is directly presented to all service recipients so that all understand their rights and all are assured access to the best independent information of their options and opportunities in formats they understand;
- Regional Quality Councils will be responsible for assuring the timely interviews of individuals living in their region and selected as part of the statewide sample of disability service users with interviews conducted by Regional Quality Council staff or by contracted entities;
- Regional Quality Councils will be linked with each other directly and through the State Quality Commission to assure efficient use of information and products identified and developed;
- Each Regional Quality Council will be linked via a common State Quality Commission website that includes an easy and clear link to Regional Quality Council pages and information on regional activities, materials and information;
- Annually the Regional Quality Council will participate with the State Quality Commission in conducting an annual Quality Conference to showcase high quality supports and efforts to achieve them, to provide a forum for presenting annual State Quality Commission Awards, to provide for conceptual, programmatic and materials awareness and sharing, and to obtain public feedback on state needs and priorities. In addition, each region will sponsor an annual quality conference to provide similar information to local and regional stakeholder audiences.

Composition: The Regional Quality Council services will be managed or contracted by the Department of Human Services (DHS)/Disability Services Division (DSD). Individuals and entities will be responsible for carrying out the directions provided in statute and by the Regional Quality Council. Designated individuals in each region will serve as a liaison to the Department of Human Services and other state agencies, the State Quality Commission, and organizations and individuals in the region. Members of the Regional Quality Council will be appointed by the State Quality Commission. Membership will include a representative from the Department of Human Services, representatives of persons with disabilities, family members, service providers, advocacy organizations, counties governments and others involved in the disability community in the region.

Structure: The Regional Quality Councils will meet at least quarterly. Minutes of the Regional Quality Councils meetings shall be maintained. Orientation sessions will be conducted when each Council is established and when new members are appointed. Special support will be built in to assure that commission

members with disabilities are comfortable with their role and the material being reviewed. A mentorship model will be used to support individuals who request assistance. Mentors will be available to meet with the individual prior to meetings, assist the person during meetings and review material covered after meetings.

Roles and Responsibilities: Regional Quality Council members will be appointed by the Commissioner with appropriate input from County Social Service organizations and other stakeholders in the Region. Each Regional Quality Council will report to the State Quality Commission, although they will be expected to work closely with appropriate state and county agencies to fulfill shared goals and expectations regarding continuous quality improvement in services and supports for Minnesotans with disabilities. Regional Chairpersons and Vice Chairpersons will lead and guide the work of the Regional Quality Councils.

Essential roles and responsibilities of the Councils are described in detail in the Essential Functions section above. Regional Quality Councils will periodically review region-specific data generated through the Outcome-Based Service Quality Review process, the Serious Incident Reporting, Investigation and Analysis process, and other quality assessment activities. They will also review regional summaries of the annual independent statewide sample of service recipients. Recommendations of the Regional Quality Councils will guide quality improvement activities in their region. The Department of Human Services and other relevant departments will support the work of the Regional Quality Councils by providing access to regionally specific reports regarding quality assurance outcomes. Each Regional Quality Council will develop an annual report to the State Quality Commission on the quality of services and supports in their region, trends in service quality, changes in law or rule needed to address quality assurance or quality improvement gaps in the region, and the activities of the Regional Quality Council during the preceding year.

An annual survey is essential to basic understanding of the effectiveness of...HCBS and related services. It responds directly to federal expectations... that states will implement HCBS management programs that include assessment of system performance.

Statewide Sample Survey of Service Users:

Primary Purpose and Rationale: The Quality Assurance Panel recommends implementation of a service outcome/system performance evaluation program that surveys on an annual basis approximately 3,400 individual service recipients, and as appropriate members of their individual families. Such a survey is essential to basic understanding and analysis of the effectiveness and responsiveness of HCBS and related services to Minnesotans with disabilities. It responds directly to federal expectations in the CMS Quality Framework that states will implement HCBS management programs that include assessment of “System Performance” (Focus Area 7 in the Quality Framework). The recommended annual survey of a statewide random sample of service recipients will not only establish compliance with federal expectations for performance evaluation, it will also provide the State

Commission on Quality, the Regional Quality Councils, the Department of Human Services, and the Legislature with current information on service outcomes essential for service management and policy development. Specifically, the recommended statewide survey will provide state and sub-state (region, county, and provider) authorities and consumers with summaries of the service outcomes and experiences of individuals with disabilities supported by HCBS and other programs operated under the auspices of Minnesota's Disability Services Division. It will provide a mechanism to monitor system performance and to establish priorities for state and regional quality improvement initiatives. It will also provide an important, independent and valid foundation for public reporting and accountability about services to Minnesotans with disabilities. The annual 10% sample of service recipients will provide an adequate overview of system performance on the state and regional levels. The system envisioned will also provide for the merging of the most recent two years of interview data to allow focus on more specifically defined subpopulations or service programs.

The Quality Assurance Panel reviewed statewide service outcome/system performance evaluation programs current being used in a majority of the states (but not Minnesota) to evaluate the quality of services provided to one or more populations of persons with disabilities.

Identifying Key Indicators of Quality: The Quality Assurance Panel reviewed statewide service outcome/system performance evaluation programs current being used in a majority of the states (but not Minnesota) to evaluate the quality of services provided to one or more populations of persons with disabilities. However, none of the states with existing statewide evaluation systems operate with an “across-disability” focus as envisioned for Minnesota. Quality Assurance Panel sub-committees (including non-Panel members from disability organizations and county governments) analyzed a variety of validated instruments currently used in other states. The subcommittees focused first on specific indicators of service quality and system performance that would be valid for all disability groups in Minnesota.

The subcommittees examined nine existing instruments including 1) The Boston University Home Care Satisfaction Measure; 2) Center on Health Systems Research and Analysis, Quality Indicators Performance Measures for Medicaid Services to Persons with Mental Retardation and Developmental Disabilities Minnesota; 3) Minnesota Department of Human Services, Aging and Adult Services Consumer Experience Survey; 4) Maine Experience Survey- Elderly/Disability; 5) MEDSTAT Participant Experience Survey Performance Indicators, MR-DD version; 6) MEDSTAT Participant Experience Survey Performance Indicators Elderly/Disability version; 7) Mental Health Statistics Improvement Program Consumer Survey; 8) Minnesota Longitudinal Study Interview (Developmental Disability), and 9) The National Core Indicators Consumer Interview and Family Questionnaire. The MEDSTAT surveys are currently used by HCBS National Surveyors and for system performance evaluation in 19 states. Panel members reviewed those specifically to determine if they would meet Minnesota's needs but determined that they did not adequately address the needs and quality of service and lifestyle concerns of all disability groups.

Having reviewed existing instrumentation, the QA Panel identified the critical quality domains that should be measured, and identified specific quality indicators that the Panel felt should be measured in Minnesota. A set of 34 outcome indicators (out of 215 reviewed) were considered universally important across disability groups. These indicators reflect at least limited coverage of each of the 6 areas of focus of the CMS Quality Framework are recommended as core items of the statewide survey of service users. (A complete list of these quality indicators can be found on the QA Panel website at www.qapanel.org. The source of these indicators and populations for which they were originally developed are shown.) Examples of the indicators selected by QA Panel members for the statewide survey of service users include the proportion of service recipients (by program, type of disability, living arrangements and breakdowns of interest) who report that:

- they are informed about existing and potential resources (including information services, choices and supports, and available public benefits), in a way that is easy to understand.
- they participate in _____ activities in the past week in which they like to participate with people other than staff.
- their direct support staff...
 - a) listen to you when you are upset
 - b) help find ways to fix problems
 - c) listen to what you want
 - d) treat you nicely
 - e) get so angry that you are afraid
 - f) ask you before using your things
 - g) treat you with respect
- other people sometimes hit or hurt their body (prompts further inquiry).
- they did not help pick their staff, but would like to.
- they have friends other than support staff and family members.
- they decide how to spend their free time when not working or in a day program.
- they feel that their services and supports have helped them to better care for their family member living at home.
- that the help they have received [in the past year] has made their life better/worse.

Linking to Other Key Data Sets: The Quality Assurance Panel recognized that additional information will be important to effectively use the data provided by sample members. Important supplemental data include: a) background

demographic, diagnostic descriptive information and functional descriptors; b) sample member's basic service use and service setting; c) information of specific importance to evaluation of services for specific diagnostic groups; and d) service expenditures. A document on the QA Panel website (www.qapanel.org) identifies the basic set of demographic, diagnostic and functional descriptors of sample members and their services and service settings considered important by the Quality Assurance Panel. The individual and service descriptor variables have been drawn from an initial draft of Minnesota's "Universal Assessment" that is currently in the development process. The Quality Assurance Panel recommends that, once implemented, the Universal Assessment data elements for each individual in the statewide sample of service users and the individual outcomes survey for the same individual be merged into a single record based on the person's Medicaid number. This will not only provide for a comprehensive set of individual descriptive variables by which outcomes can be analyzed, it will reduce redundant data collection.

Such a data set will provide a powerful capacity to evaluate the quality and cost-effectiveness of services to persons with disabilities in Minnesota with relatively limited costs for new data collection.

The Quality Assurance Panel recommends that periodically service payment files for these same individuals be merged into a single record that thereby includes individual demographic, diagnostic and function characteristics; service types and settings; service and lifestyle satisfaction and outcomes; and service and health expenditures. Such a data set will provide a powerful capacity to evaluate the cost-effectiveness of services to persons with disabilities in Minnesota with relatively limited costs for new data collection. This work should be conducted as a fundamental aspect of the "System Performance" evaluation under the leadership of the State Quality Commission and/or Department of Human Services.

The Panel further recommends that annual survey files be merged into two year data sets to provide sufficient sample size to identify "low incidence" disabilities, demographic groups and service categories and to allow statistical controls for individual differences in multivariate analyses of factors predicting outcomes.

In addition to ongoing data collection, the Quality Assurance Panel recommends that the State Quality Commission view the Statewide Sample Survey as a mechanism for conducting periodic studies of emerging areas of importance and concern. Such areas might range from evaluation of individual experiences (e.g., knowledge and use of information from Regional Quality Councils) to gathering data on service inputs such as staff turnover, vacancies, wages and benefits in the service settings in which the sample members receive services and supports.

