

# Home and Community-Based Service Quality Outcome Standards

Disability Services Division

September 2012



## Quality Outcome Standards: A Report to the Minnesota Legislature

For more information, contact:

Minnesota Department of Human Services

Disability Services Division

P.O. Box 64967

St. Paul, MN 55164-0967

(651) 431-2400

This information is available in other forms  
(such as Braille, large print or audio) by calling:

(651) 431-2400

Or contact us through the Minnesota Relay Service at:

(800) 627-3529 (TTY)

(877) 627-3848 (speech-to-speech relay service)

The estimated cost of preparing this report is approximately \$1500.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

**The Quality Outcome Standards Legislation**

---

Sec.24. Minnesota Laws 2009, chapter 79, article 8, section 81, is amended to read:

**Sec.81. ESTABLISHING A SINGLE SET OF STANDARDS.**

(a) The commissioner of human services shall consult with disability service providers, advocates, counties, and consumer families to develop a single set of standards, to be referred to as "quality outcome standards," governing services for people with disabilities receiving services under the home and community-based waiver services program to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the psychotropic medication checklist. The standards must:

- (1) enable optimum consumer choice;
- (2) be consumer driven;
- (3) link services to individual needs and life goals;
- (4) be based on quality assurance and individual outcomes;
- (5) utilize the people closest to the recipient, who may include family, friends, and health and service providers, in conjunction with the recipient's risk management plan to assist the recipient or the recipient's guardian in making decisions that meet the recipient's needs in a cost-effective manner and assure the recipient's health and safety;
- (6) utilize person-centered planning; and
- (7) maximize federal financial participation.

(b) The commissioner may consult with existing stakeholder groups convened under the commissioner's authority, including the home and community-based expert services panel established by the commissioner in 2008, to meet all or some of the requirements of this section.

(c) The commissioner shall provide the reports and plans required by this section to the legislative committees and budget divisions with jurisdiction over health and human services policy and finance by January 15, 2012.

# Quality Outcome Standards: A Report to the Minnesota Legislature

## Table of Contents

---

<b>The Quality Outcome Standards Legislation .....</b>	<b>3</b>
<b>Executive Summary .....</b>	<b>6</b>
<b>I. Purpose of Report.....</b>	<b>9</b>
<b>II. Background.....</b>	<b>9</b>
<b>III. Minnesota’s HCBS Quality System Practices.....</b>	<b>10</b>
<b>IV. HCBS Waiver Provider Standards.....</b>	<b>14</b>
Residential Support Services and Quality Outcome Standards Stakeholder Group	15
Provider Enrollment and Provider Standards Initiative	15
HCBS Waiver Provider Standards: The Combination of Initiatives	17
Rule 40 Changes/Jensen Settlement Agreement .....	18
<b>V. Timeline for Implementation &amp; Recommendations .....</b>	<b>19</b>
<b>Appendices .....</b>	<b>22</b>
Appendix A: Quality Initiatives that Support the Quality Outcome Standards	22
MnCHOICES .....	22
Disability Waiver Rate System Initiative .....	23
The Minnesota Participant Experience Survey (MN PES)	23
Disability Linkage Line® (DLL) .....	25
HCBS Provider Report Card .....	25
The State Quality Council .....	26
Appendix B: A Walk-Through of Minnesota’s HCBS Quality System	27
Appendix C: RSS and CRS Statutory Authority .....	29
Appendix D: HCBS Quality System Practices.....	30
Appendix E: HCBS Quality Framework.....	33
Appendix F: ‘Phased’ Implementation Plan & Scope	34
Appendix G: State Quality Council duties; Statute 256B.097	36
Appendix H: DHS Continuing Care Administration Mission, Vision and Values	40

## Quality Outcome Standards: A Report to the Minnesota Legislature

Appendix I: RSS/QOS Stakeholder Workgroup Participants	41
Appendix J: RSS/QOS Stakeholder Recommendations for Community Residential Setting License and Residential Support Services Standards	42
Appendix K: RSS/QOS Stakeholder Quality Outcome Standards Recommendations	48
Appendix L: Stakeholder recommendations for Quality Outcome Standards	59
Appendix M: PEPSI Intensive Group Stakeholder Member List	61
Appendix N: PEPSI Expanded Work Group Members	62