Data Gathering: The Quality Assurance Panel recommends that data collection on the outcome indicators be conducted under the auspices of the Regional Quality Councils, but that data is gathered according to a statewide schedule so that timely analyses are carried out. A random sample of service users would be selected by the state Department of Human Services according to registries of current program participants. Regional Quality Councils would receive a listing

of randomly selected individuals and the counties. From these listings individuals would be contacted to schedule interviews by staff of the Regional Quality Council or its contracted entities. Interviews could be conducted by phone or in person using computer assisted interviewing protocols in which the data are entered directly into laptop or desktop computers by the interviewer. It will be the responsibility of each Regional Quality Council to assure that interviewers have been successfully trained according to standards and criteria established as part of the survey development process. In addition to the survey's quantitative data collection on individual outcomes, the individual service user visits will provide important opportunities to monitor the well-being and unmet needs of service recipients and provide additional information to the Regional Quality Councils on services within the regions and the needs of those receiving them.

Data Use: Once quantitative data are gathered and edited they will be transmitted to the Department of Human Services. Merging with other related data files (e.g., the Universal Assessment or payment files) will then occur. Files will then be stripped of sample member identifying information and used by employees of the State, the State Quality Commission or a contracted entity to provide both state and regional data summaries.

The statewide survey will fulfill a number of important purposes... understanding of the rural performance of the service system... areas of relatively low performance... an essential foundation for an annual report to the legislation on the states and customer of services.

The statewide survey will fulfill a number of important purposes. On the state level it will respond to federal expectations and state responsibilities for assessment of the overall performance of the service system for Minnesotans with disabilities. It will play a crucial role in identifying areas of relatively low performance from which the State Quality Commission can plan quality improvement initiatives. It will allow identification of specific disability or demographic subpopulations whose outcomes require specific attention. It will permit analysis of general effectiveness and cost-effectiveness of various services models. The annual statewide sample survey program will provide an essential foundation for an annual public report to the Citizens of Minnesota on the status and outcomes of services for Minnesotans with disabilities.

On the regional level the individual outcome data and the merged individual characteristics, services and expenditures data will be an exceptionally valuable asset to evaluating service effectiveness. These data, along with data from program quality reviews, incident reporting and investigation activities, and general public input will guide quality improvement plans and activities at the regional level.

These data, along with data from program quality reviews, incident reporting and investigation activities, and general public input will guide quality improvement plans and activities at the regional level.

Final Instrument Development: A core set of recommended indicators of system performance has been identified by the QA Panel, but the bulk of instrument development remains to be completed. Given the importance of these indicators in reflecting the desired outcomes for services and supports to Minnesotans with disabilities, the QA Panel recommends that the Legislature commit in this biennium to developing a consumer survey that meets the cross-disability needs of Minnesota. This would allow for the full public and

government input on the desired domains of the indicators as well as those required by CMS. It would provide time for the identification of quality indicators of importance in each domain and to develop individual survey items for each of the quality indicators. Reviewers representing specific disability groups will be engaged to identify indicators that may not be part of the common survey, but that would be important for specific subpopulations. A period of field-testing and psychometric evaluation should then precede finalization of the survey. Following the completion of a final and field-tested assessment, an interviewer training program will be developed, tested and implemented. The Panel estimates that final survey development, field-testing and training program development will require approximately 18 months after which the first statewide sample can be drawn and the first full data set can be collected and analyzed.

Outcome-Based Service Quality Review:

Primary Purpose and Rationale: The Quality Assurance Panel recommends a substantial, high priority state commitment to the development and implementation of a state program of outcome-based quality review. A new focus on outcome-based quality review, in conjunction with review of compliance with quality-relevant regulations, will notably contribute to improved quality of services received by people with disabilities by introducing assessment measures that are directly related to service quality and to the program improvements that make people's lives better.

A new focus on outcome-based quality review, in conjunction with review of compliance with quality-relevant regulations, will notably contribute to improved quality... by introducing assessment measures that are directly related to service quality

The new outcome-based quality assessment program for service quality monitoring will include both licensed and unlicensed services. It will be based on outcome-based interviews of a sufficient sample of individuals and caregivers supported by an organization to determine organizational performance with sufficient reliability to determine the level of service quality, issue program licenses as called for, recommend remedial activities, and inform the need for general and specific training, technical assistance, consumer education, and other service improvement activities.

The Quality Assurance Panel recognizes that the development of an outcome-based quality review program is a key area of focus within the Department of Human Services as part of the Quality System Architecture Initiative. The Quality System Architecture Initiative recommendations for outcome-based quality review will be forthcoming. The Quality Assurance Panel is supportive of the initial directions of the Quality System Architecture Initiative and urges the Legislature to view this initiative as important to Minnesotans with disabilities and to Minnesota's standing with federal Medicaid authorities. As this outcome-based service quality review system is developed the Panel recommends that it reflect the following considerations.

Key Considerations for a Program of Outcome-Based Quality Review:

- Licensing activities as they are currently implemented in Minnesota do not include large numbers of service recipients with disabilities and the focus of reviews that do occur comprise only a part of the needed Outcome Based Review process. Minnesota must commit to reforms for establishing performance measures and indicators across service types and settings irrespective of whether or how those service types and settings are licensed, and must use the results of those measures to improve service performance.
- The Quality Assurance Panel recognizes that Minnesota's Region 10 Quality Assurance Commission is a significant, nationally regarded leader in the development and implementation of outcome-based quality assurance and improvement. It has contributed through its mission and success over the past decade to the new expectations of CMS that outcome-based approaches to quality assurance and improvement be adopted in state home and community-based services programs. It has modeled important procedures in developing outcome-based quality assurance programs that reflect community value and elicit community support and participation. Its achievements and leadership as a regionally managed entity have demonstrated the strength and benefits of regional approaches to quality assurance. The QA Panel recognizes that in efforts to respond to the state's responsibility for an outcome-based quality assurance program, it is important to provide opportunities, with appropriate standards, for regional programs to be developed and sustained.
- An important lesson from the study of Region 10 initiative was the importance of substantial stakeholder input in developing a definition of quality, identifying the domains of quality, drafting and reviewing specific indicators of quality, and designing the means of assessing quality, including the engagement of community members in the quality review process.
- The new state quality assurance program should include options for regions to adopt alternative systems, including the Region 10 model. While the benefits of developing alternative outcome-based systems such as Region 10's, will be less evident as the state develops a high-quality, outcome-based system, the Region 10 experience has shown significant benefits of regionally-developed alternatives, especially that of substantial community engagement and commitment to community members with disabilities.
- If a region proposes an alternative to the state quality assessment system, it should be required that all counties in the region participate in it so that quality review activities and findings contribute to the efforts of the Regional Quality Councils to build evidence-based regional quality improvement initiatives. Furthermore, all regions including those using alternative systems should be expected to measure a core set of indicators so that statewide analyses can be done for those indicators. In permitting alternative regional approaches, the state will have responsibility for establishing standards for alternative outcome-based quality assurance programs, including the quality and comprehensiveness of the review processes, mandated protections, and so

forth that will assure effective, well managed regional programs, should any be established.

- In its study of regionally-based quality assurance programs, the QA Panel noted substantial advantage to moving toward regionally based quality review teams that could work in close cooperation with the Regional Quality Councils and contribute directly to identifying quality improvement needs and being integrated into efforts to respond to those needs. The Panel noted in discussions with Division of Licensing personnel that much of the work of the Division staff is already geographically concentrated. The Panel views it of long-term benefit to plan for the regionalization of the state quality assurance operations, including state participation in regionally developed programs.
- A key function of the outcome-based service quality reviews will be to collect, analyze and intervene on information about service outcomes at the individual, provider, county and regional levels. Activities in this area will supplement information provided by the statewide sample survey of service users by providing specific information to assist local and regional providers and government agencies to identify and make changes to improve the quality of supports and services offered to citizens with disabilities in Minnesota.

In recommending an outcome-based approach to quality assurance to replace traditional quality assurance based on rule compliance, the Panel recognizes the importance of current Division of Licensing personnel to the new program. Minnesota cannot afford to lose the skills and commitment of current licensing personnel in the pursuit of developing better ways to use their talents. It is important in recognizing and supporting current licensing personnel that their knowledge and experience contribute to the design, development and implementation of the new quality assurance program.

Incident Reporting, Investigation and Analysis:

Primary Purpose and Rationale: The purpose of Minnesota's program of mandated incident reporting is to protect people with disabilities by identifying and responding to circumstances in which they are endangered, injured, denied rights or exploited. Through investigation and analysis of patterns abuse, neglect, denial of rights, exploitation and other abuses can be responded to immediately and over time reduced and prevented by program improvement initiatives. To achieve such goals the Quality Assurance Panel recognized several essential features of an effective Minnesota approach to incident reporting, investigation and analysis.

Essential Characteristics of an Effective System: The QA Panel recommends that the state's incident reporting, investigation and analysis system incorporate these essential characteristics:

- **Timely:** A system in which complaints and critical incidents are investigated soon after they occur (e.g., before staff turnover or lapsed memory makes the investigation difficult);
- **Accessible:** Individuals and families access the system to share concerns, get help to stop a problem from continuing, and to get help from an advocate when needed to express or follow up on a concern;
- **Informative:** Consumers and families have access to high quality, easy-to-use, reliable information they understand to make decisions;
- **Responsive:** A system that triggers appropriate action (e.g., investigation by police, state officials, county case managers and service providers) based on established, appropriate standards of responsible conduct;
- **Understandable and Simple:** Incidents of injury, endangerment, denial of rights, exploitation, etc. must be responded to and everyone should know their specific responsibility and required actions in doing so, unfiltered by agency practice and culture;
- **Responsible:** There are clear lines of responsibility for investigations and their timely completion, reporting of the results of investigations and decisions based on them and the reasons for those decisions;
- **Transparent:** An accountable system produces regular public reports of its outcomes (good and bad) so that people at all levels of the system understand how information the system is functioning and how information is being used by the system to achieve acceptable and improving levels of quality;
- **Trustworthy:** Individuals in and out of the service system must be assured and feel confident that the system of identifying and responding to incidents is fair, just, appropriate in consequences, and committed to its charge of protecting vulnerable citizens, and stakeholders must have confidence that the system will work as it is designed to work;
- **Robust:** A program that expects efforts in reporting and investigating incidents of injury, endangerment, denial of rights, exploitation, etc., will be serious in analyzing the resulting data to identify problems in its systems of supports and individual support agencies;
- **Dedicated:** A program that gathers and analyzes data on reported incidents of injury, endangerment, denial of rights, exploitation, etc., must be committed to using the products of reporting and data collection and analysis to actually decrease the likelihood of future incidents through identifying needed planning, policies, and training because if reporting does not yield improvement, reporting is discouraged;
- **An Effective, Common Automated Data Management System:** There must be appropriate communication within and across various components of the system for disposition of complaints with appropriate levels of access to information for various stakeholder groups within the boundaries of data

practices requirements. Information must be integrated across the various components of the system through the use of technology to link dispersed settings through a web-based database. Data elements in such a data base would include: complaints, dates, responsible entity, status, resolution. These data elements could be built into a broader searchable database that includes data management fields such as communication logs between staff or with family members (e.g., “John is upset this afternoon-something happened on the bus but he hasn’t wanted to talk with me about it. I left a message for the van driver to call”). The searchable data base could include assessments, service plans, emergency data, service plans, health data, and other important information. People who need access to different parts of this data would include state agencies (health, human services, licensing), county offices (social services, health, vulnerable adults, child protection), mandated reporters (who might initiate reports using the system) and others. Any such system would have safeguards to comply with data privacy standards and assure access to specific information is granted only to those authorized to view it;

- **Data Analysis and Reporting System:** An automated data management system of critical incidents is of little merit if it is not used. A data reporting system should feed a robust program of analyzing and providing reports on complaints and critical incidents and dispositions. The system should be built to have the capacity to generate reports for individual providers, for individual counties and for the regional quality councils. In addition, the system would have the capacity to aggregate this information across regions to contribute to the priorities set by Regional Quality Councils and to support statewide reporting on system performance;
- **Feedback Loops and Searches for Patterns:** The State Quality Commission and the Regional Quality Councils should have the responsibility to examine reports at the state and regional levels (respectively) to look for patterns, identify challenges, suggest solutions or make other recommendations on at least an annual basis;
- **Contributing to a Culture of Improvement:** A data management system reinforces engagement in it by creating a culture of quality improvement based on it. It creates incentives for reporting because the information is used to make changes that improve services to individuals and more generally. It challenges providers, counties, Regional Quality Councils, and other system participants to identify and respond to problems, rather than simply awaiting investigations.

Roles and Responsibilities: Regional Quality Councils will have responsibility for periodically examining the extent to which the incident reporting, investigation and analysis system in its communities are effective in identifying and addressing system gaps and challenges at the local and regional level and in making recommendations to the State Quality Commission about gaps and challenges at the state level that require attention. Regional Quality Councils will review annual and periodic data analysis reports on incident reports and

investigations to look for patterns, identify challenges, suggest solutions and make recommendations to address issues that emerge from review of those reports. Regional Quality Councils will be responsible to design and implement systemic interventions such as training at the Regional level based on the results of their reviews.

The State Quality Commission will be responsible for reviewing the recommendations and interventions from the Regions to identify statewide interventions or system changes that may be needed. Recommendations requiring policy change will be forwarded to the responsible Department or Division through the State Quality Commission liaison for that Department or Division. The State Quality Commission will also prepare reports and recommendations regarding challenges and needs that require legislative action to remedy. Reports of the Regional Quality Councils and the State Quality Commission will be publicly available and will be posted to their websites.

Data Sources: Initially, the data used by the State Quality Commission and the Regional Quality Councils will be drawn from information the Department of Human Services, the Department of Health, and the licensing divisions currently collect. Initially, these reports will be provided in a format that does not specifically identify individuals or organizations. As the state data management system is refined and upgraded, mechanisms for reviewing information on a provider specific, and county specific basis will be developed. Information from the Department of Human Services and the Department of Health will be supplemented by analyses by the Ombudsman's offices and the Protection and Advocacy systems as appropriate. Over time, the Panel anticipates that other data, such as county level licensing and monitoring data for both licensed and unlicensed providers may also be used in developing regional quality improvement goals and interventions.

Implementation: The QA Panel recommends that a phased approach be used to design and implement the new incident reporting, investigation and analysis system. In the first two years, reports used by the Regional Quality Councils and State Quality Commission will be based on existing DHS and Health Department data collection and reporting activities. Public reports of outcomes will be developed with review at the State and Regional levels to identify and implement quality improvement plans to address challenges or issues that are identified.

At the same time, however, specific designs for a revised system that incorporates the improvements noted above should be pursued by the Departments of Human Services and Health with citizen input from the State Quality Commission and/or the Regional Quality Councils. This should be done in conjunction with the Real Choice Systems Change DataMart initiative and the Quality System Architecture Initiative. The Quality Assurance Panel agrees with the Department of Human Services that this is a top priority for quality assurance and improvement.

Costs and Resources

It is estimated that in Fiscal Years 1 and 2 (2007-8 and 2008-9) the component costs of the recommended system will be:

Table 1: Summary of Estimated Costs of Recommended Quality Assurance and Improvement Reforms Components

System Reform Component	Estimated Expenditures	
	Year 1	Year 2
State Quality Commission		
Personnel (including fringe)		
Office, equipment and materials		
Meeting expenses and travel		
Materials development and dissemination		
Consultants/outside trainers	\$ 241,621	\$ 223,921
Regional Quality Councils (6)		
Personnel (including fringe)		
Office, equipment and materials		
Meeting expenses and travel		
Materials develop/dissemination		
Consultants/outside trainers	\$2,414,502	\$2,307,822
Statewide Survey and Analysis**	\$ 242,600	\$ 506,480
Outcome-Based Service Quality Review	*	*
Incident Reporting, Investigation, Analysis	\$100,000***	\$100,000***
Total	\$2,898,723	\$3,138,223

(See Appendix E for budget breakdown for the first two years.)

*The cost of this component is yet to be determined as design specifications are currently under discussion by the Department of Human Services.

** Survey cost estimates are based on conducting surveys with HCBS recipients only for the first two years. Additional costs will be incurred as additional target groups are added to the sample.

***This is the cost to provide statewide and regional reports based on the current system, and to design the reformed incident, reporting, investigation, and analysis system. Final annual costs for this component will depend on the design details.

State Quality Commission Resources and Costs:

The Panel recommends that the State Quality Commission operate at a staffing level equal to 1.25 full-time equivalent (FTE) professional positions and a 1.0 FTE support staff position. The professional staff level would be distributed into a range of administrative, data analysis, report writing, web-site development and analysis roles consistent with functions outlined above, roughly distributed as 0.5 FTE coordinator and liaison, 0.25 FTE webmaster, 0.25 data analyst and 0.25

FTE technical writer/analyst. The administrative assistant will arrange and manage meetings of the State Quality Commission, process travel and reimbursement requests, provide a record of the meetings, develop documents as needed, support communications with Regional Quality Councils, and other responsibilities as they arise. In addition, the Commission will need funding for quarterly, 1 ½ day meetings of the State Quality Commission members, including approximately 8 of 18 members who would be from outside the metropolitan Twin Cities. The State Quality Commission will sponsor a 1 ½ day annual meeting of the Regional Quality Councils with funding allocated for an average of 2 outside presenters. General office and meeting space, technology equipment (2 computers, 2 telephones a fax machines with a third dedicated telephone line), office furnishings and office supplies will also be required. The travel budget should include resources for the Commission Chairperson to make 2 visits to each of the Regional Quality Council meetings per year (12 trips) in addition to supporting the travel expenses of members coming to meetings from outside the metropolitan Twin Cities.

Regional Quality Council Resources and Costs:

Each Regional Quality Council should be supported at a minimum of 2.0 FTE of professional staff and 1.0 FTE of administrative and program support. The minimum professional staffing of the Regional Quality Council would be roughly distributed as 1.0 FTE coordinator and liaison, 0.2 FTE webmaster, and 0.8 FTE technical writers/analysts. Minimum staffing should be adjusted upward based on the number of individuals receiving disability services in the region, up to 3.0 FTE professional positions and 1.0 support positions in the Twin Cities metropolitan area region. The support staff members would arrange and manage meetings of the Regional Quality Councils, process travel and reimbursements, provide record of the meetings, develop documents as needed, support communications with the State Quality Commission and other Regional Quality Councils and other responsibilities as they arise. In addition, the Commission will need funding for quarterly, one day meetings of the Regional Quality Council members. The Regional Quality Councils will also sponsor a one day annual region meeting with funding allocated for an average of two out-of-region presenters. General office and meeting space, technology equipment (2 computers, 2 telephones a fax machines with a third dedicated telephone line per region), office furnishings and office supplies will also be required. The travel budget should include resources for the regional chairperson and three members to attend the annual meeting of Regional Quality Councils sponsored by the State Quality Commission. This commitment will permit: organizing Quality Regional Quality Council meetings; identifying, acquiring, developing and sharing needed resources with other Regional Quality Councils and the State Quality Commission; providing technical assistance, developing and disseminating resources to consumers, county staff members and services providers; gathering, summarizing and sharing data from the quality assurance program component with the Regional Quality Council members; developing an annual training

program based on State and Regional priorities objectives, quality assurance data and other public input; and drafting an annual Regional report on quality.

It is recommended that \$500,000 per year be divided among the 6 Regional Quality Councils to support consumer and caregiver education and training programs and materials. Such funds would be distributed by the State Quality Commission to support the priorities and activities proposed by each region with consideration to the relative size of the populations supported by the regions. It is further recommended that any the regional roles designed as part of the “outcome-based service quality review” and “incident reporting, investigation and analysis” programs be sufficiently funded so as to not detract from other of the Regional Quality Council roles and responsibilities described above.

Statewide Sample of Service Users Resources and Costs:

The Quality Assurance Panel estimates that it will take 18 months and cost approximately \$130,000 (\$65,000 in each year of the biennium) to develop, field-test and complete psychometric assessment of the *Minnesota Service Quality Assessment* instrument. We also estimate a cost of \$1,600 per year for the first two years to support an advisory committee to meet four times per year to provide advice and guidance on the survey development.

The QA Panel, upon advice of DHS, is recommending that approximately 10% of service users be sampled each year. Two years of data could be combined to analyze differences between programs or counties that are too small to have reliable data with a one year sample. The budget is based on the number of participants in the HCBS Waiver programs and does not include fee-for-service Medicaid Recipients in the first two years. Going forward, the QA Panel recommends adding fee-for-service Medicaid recipients in the targeted populations to the sample once the survey is up and running. DHS estimated that the total number of HCBS plus fee-for-service recipients in 2009 will be 33,860, in 2010 will be 35,941 and in 2011 will be 37,850. If a 10% sample of all such recipients is drawn in 2009, a total of 3,386 surveys will be needed. Of course sample size may be reduced or increased depending on the level of precision required and the budget available.