# Quality Outcome Standards: A Report to the Minnesota Legislature

## Executive Summary

---

This report has been prepared to answer two mandates from the Minnesota Legislature:

- Minnesota Law 2009, chapter 79, article 8, section 81, requiring the creation of a ‘Single Set of Standards’, for Home and Community-Based Service (HCBS) disability waivers<sup>1</sup>, later deemed ‘Quality Outcome Standards’ (QOS)<sup>2</sup>, and;
- Minn. Stat. §245A.11, Subdivision 8, which created a new Community Residential Setting (CRS) license for Residential Support Services (RSS)<sup>3</sup>.

The first mandate required the commissioner of the Department of Human Services (DHS) to submit a report and a set of plans for the implementation of the Quality Outcome Standards for Home and Community-Based Services (HCBS). The second mandate asked for statutory language and an implementation plan for the introduction of the Community Residential Setting license. This report provides the implementation plan for both requirements through a newly developed HCBS Quality System Practices<sup>4</sup>, and the creation of a consolidated set of provider service standards.

The HCBS Quality System Practices shape the quality of the HCBS system, while the provider service standards govern the health, safety and welfare of participants of waiver services. Five Quality System Practices set the standard for an aspect of the HCBS system: access; consumer choice; service standards; service outcomes, and; service review. Many sources influenced the creation these standards:

- The Center for Medicare & Medicaid Services (CMS) Quality Framework (Appendix E);
- A list of principles submitted by a stakeholder group convened to help shape the Quality Outcome Standards (Appendix L);
- The six division goals of the DHS Disability Service Division (Appendix H), and;
- The Domains of a Meaningful Life (Appendix H) adopted by the Continuing Care Administration of DHS as important components of the support to which a person with disabilities is entitled

The Quality Outcome Standards legislation called for a transformation of the HCBS system to a person-centered model. Meeting the expectations of this legislation is a priority for the Department. DHS has a number of ongoing initiatives meant to address the quality of Minnesota’s HCBS system. A report to the 2011 Legislature summarized a number of the initiatives seeking to improve the quality of the HCBS system<sup>5</sup>. This current report will explain how each of those initiatives will support the HCBS Quality System Practices and create a thorough quality management framework for HCBS. This report provides an update to the Minnesota Legislature on the timelines for the implementation of each initiative.

The expectations of the Quality System Practices will be fulfilled once these quality initiatives become operational. The HCBS Waiver Provider Standards Initiative will create a consolidated list of standards that govern waiver services. These standards will provide for oversight and assurances within services that were

---

<sup>1</sup> Minnesota offers four Medicaid Home and Community-Based Service disability waivers: Brain Injury (BI); Community Alternative Care (CAC); Community Alternatives for Disabled Individuals (CADI), and; Developmental Disability (DD). Minnesota does administer a fifth waiver, the Elderly Waiver (EW), that is not considered a disability waiver.

<sup>2</sup> Minnesota Law 2009, chapter 79, article 8, section 81 was amended in MN Laws 2010, Chapter 352, Article 1, Section 24.