The budgeted data collection activities include interviewer training; data collection and editing; data management, analysis and summarization; and responding to requests for tailored analyses. Costs include \$75 per consumer for survey implementation (identification of interviewees, scheduling and conducting interviews, travel, editing and flow-up and transcribing interviews) and \$1.50 each for printing surveys if paper surveys are used. If computer aided interviews are used, information will be entered directly into laptop computers and no paper surveys will be needed. Ongoing costs also include 2.0 FTE data analysts and report writers to provide the analytic support to develop statewide and regional summaries and tailored analyses of the data gathered (\$176,000 during Year 1 and

\$181,289 in Year 2). The estimated total cost for this activity is expected to be \$242,600 for the development year and \$506,480 in the year the survey is fielded statewide. As additional groups are added to the sample, these costs will increase commensurately.

By way of comparison, the Department of Health contracts with a vendor from California to conduct 14,000 face to face interviews with Minnesota nursing home residents at a cost of \$650,000 per year with a \$30,000 contingency in the event that travel costs increase due to weather (additional cost for meals, lodging) during winter months. The interviews are conducted by “mature” interviewers (but not necessary health professionals) from Minnesota who are trained by the contractor to establish inter-rater reliability before being assigned cases. Nursing homes are congregate care settings so many interviews can be completed at each location. In contrast, the surveys proposed by the QA panel are for community supports in settings where 4 or fewer people live together so travel costs for each survey are anticipated to be greater than for the nursing home surveys.

Outcome Based Service Quality Review Resources and Costs:

The Quality Assurance Panel discussed recommendations regarding outcome-based service quality review. The QA Panel expects there to be a significant cost associated with this effort but it is premature to estimate the costs of this component of the new system since many details remain to be worked out regarding the overlap between the Outcome Based Service Quality Reviews and current Licensing and other monitoring processes used by the Departments of Human Services and Health. The Panel anticipates that costs for this new approach will exceed the current resources devoted to licensing because both licensed and unlicensed services will be included, and because current licensure expenditures and staffing have not kept up with growth in the number of persons with disabilities receiving publicly funded supports in Minnesota.

Incident Reporting, Investigation and Analysis Resources and Costs:

Key cost elements for the changes to the incident reporting system include the cost of improving technology to track, analyze and report information from both the outcome based service quality review process and the vulnerable adult and maltreatment of minors’ data collection systems. In addition to the technology, human resources (expertise and time) will be needed at both the state and regional levels to extract information from the data collection systems, and to analyze and evaluate that information so that needed data-based system initiatives can be created to address problems and so that the outcomes of those initiatives can be tracked. The Regional Quality Council members will be responsible for reviewing the data and creating recommendations but they will need technical assistance to do so. Expertise and time will also be needed to create public

reports describing quality outcomes at the state and regional level and to disseminate those reports in print and electronic formats.

The Quality Assurance Panel recommends that \$100,000 annually for the first two years be allocated to begin producing annual reports from existing state incident reporting, investigation and analysis activities, and to design revisions to that process to incorporate the improvements identified as needed by the Panel. These resources will support data analysis and report writing activities by Departments of Human Services and Health staff. They will also support the design of the new system.

The Panel anticipates that there will be additional expenses associated with upgrading the technology and data management systems to support the recommended improvements. Once those improvements have been made, there will also be ongoing costs associated with ensuring that the data that are generated are used to make improvements to address the identified challenges. The exact details of these ongoing costs will be identified as the final design of the revised system is articulated.

Funding Sources:

As a response to requirements of CMS to establish an effective infrastructure of quality assurance and improvement, these expenditures would be reimbursed at the Medicaid administrative rate (50% federal funds overall but an estimated 40% effective rate since the proposed activities will eventually involve services not funded through Medicaid).

Implementation and Timelines

The Quality Assurance Panel recommended that a phased approach be used to implementing the recommended changes to Minnesota's Quality Assurance and Improvement System. The QA panel recommends the State Quality Commission, the Regional Quality Councils, and the Statewide Outcome-Based Survey of Service recipients be funded and implemented beginning in 2007. The QA panel also recommends that the first phase of refining the incident reporting, investigation and analysis system be funded in this biennium. Revisions to the outcome-based quality review program should begin as soon as the Quality System Architecture Initiative completes its work and recommendations.

Furthermore, the Panel recommends that the changes to the quality assurance system begin by focusing on HCBS "waiver" services for persons ages 65 and younger with disabilities. The vision is that eventually, this system would also be applied to services funded under other funding streams including state and county funded services and other non-waiver funded services could be added as the state and Regional Quality Councils develop efficient working structures and processes. The Panel estimates that final survey development and field testing

will require approximately 18 months after which the first statewide sample can be drawn and the first full data set can be collected and analyzed.

Additional Project Reports and Resources

The Quality Assurance Panel reviewed many documents and resource materials in preparing this report. To reduce the length of this report, those documents have been compiled into a separate resource document. Those documents are available in both print and electronic formats (see www.qapanel.org). Those documents include:

- DHS Quality Assurance Panel Minnesota Key Informant Phone Interview: Summary of Results, December 2006
- Current Statewide Quality Assurance Activities by Service Type
- Overview of Regional Quality Councils: Examples from Four States
- Proposed Outcome Indicators
- A Case Study of the Massachusetts Department of Mental Retardation's Development & Implementation of Quality Councils
- DHS HCBS Waiver Compliance Review Study

Appendix A Panel Members

Panel Members

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Hennepin County Human Services/Public Health
Minnesota Home Care Association
Consumer Representative
Otter Tail County Human Services
DHS-Disability Services Division
DHS-Department of Licensing
Minnesota Department of Health
Minnesota Disability Law Center
Brain Injury Association of Minnesota
Consumer Representative – parent – Region 10
Arc of Minnesota
Ombudsman for MH/DD
Hiawatha Homes, Inc.
MS Society
Region 10 Quality Assurance Commission

Project Officer

Becky Godfrey DHS-Disability Services Division

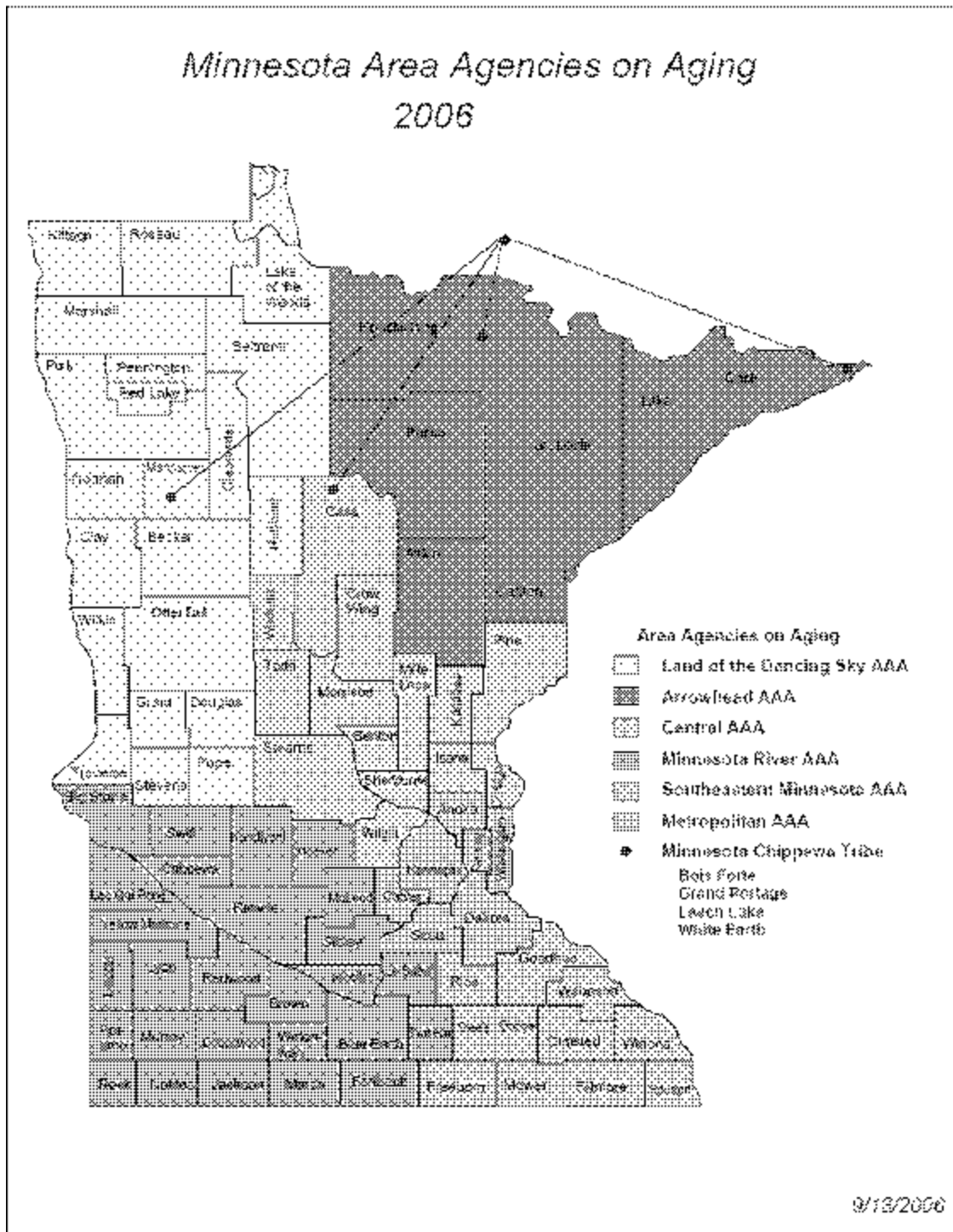
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Appendix B: Possible Regional Configuration



Appendix C: Review of Quality Assurance Efforts

The Legislature's mandate to the QA Panel included that it review current models of QA, with specific attention on local and regional models, and providing findings regarding the "best components, role and functions of such models." This report summarizes the findings of these reviews. These reviews included original data collection (focus groups, interviews, and surveys), case studies of models of interest, and collection and review of existing documents.

Status and Reforms of Quality Assurance in Minnesota

Current Quality Assurance Activities by Service Type:

The Quality Assurance Panel requested an overview of Minnesota's current publicly funded quality assurance activities to understand how the regional and local activities it was discussing fit with the overall picture. A detailed summary can be found on the project website at www.qapanel.org.

Currently, elements defining and regulating service quality are included in the (MHCP) enrollment process, the 245B license, the Department of Human Services licensing process, and several specific Department of Health licenses, registrations and certifications. Quality assurance also depends on county regulation of services at the provider level through county licensing, county contracts and county purchase agreements. Counties focus specifically on the quality of supports provided to individuals through service agreements and plans, case management activities, targeted and public health nursing, and service plans. Individual provider quality standards are evident in professional and paraprofessional degrees, licenses, certifications and registrations, other credential, and background study requirements. A complaint and incident reporting system exists to handle licensing complaints, critical incident reports, and reports of alleged maltreatment. Due process safeguards are built in to each of the various design elements to ensure that the legal rights of system participants are protected.

Remediation efforts include correction orders, order of conditional licensing, sanctions such as suspension or revocation of a license, fines, or injunctions against the continued operation of a program, and informal problem solving efforts by case managers and other county staff to address problems, and more formal processes involving termination or non-renewal of contracts or purchase agreements. Separate remediation processes exist for the incident reporting system and for the background study process.

Publicly funded advocacy is provided by the Ombudsman offices, the Minnesota Disability Law Center, and various appointed Councils and Committees, and units in the Department of Human Services. Licensing activities focus on discovering non-compliance with rules and issuing orders of corrections. County activity focuses on establishing contracts, licenses or purchase agreements, monitoring adherence to those contracts, and responding to problems on an individual and

agency basis. In their aggregate, however, these programs provided extremely limited attention to the system performance analyses and improvement expectations of the Quality Framework.

Minnesota's crisis
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Division of
Licensing....
Quality assurance
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While each aspect of quality assurance in Minnesota has a valid foundation in a specific concern about one or more target populations, the sum total of these various aspects is a disjointed and often dysfunctional impediment to the specific outcomes desired by people with disabilities, and the required attention to such outcomes articulated in the CMS Quality Framework. The Panel noted that despite undeniable commitment and skill, staff of the Division of Licensing has not received resources sufficient to adequately respond to the rapid growth in service recipients and even more notably service settings. Clearly, Minnesota's quality assurance and improvement crisis in cannot be solved by placing ever more responsibilities of a Division of Licensing that is understaffed, under-funded and under-valued. Quality assurance must be redesigned.

DHS HCBS Waiver Compliance Review Study:

The DHS HCBS Waiver Compliance Review Study was designed to support the assurances that DHS makes to the Centers for Medicare and Medicaid (CMS) about Home and Community-based Services (HCBS) under five waivers (EW, CAC, CADI, TBI, and MR/RC) and the Alternative Care program. DHS is using the program to both monitor compliance with state and federal regulations and identify successful practices that improve the quality of services to HCBS participants. The waiver review process employs seven methods for collecting data to substantiate the States' assurances: 1) Participant case files; 2) contracts held by the county for services; 3) policies developed by the county to guide it in administering the HCBS programs; 4) a survey instrument completed by county staff; 5) interviews with administrative and supervisory staff; 6) a focus group of staff working across the six HCBS programs, and 7) county operational indicators developing using state data. Information and data collected during the reviews are analyzed and used to prepare a report for each lead agency. Reports include feedback about promising practices, program strengths and areas needing improvement. Further summary of the Waiver Review Project can be found on the project website at www.qapanel.org.

Local Quality Assurance Models (County Interviews):

Interviews were conducted in fall 2006 with 30 officials from 14 counties regarding county quality assurance strategies and their perceptions of the current status and effectiveness of quality assurance in Minnesota. Participants represented 4 metropolitan 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, and Goodhue). Interviews were conducted either face-to-face or by telephone. Particular attention was paid to county models in places where more comprehensive quality initiatives were underway. In Hennepin County, for example, an annual consumer survey is being used across all populations served to assist the county in gathering information about quality. The contents of that survey were reviewed as the QA Panel worked on recommendations for the statewide survey. In addition, the panel heard

directly from Hennepin County staff about the elements of their quality assurance model.

Highlights of the county interviews are summarized below. They are categorized under the CMS Quality Framework headings of discovery, remediation and improvement. The findings are reported in greater detail on the project website at www.qapanel.org.

Discovery

- Consumer satisfaction surveys 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 CAC/CADI/TBI (CCT) funded services);
- Licensing and contracting practices ranged from very informal to comprehensive and structured practices;
- There is limited effort to measure individual outcomes in most counties;
- Counties assume providers holding 245B licenses are qualified by virtue of the license. Few have additional mechanisms to monitor qualifications;
- 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.

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;
- Remediation is viewed 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 often through a county case manager or team.

Improvement

- Some counties described well developed systems including using formal gaps analysis for identifying unmet needs and developing new services, other counties expressed passive and powerless roles in service development and 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 opportunities to expand services;

- County efforts to increase knowledge of effective practices varied considerably;
- 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;
- 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.

Critical Incident Reporting System

- 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 counties respondents noted that they felt complaints were not taken seriously by the state which then discouraged further reporting;
- Many respondents noted that communication between various parts of the system was not working well.

Managed Care

- There was a great deal of uncertainty about quality assurance roles and responsibilities being under-managed for services provided by managed care entities. 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;”
 - “Who is responsible for QA for long term care for people in managed care? Anytime services are operating across counties or across payers, QA is a challenge;”
 - “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 just don’t know where to go to get our questions answered.”

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 noted the importance of timeliness, clarity and specificity of information provided to counties especially about major changes in quality assurance. They requested an improved flow of information about quality definitions, designs and expectations, access to tools with which to do their own quality assurance work, improved training on new initiatives prior to implementation, including video conferencing, in person training, and technical support, and a more integrated relationship with activities and expectations emerging within DHS;

- Consumers and families involvement in quality assurance activities, with some respondents noting that regionalizing quality assurance activities would facilitate this;
- Assistance with survey and interviewing tools and strategies for assessing individual and provider outcomes, with several respondents noting a lack of internal resources to develop good instruments and others noting the general benefits of standard instruments that could be used across counties;
- DHS service, satisfaction and consumer outcome data should be translated into meaningful reports that counties and consumers can use to make decisions;
- Additional resources for quality assurance activities, to address specific quality challenges such as staff turnover, to support people whose needs were particularly expensive to meet, and methods and incentives to provide increased choices for consumers;
- Standardizing various components of the system across waiver groups and populations including care plans, satisfaction surveys, provider contracts, service rates, service menus, assessment instruments and procedures, and quality standards.

Related Minnesota Quality Study Groups

Quality assurance in Minnesota depends on a licensing program for HCBS and other community support that has become and increasingly complicated web of rules...

Minnesota’s current approaches and resources for quality assurance fall far short of the new national standards and the basic criteria identified by the Panel. Quality assurance in Minnesota depends largely on licensing programs for HCBS and other community supports that have become an increasingly complicated web of rules that are different for different services and settings with relatively little concurrence with the areas and functions of the Quality Framework or the criteria for a contemporary quality assurance program. Furthermore, many supports paid for by state and federal funds are provided by unlicensed individuals or organizations.

2003 Quality Design Commission:

The 2003 Quality Design Commission: “A long-term care system serving Minnesotans that provides high quality care...provides objective performance assessment, timely and appropriate response to consumer complaints and protection of rights.”

As part of its Real Choices System Change grant from CMS, the Department of Human Services created a Quality Design Commission. In 2003 that report issued by the Commission called for significant modernization of Minnesota’s present system of quality assurance that was informative to and consistent with the discussions of the Quality Assurance Panel. The Commission reported:

We envision a long-term care system serving Minnesotans that provides high quality care. Such a system:

- *Ensures reasonable access, high quality and affordable care;*
- *Rewards good outcomes for both excellent performance and improvements in performance;*

- *Provides protections for the vulnerable including those lacking a family and those unable to make decisions; and*
- *Provides objective performance assessment, timely and appropriate response to consumer complaints and protection of consumer rights.*

The Quality Design Commission further observed that:

The 2003 Quality Design Commission: “The [Quality] Framework comes during difficult economic times... [but] the Commission is adamant in its support of the forces of quality assurance in the face of these challenges.”

“Quality assurance saves money in the long term: Businesses have known for some time that investing in up front quality assurance saves money in the long run. The tradition of reacting to problems, punishing providers for non-compliance is expensive and outdated....”

“A Consumer-driven Quality Assurance System helps to set priorities within limited resources. The Commission acknowledged that discussion of the [CMS Quality] framework comes during difficult economic times and budget crises... The Commission is adamant in its support of the focus on quality assurance in the face of these challenges.”

“Information and Advocacy is essential: Many individuals navigating the human services system need advocacy and assistance. It is important that people have access to individual advocacy services that are not county-based.”

Residential Services Innovations Retreat:

In October 2006, the Department of Human Services sponsored a retreat involving 80 stakeholders from roles service delivery, state and county government, advocacy, and service use to examine barriers in access to high quality residential supports for persons with disabilities. Participants in that retreat recognized the current systems of licensing and quality review as a major impediment to achieving high quality, person-centered services. They called for major reform of the quality assurance system, recommending specifically that the Department of Human Services:

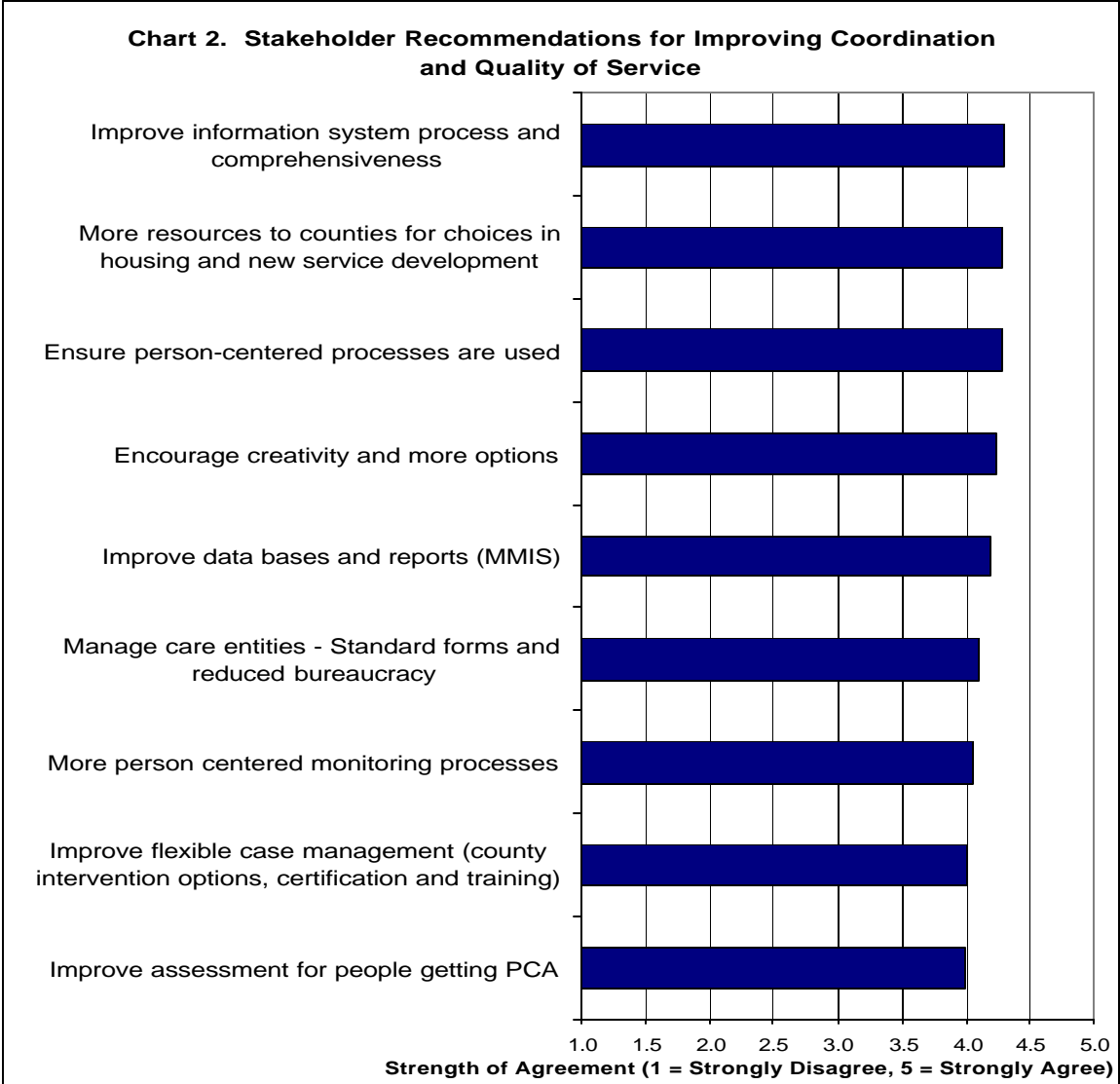
- *Assign to the Disability Service Division the responsibility of designing with stakeholders a new approach to licensing/quality assurance that establishes individual outcomes (including health and safety) and quality of life as a primary focus of licensing/quality assurance programs and risk management (to increase freedom and responsibility);*
- *Replace regulatory framework with a regional model that engages community stakeholders, people with disabilities and the people selected by persons with disabilities in a program focused on effectiveness in achieving outcomes and in which quality assurance findings “bubble up” to initiatives to improve services (“to build healthier communities and facilitate full citizenship”).*

Case Management Reform Study:

As the QA Panel was conducting its reviews, another state study was focused on case management practices and possible references. This study included focus groups involving 245 Minnesotans examining ways to improve the coordination

and quality of services for persons with disabilities. These focus groups involved a range of stakeholders, but primarily case managers (41%) and other county officials (16%). Key themes from interviews with county officials about case management reforms were identified and given to the participants in the form of a questionnaire. Participants were asked to rate the focus group recommendations for their strength of agreement on a five-point scale. Figure 4 presents the 8 items out of 22 total that had an average rating of greater than 4.0 (agree) by the strength of stakeholder agreement. These items fit into major categories:

- *Improved amounts, quality and of useable information and data;*
- *Increased support for more and more creative options; and*
- *More person-centered (less bureaucratic) focus in support monitoring and service development.*



A second set of focus groups were conducted in November 2006 in four locations (Duluth, New Ulm, St. Cloud, and Richfield). A total of 172 people participated including 11 consumers and family members, 110 county representatives, 34 providers and 17 advocates, and other stakeholders. Participants discussed a series of reforms that were supported by the focus groups in the first round and were of interest to the Department of Human Services (systems coordination, increased individualization, choice of case manager, and regionalization including functions such as contracting, licensing, and quality assurance). The following questions were used to prompt further discussion:

- How can we effectively engage consumers, families and community members in local and regional quality assurance and improvement efforts?
- If Minnesota created regional quality councils, what functions should those councils perform?
 - Review regional data on quality outcomes for individuals;
 - Review regional licensing, VA, maltreatment and incident reporting outcomes; and
 - Establish regional quality improvement targets and develop and implement strategies to achieve goals.
- What kinds of people should be represented on local or regional quality councils?

Comments related to regionalization made by the 17 discussion groups are summarized here.

Benefits: Focus group participants identified a variety of potential benefits of regionalizing some or all of the quality assurance functions under discussion. Among those benefits were that regionalizing efforts could save time and money where counties are currently duplicating efforts and could coordinate their efforts. Participants also identified the potential advantages of increased choice of case managers, improved relationships with providers, and improved monitoring of providers who serve in multiple counties. Specific benefits were identified related to activities in which Regional Quality Councils might engage. For example, Regional Quality Councils could pool resources for scarce services: medical, dental, psychiatry, mental health, crisis supports; pool training for county staff and for providers, families and consumers; or use common contracting language across participating counties. Participants noted that regional collaboration could offer increased opportunity for staff to have peer mentors on best practices in QA. Finally participants noted that regional efforts could increase the objectivity of quality reviews, help maintain or improve quality, particularly in smaller counties, and increase uniformity in measurement, licensing and oversight.

Concerns: Participants identified a variety of concerns that would need to be worked out as regional efforts were developed. Those concerns included logistical issues such as wondering how the regions would be constructed (both

geographic and population density), concern that specific staff would be needed to support the functions of the regional group and concern that resources be available to support specific regional QA activities such as conducting surveys or other reviews, concern about how legal questions such as joint powers would be handled, and questions about how risk and liability would be addressed. Other concerns included a desire to be sure that regional efforts reduce not add to the layers of bureaucracy and mandates counties currently manage. Finally, practical issues included clarity of roles for various participants, concern that local quality monitoring efforts continue, that turf issues are handled sensitively, and that negotiations could be successfully completed to establish and sustain the regional efforts.

Recommendations: Participants made recommendations about possible tasks or activities of regional quality groups, how regional quality activities might be organized or structured, and about what types of participants should be involved in regional quality activities. Focus group participants identified a wide range of tasks that regional quality groups could work together. Topics included: contracting, licensing, monitoring unlicensed services and providers, using resources, rate setting, assessing individual outcomes, monitoring provider outcomes, quality assurance, reviewing incident reports and vulnerable adult issues and trends, establishing and monitoring quality improvement targets, monitoring service availability and building provider capacity in new program areas, crisis prevention and response, waiver management, provider development, training for individuals, providers and county staff. Some groups were very interested in having regional quality groups manage licensing functions while others were more interested in having the regional groups focus more on quality improvement initiatives. Participants recommended that broad stakeholder input be used to identify the functions of the regional quality councils.

Participants made recommendations about how regionalized quality efforts might be done. Many recommendations focused on how to involve consumers and families the efforts. For example, participants recommended that meetings are held in community settings, that transportation, food and child care be provided to allow families to participate and that participants be trained to be culturally competent. Participants also emphasized the need to engage local community members – faith communities, employers, and neighbors. Participants recommended that regional efforts need to have good data (from state, county and provider sources), promote best practices, look at outcomes for individuals, have authority to implement any mandated activities they are responsible to complete, have access to lead agency staff (e.g., licensing, Department of Health, and County staff), have access to an effective technological support system, and have effective communication between counties, regions, state and other stakeholders.

Finally, participants listed a variety of stakeholder groups they thought should be invited to participate in regional quality efforts. They recommended that the composition reflect the region's cultural make up and size, and have some interaction with a statewide group. Specific participants mentioned included consumers, families, advocates, providers, licensors, county staff such as

managers, supervisors, case managers, adult protection, contract managers, licensors), professionals (such as psychologists), teachers, community members, state staff. One group suggested that the group include no more than 15 people, but others suggested that work groups accountable to the larger group could be formed around specific functions (such as vulnerable adult issues).

Local and Regional Quality Assurance Models

A specific mandate of the Legislature to the QA Panel was to review regional and local quality assurance models and to make recommendations regarding best components, role and function of such models. To fulfill this commitment the QA Panel identified and reviewed regional models in Minnesota and in four other states. Minnesota has only one regional quality assurance program, the Region 10 Quality Assurance Commission. The Panel received information directly from Region 10 participants as well as from focus groups and surveys of Region 10 participants. In addition, Panel members received case studies and associated program descriptions from the states of Massachusetts, Florida, Tennessee and Nevada which employ regional quality assurance models. Our review of local quality assurance models is summarized above in the county interview section of this report.

Local and Regional Models in Other States:

The Panel reviewed information about regional quality assurance models in Nevada, Tennessee, Florida and Massachusetts through presentations, case studies and interviews with state officials. A brief summary of key features of these is provided on the project website at www.qapanel.org. After reviewing the models the Panel found the Massachusetts model of particular relevance to the mandate to the Panel and the specific challenges in responding to CMS expectations. The Massachusetts model was particularly well documented in manuals and reports.

The Massachusetts' Office of Mental Retardation has made a substantial investment in its quality assurance system. Although most of this work was completed well before the CMS Quality Framework was developed, the Massachusetts system is quite consistent with the Framework. Among the relevant important features of the Massachusetts Quality Assurance system were the following:

- 1) Regional management of quality assurance reviews and analysis of outcomes data;
- 2) A quality assurance review program with primary focus on individual outcomes and experiences of a sample of persons being served as the basis of licensing decisions;
- 3) A statewide survey of a substantial sample of all service recipients, including these in community and institutional services settings, to permit statistical analysis of the characteristics, service types and settings, outcomes and

experiences and variations in outcomes and experiences associated with differences in individual characteristics and service types and settings;

- 4) A comprehensive public report of the status, trends, achievements and challenges faced by the state in providing services with the desired outcomes to service recipients;
- 5) Analysis and use of data derived from quality review, incident reporting, and statewide surveys to generate service improvement priorities on both the state and regional levels.