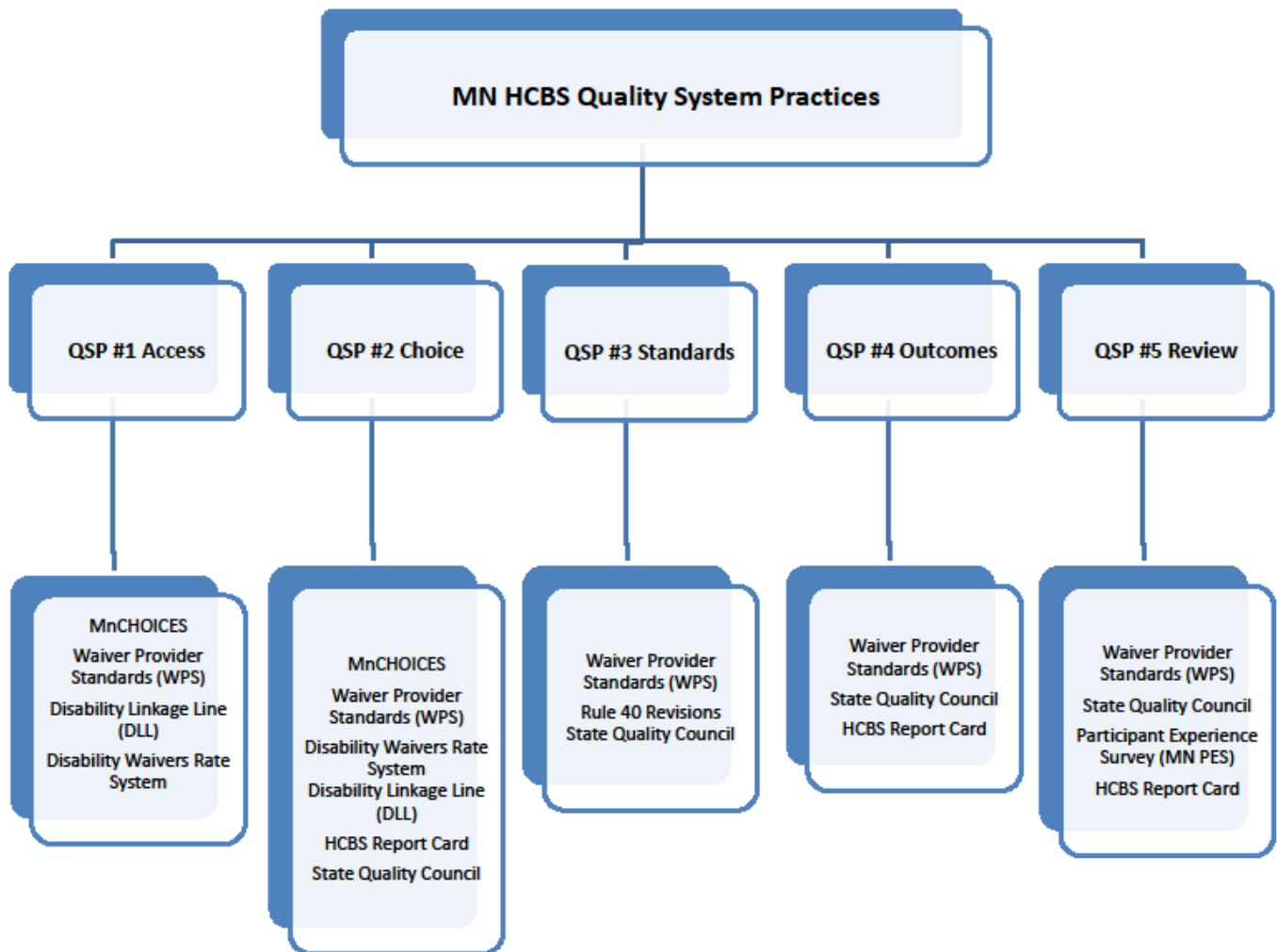
<sup>3</sup> The Residential Support Service is authorized by Minn. Stat. §256B.092, Subdivision 11.

<sup>4</sup> The proposed HCBS Quality System Practices are detailed in Section II and Appendix D

<sup>5</sup> That report was titled [Quality Management in HCBS 2011: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services](#), and can be found at <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6332-ENG>

## Quality Outcome Standards: A Report to the Minnesota Legislature

formerly unregulated at the state level. MnCHOICES will ensure that all persons in need of services have a person-centered assessment and service plan. The Disability Waivers Rate System initiative will make sure that all providers of service receive equitable pay for services rendered. A future HCBS provider report card, along with the public list of providers available through [www.minnesotahelp.info](http://www.minnesotahelp.info) will provide contact information and quality of HCBS providers. The Participant Experience Survey will provide participant feedback for the system. The State Quality Council will provide oversight of the quality-improvement efforts. The diagram below illustrates the aspect of the HCBS system each Quality System Practice will govern, and the quality initiative supporting it. The initiatives are described between section IV and Appendix A.



The HCBS Quality System Practices will improve the experience of a person in need of services by improving upon some aspect of the HCBS system. The many quality initiatives, consolidated into the HCBS Quality System Practices, will change the way a person accesses, designs, and controls their services. The expectation is that the person in need of services is the focal point of every aspect of service delivery. The five quality system practices will serve as the benchmarks for each component of the HCBS delivery

## Quality Outcome Standards: A Report to the Minnesota Legislature

system; providers, case managers, lead agencies and DHS. Each part will focus on serving Minnesota's citizens with disabilities with their consideration and direction. A sample walk-through of the system from a participant's view is located in Appendix B.