A detailed description of the Massachusetts model can be found on the project website at www.qapanel.org.

Challenges in Applying the Massachusetts Model in Minnesota:

Although the primary features observed in Massachusetts were considered important components of a high quality, regionally-based quality assurance and improvement system, the Panel recognized that Minnesota faces a number of additional challenges in designing its system. These include:

- 1) **Minnesota's commitment to a broad disability rather than categorical approach to services:** Reaching consensus on outcomes of importance to all persons with disabilities is more difficult than doing so categorically. Although the QA Panel has recommended adoption of a model similar to that in Massachusetts, it recognizes that the Massachusetts program of interest was designed for their developmental disabilities services. Other state models examined were also categorical in nature;
- 2) **Minnesota currently invests far less than will be needed to reform quality assurance in a manner consistent with expectations:** Minnesota's investment in quality assurance and improvement must be increased. Each of Massachusetts regions has a well-developed staff complement of professionals dedicated to management of a regional quality assurance program; and
- 3) **The capacities within different areas of Minnesota to manage a quality assurance and improvement system vary from region-to-region:** Different regions in Minnesota have different foundational resources with which to manage substantial reforms.

Minnesota's Region 10 QA Commission:

Region 10 (Southeast Minnesota) is the only area in Minnesota in which a quality-assurance and improvement system is operating a regional model. The Region 10 Quality Assurance Commission model is based on participant outcomes and satisfaction, with a significant focus on quality improvement. The Region 10 Quality Assurance Commission fulfills responsibilities for licensing of services for persons with developmental disabilities that would otherwise be carried out by the DHS Division of Licensing. In conducting its licensing/quality

In addition to licensing functions the Region 10 review focuses on gathering information that can be used to improve the lives of individuals....

assurance program the Region 10 Quality Assurance Commission developed its own outcome-based program review and licensing standards and interview protocol, called VOICE, which is implemented by teams of stakeholders including county and state staff, service providers, service recipients, family members and other community members. Region 10 has its own mostly outcome based Standards of Quality that replaces the Consolidated Standards. In addition to licensing functions the Region 10 review gathers information that can be used to improve the lives of individuals who are sampled for the licensing reviews. Results of the quality reviews are used in developing an agenda for both organizational and region-wide quality improvement. Because of CMS pressure to develop an outcome based system and because of the Legislature’s interest in regionally-based models extensive review was conducted of the Region 10 model.

One of the important aspects of quality assurance from the perspective of Region 10 participants is its capacity to change people’s lives.

Focus Groups of Region 10 Stakeholders: Two focus groups were conducted by John O’Brien, a consultant to the University of Minnesota, with Region 10 stakeholders. One involved service provider managers and county officials; another involved persons with disabilities, family members and direct support providers. Major themes of the focus groups included the distinctions between the Region 10 quality assurance review and traditional licensing reviews (i.e., the types of reviews experienced prior to implementing the Region 10 model). These distinctions about traditional quality assurance and personal outcome-based quality assurance are summarized in Chart 3 (developed by John O’Brien).

Chart 3. Region 10 Stakeholder Perspectives on Traditional and Personal Outcome-Based Quality Reviews

Traditional QA Reviews	Personal Outcome-Based Reviews
Focus on programs	Focus on individual person
Quality defined as characteristics of a program by a distant bureaucratic authority	Quality defined by person and those who know the person
Separate inspections of day, residential and other services at different times.	Looks at the person’s whole life and the contribution each service makes to quality
Most attention on compliance with rules and correcting deficiencies defined by rules	Attention to facilitating a person’s wants and dreams.
Parents, family members, friends have little if any voice in judging quality.	Process facilitates person, family, and friends in defining and judging quality.
Focus on compliance with standards	Focus on action to move toward what the person wants in their life
Many standards judged by adequacy of documentation using professional language (e.g., “completes objective 3 times out of 5”)	Quality judged by match between what person wants and what person gets or does; expressed in ordinary language.
Information gathered and shared in abstract, bureaucratic form.	Information gathered and shared in a form and in language the person can use to communicate with others if they choose.

Outcome-Based Reviews: Increasing a person’s control of their own life is a primary purpose.

Chart 3. Region 10 Stakeholder Perspectives on Traditional and Personal Outcome-Based Quality Reviews

Traditional QA Reviews	Personal Outcome-Based Reviews
Quality is responsibility of system and service provider	Quality is responsibility of the Quality Circle (those with investment and/or responsibility in the person’s well-being).
Process and standards set and revised centrally. No routine feedback on the process from those inspected.	Process designed and continually improved by regionally responsible group. Regular feedback from focus people and Quality Circles.
Little concern for the degree of control a person has in their life	Increasing a person’s control of their own life is a primary purpose
Process is prescriptive: Demonstrate compliance or you will loose your license.	Process is creative: Here are things to figure out that will make this person’s life better.”

... participants view their outcome-based process to have the capacity to change people’s lives.

The capacity to nurture community engagement through regional opportunities to learn, identify challenges and to grow in a sense of influence and shared commitment is viewed as important role and function of a regional approach.

At the conclusion of the focus groups, O’Brien developed general observations about the Region 10 participants and their perceptions of the Region 10 process. These included:

- Region 10 participants view their outcomes-based process to have the capacity to change people’s lives;
- Participants reported that the person-centered approach allowed people in the Quality Circle to learn more about the person and what would make a difference in their life;
- Participants reported that the Region 10 model changed not only policy, but relationships and attitudes in the counties in which it operates. One service coordinator said, “Voice has changed the way we think. We no longer use language that separates people into professionals, who have the knowledge and others, who have no authority to speak because they can’t use professional terms;”
- Region 10 participants feel that it is important that process was developed by a regional stakeholder group. It is viewed as important that the values on which the program was built are the values that emerged from the community and the work of the stakeholder group;
- Community ownership is perceived as important and achievable only through supporting the community to take responsibility for defining quality and acting to improve quality. The capacity to nurture community engagement through regional opportunities to learn, identify challenges and to grow in a sense of influence and shared commitment is viewed as important role and function of a regional approach; and
- Focus group participants emphasized the importance of quality assurance as a continual process of improvement, not merely a periodic inspection.

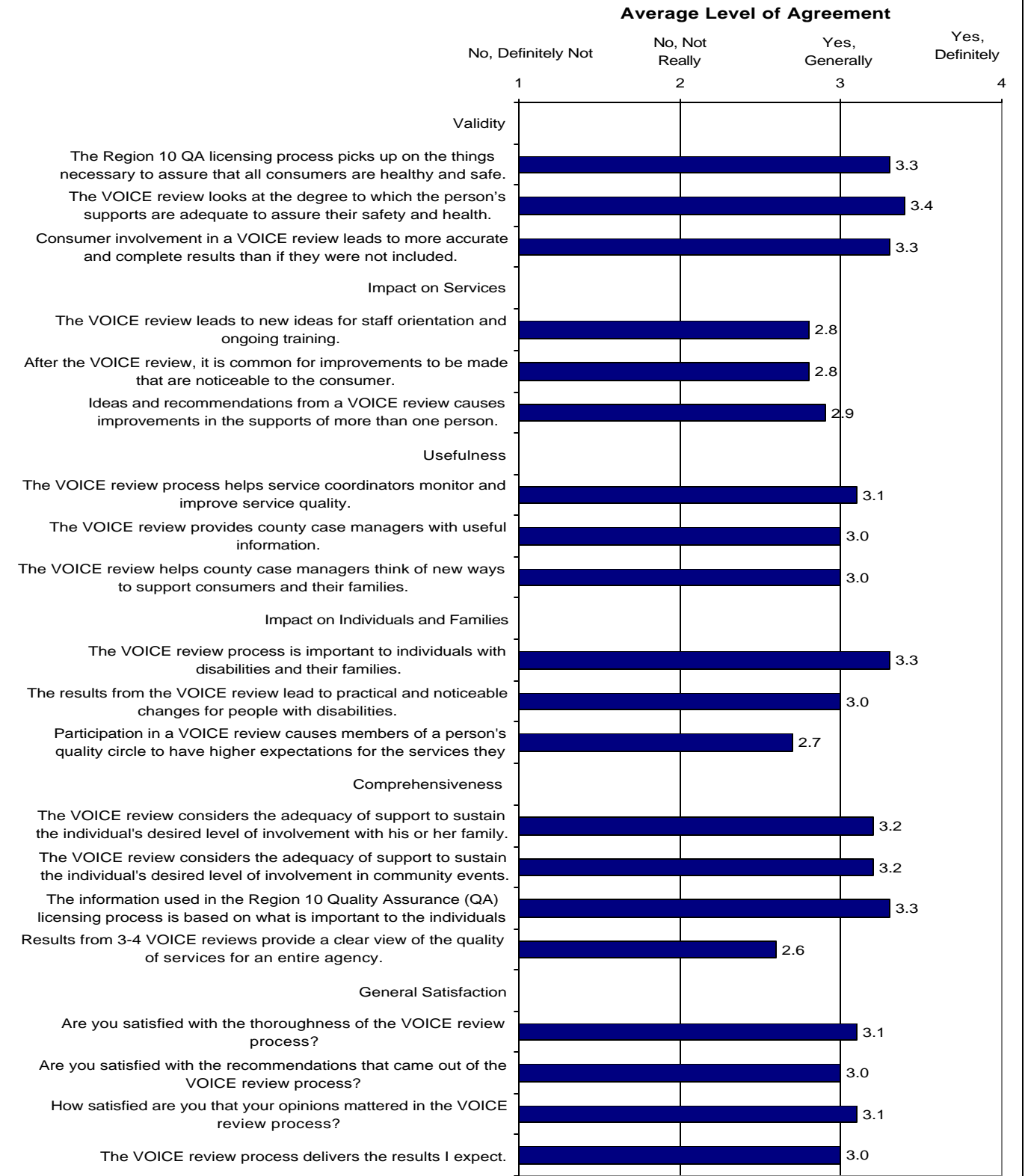
Surveys of Region 10 Stakeholders: Based on the observations focus group participants a set of questionnaires was developed to survey stakeholders in the Region 10 (Southeast) area of Minnesota. Questions of importance to evaluating the benefits and development challenges of outcome-based, regional quality assurance programs were included. The survey was mailed to samples of individuals representing 3 groups of stakeholders: 1) persons with disabilities and family members; 2) direct support and administrative service providers and advocates; and 3) county service coordinators and other officials. A total of 168 surveys were distributed to stakeholders in 5 Region 10 counties participating in the Quality Commission. Distribution was managed according to sampling instructions provided to county agencies. A total of 93 (55%) of the distributed questionnaires were returned. Overall, participants rated the quality of the Region 10 review process as 4.9 on a scale of 1 (very poor) to 6 (excellent). Chart 4 presents a summary of key findings from these stakeholder surveys.

Stakeholders participating in the Region 10 Quality Assurance program and its outcome-based VOICE preview process express high levels of support. Ratings of greater than 3.0 (between generally agree and definitely agree) were noted for:

- The process picking up on things necessary to assure health and safety;
- The process being based on sound information;
- People who know the person best providing the information for the review;
- Providing service cording useful information and information helpful in improving services;
- Providing family members with information to help them evaluate the quality of services;
- Gathering information in the licensing process that is useful to the individuals being served; and
- Encouraging support team members to become more active in people's lives.

Participants rated the overall quality of the review process as 4.9 on a 5 point scale. Lower ratings were given for: 1) whether conducting the reviews on a sample of 3 or 4 individuals per service providing agency is sufficient for making a licensing decision (2.6); and 2) whether the process leads a person's quality circle to increase expectations for services (2.7).

Chart 4: Responses of Key Informants Regarding the Regional Quality Assurance in the Five Counties Participating in the Region 10 Quality Assurance Commission Program



Appendix D: Proposed Legislation

02-14-07

Section 1 [256B.xxx] State and Regional Quality 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, a statewide quality assurance and improvement system for Minnesotans receiving disability services is established. The disability services included are the home and community based services waiver programs for persons with developmental disabilities, traumatic brain injury, and for those who qualify for nursing facility or hospital levels of care under 256B.092 subdivision xx and 256B.49; home care services under 256B.0651; Family Support Grant under 256.32; Consumer Support Grant under 256.476; and Semi-Independent Living Services under 256.275. The statewide quality assurance and improvement system shall include a state quality commission, six regional quality councils, an outcome based quality review component and a comprehensive system for effective incident reporting, investigation, analysis and follow-up.

Subdivision 2. **State Quality Commission.** The commissioner shall appoint the members of the State Quality Commission including representatives from the following groups: disability service recipients, at least one member from each Regional Quality Council, disability service providers, disability advocacy groups, county human service agencies and state agency staff from human services, health and ombudsman for mental health and developmental disabilities. The State Quality Commission shall assist the departments of human services and health in fulfilling federally-mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota; establishing state quality improvement priorities with methods for achieving results and providing an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities and activities undertaken by the commission during the previous state fiscal year.

Subdivision 3. **Regional Quality Councils.** a. The commissioner shall establish six Regional Quality Councils of key stakeholders including regional representatives of disability service recipients, disability service providers, disability advocacy groups, county government, and state agency regional staff from human services, health and ombudsman for mental health and developmental disabilities.

b. The regional councils shall:

- (1) direct and monitor outcome-based quality assurance programs,
- (2) analyze and review quality outcomes and critical incident data,
- (3) provide information and training programs for persons with disabilities, including service recipients and their caregivers, on service options and quality expectations,
- (4) disseminate information and resources developed to other Regional Quality Councils,
- (5) respond to state level priorities and
- (6) establish regional priorities for quality improvement,
- (7) submit an annual report to the State Quality Commission on the status, outcomes and improvement priorities and activities in the Region,
- (8) choose a representative to participate on the State Quality Commission and assume other responsibilities consistent with the priorities of the State Quality Commission.

c. The regional councils shall maintain staff and manage resources needed, consistent with funding and direction from the commissioner and the state quality commission.

Subdivision 4. **Annual Survey of Service Recipients.** The commissioner, in consultation with the State Quality Commission shall conduct an annual independent statewide survey of service recipients, randomly selected, 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 (CMS) Quality Framework and analyze whether desired outcomes for persons with different demographic, diagnostic, health and functional needs, receiving different types services, in different settings, with different costs have been achieved. Annual statewide and regional reports of the results will be published and used to assist regions, counties and providers to plan and measure the impact of quality improvement activities.

Subdivision 5. **Outcome-Based Quality Review.** The state commission shall designate an outcome-based quality review program to assure that quality assessment and licensing practices

are founded on valid, reliable assessments in areas consistent with the CMS Quality Framework. The outcome-based quality assessment program for service quality monitoring will include both licensed and unlicensed services. It shall include outcome-based interviews of a sufficient sample of individuals and caregivers served by an agency to provide reliable information with which can be used to determine the level of service quality, issue program licenses as needed, recommend remedial activities, and inform the need for general and specific training, technical assistance, consumer education, and other service improvement activities. The assessment and review program can be used by regional councils for an alternative quality assurance program should counties in a region seek to develop an alternative to the state licensing system pursuant to the process established in 256B.095 through 256B.0955.

Subdivision 6. Incident Reporting, Investigation, Analysis and Follow-up Improvements.

The commissioner shall improve the system of incident reporting, including reports made under the Maltreatment of Minors and Vulnerable Adults Acts, investigation, analysis, and follow-up for disability services to assure that incidents that may have jeopardized safety, health, civil and human rights, service-related assurances, and other protections of disability service recipients to be free from abuse, neglect and exploitation are reviewed, investigated, acted upon in a timely manner. Information, data and analysis from the reporting system shall be used at the provider, county and regional levels to improve services for recipients and shall be provided in a standardized format on a regular basis to Regional Quality Councils, State Quality Commission and appropriate State and County agencies.

Sec. 2. **Effective Date.** Subdivisions 1 through 6 are effective July 1, 2007 subject to the following phased implementation:

- (a) the State Quality Commission shall be established by July 1, 2007,
- (b) the six Regional Quality Councils shall be established by January 1, 2008 and will begin assisting with the statewide interviews of service recipients in their regions when those surveys are fielded statewide.
- (d) the statewide survey of service recipients shall be developed beginning July 1, 2007 and field-tested during 2008 with implementation beginning on or before January 1, 2009
- (f) the outcome-based quality review process shall be designed and implemented based on the work of the State Quality Commission and Regional Quality Councils, information from the

statewide service user survey and the incident reporting data, as funding allows after July 1, 2009.

(g) Improvements in the incident reporting, analysis and data systems shall begin July, 2007, with the development of public reports from existing data. A work group will develop, design and make recommendations for the remaining improvements needed by December, 2008.

Sec. 3. Appropriations.

(a) -----shall be appropriated from the general fund to the commissioner of human services for the fiscal year ending June 30, 2008, to develop and establish the Quality Assurance and Improvement System according to the schedule set forth in Section 2.

(b) Beginning July 1, 2008, \$ million from the general fund shall be appropriated to the commissioner of human services each year for the implementation of the Quality Assurance and Improvement System and added to the base budget for the department. Federal Medicaid match obtained for this function shall be dedicated to the commissioner for this purpose.

Appendix E: Cost Estimates for First Two Years

Table 1: Summary of Estimated Costs of Recommended Quality Assurance and Improvement Reforms

System Reform Component	Annual FTE/Rate/Amount	Estimated Expenditures	
		Year 1	Year 2
State Quality Commission			
Personnel (including fringe)			
Professional positions	1.25	\$ 110,000	\$ 113,300
Support positions	1	\$ 50,000	\$ 51,500
Quarterly Meeting expenses (food, room rental, equipment rental x 1.5 days)	18 participants x 4 meetings	\$ 3,800	\$ 3,800
Statewide meeting with regions (food, room rental, equipment rental x 1.5 days)	42 participants	\$ 2,300	\$ 2,300
<u>In-state Travel</u>			
Mileage	46 trips *100 miles @ \$0.48 per mile	\$ 2,208	\$ 2,208
Hotel and Meals in St. Paul	46 nights @ \$150 each	\$ 6,900	\$ 6,900
Office: rent, equipment, supplies	\$26,850 per FTE in Year 1, \$16,850 per FTE ongoing	\$ 60,413	\$ 37,913
Consultants/outside trainers	4 days @ \$1000/day + expenses	<u>\$ 6,000</u>	<u>\$ 6,000</u>
Subtotal		\$ 241,621	\$ 223,921
Regional Quality Councils (6) *			
Personnel (including fringe)			
Professional positions	13	\$1,144,000	\$1,178,320
Support positions	6	\$ 300,000	\$ 309,000
Quarterly Meeting expenses (food, room rental, equipment rental for 1 day)	18 participants x 4 meetings x 6 regions	\$ 10,800	\$ 10,800
Regional quality conference (food, room rental, equipment rental)	1.5 days x 50 participants x 6 regions	\$ 16,200	\$ 16,200
<u>In-state Travel to state conference</u>			
Mileage	24 trips *100 miles @ \$0.48 per mile	\$ 1,152	\$ 1,152
Hotel and Meals in St. Paul	24 nights @ \$150 each	\$ 3,600	\$ 3,600
Office: rent, equipment, supplies	\$26,850 per FTE in Year 1, \$16,850 per FTE ongoing	\$ 402,750	\$ 252,750
Consultants/outside trainers	4 days @ \$1000/day + expenses * 6	\$ 36,000	\$ 36,000
Consumer and Caregiver Education, Training, and Priority Quality Initiatives		<u>\$ 500,000</u>	<u>\$ 500,000</u>
Subtotal		\$2,414,502	\$2,307,822
Statewide Survey and Analysis			
Survey support (interviewer training, data collection and editing, data management, analysis, summaries, and regional reports)	2	\$ 176,000	\$ 181,280
Meeting expenses (food, room rental, equipment rental)	(4) 3 hour advisory committee meetings	\$ 1,600	\$ 1,600
Survey printing/Computer software	3,400 surveys x \$1.50		\$ 5,100
Contract interviewers (10% sample)	\$75 x 3,400 surveys		\$ 255,000
Contracted survey development and field testing	\$65,000 per year for 2 years	<u>\$ 65,000</u>	<u>\$ 65,000</u>
Subtotal		\$ 242,600	\$ 506,480
Outcome-Based Service Quality Review**		-	-
Incident Reporting, Investigation, Analysis**		Design Implementation Plan	\$ 100,000
Total ***		\$2,898,723	\$3,138,223

*Year 1 costs will be lower if the Regional Quality Councils do not all start in July of 2007. **These estimates do not include regional level outcome based service quality review and ongoing incident reporting, investigation and analysis activities. ***40% of costs would be reimbursed by the Federal government as a Medicaid administrative expense based on the proportion of program recipients who are Medicaid beneficiaries.