The Minnesota HCBS Quality System Practices and the attached timeline meet the requirements of both state *and* federal mandates. Many of the initiatives listed above are addressing federal mandates for HCBS system change, which is necessary to continue to receive federal financial participation for HCBS. Additionally, the Quality System Practices begin to integrate what have been, at times, disparate activities.



## I. Purpose of Report

---

This report was prepared for the Minnesota Legislature in accordance with Section 24 of Minnesota Laws 2009, chapter 79, article 8, section 81, paragraph (c)<sup>6</sup>, (the QOS legislation). The QOS legislation required the Department of Human Services (DHS) to submit a report and plans for the development of a single set of ‘quality outcome standards’ for home and community-based service disability waivers<sup>7</sup>. This report intends to satisfy the reporting requirement of the QOS legislation.

This report will also provide the implementation plan for the Community Residential Setting (CRS) license. The Community Residential Setting was created by Minn. Stat. §245A.11, Subd. 8., and will be the physical plant standards for the setting from which Residential Support Services (RSS) are offered to persons with disabilities. The Residential Support Service is a new service authorized in Minn. Stat. §256B.092, Subd. 11, and is intended to be the service provided to individuals in settings that is not the primary residence of the license holder. These settings are commonly referred to as “corporate foster care.” This report explains DHS’ timeline for the introduction of the Community Residential Setting license.

## II. Background

---

Medicaid Home and Community-Based Service (HCBS) waiver funds assist people with disabilities and seniors to live in their homes and communities, rather than institutions. HCBS waivers allow for payment of services otherwise not covered under the Medicaid program in the state plan. To qualify for a disability waiver service a person must have a disability, qualify for Medicaid and be in need of an institutional level of care<sup>8</sup>. Approximately 35,000 people participate in one of Minnesota’s four disability waiver programs<sup>9</sup> at an annual cost of nearly 1.52 billion dollars<sup>10</sup>. Roughly half of this amount is funded federally through the Centers for Medicare & Medicaid Services (CMS). Funding through CMS depends upon the continued approval of Minnesota’s waiver applications and ongoing compliance with HCBS program requirements established by CMS. Institutions provided nearly all services to people with disabilities prior to the offering of HCBS waivers. Thanks to the waivers and home care, currently more than 94% of people with disabilities who access long-term services and supports in Minnesota receive services in their own homes or other community-based settings.

The Minnesota Legislature passed legislation in 2009 requiring the creation of a “single set of standards” for HCBS. In 2010, the law was amended to refer to the new standards as “quality outcome standards.” DHS, through a contracted agency, convened a stakeholder group to develop the standards<sup>11</sup>. The group concluded by submitting a set of standards for HCBS service providers, and a set of principles to address the quality of HCBS. DHS has refined those products further by integrating them with other quality initiatives. DHS submitted a Legislative report in February 2011 regarding Quality Management in HCBS<sup>12</sup>. As the report indicated, DHS has been working to make sure that the HCBS waiver system meets all federal and local

---

<sup>6</sup> The Law was amended in MN Laws 2010, Chapter 352, Article 1, Section 24 and titled ‘The Quality Outcome Standards’

<sup>7</sup> See Footnote 1

<sup>8</sup> ‘Institutional Level of Care’ refers to the level of care necessary at a hospital, nursing facility, or Intermediate Care Facility for Developmental Disabilities (ICF/DD).

<sup>9</sup> See Footnote 1

<sup>10</sup> This number includes the cost of State Plan Home care services (skilled nursing, PCA, private-duty nursing, Home Health Therapies)

<sup>11</sup> See Appendix I for a list of stakeholder members

<sup>12</sup> [Quality Management in HCBS 2011: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services](#)

## Quality Outcome Standards: A Report to the Minnesota Legislature

mandates as well as the needs of the people it serves. The requirements of the QOS legislation have provided the opportunity to outline a plan that integrates all quality initiatives.

DHS is submitting two items to Minnesota Legislature that, together, satisfy the requirements of the QOS legislation:

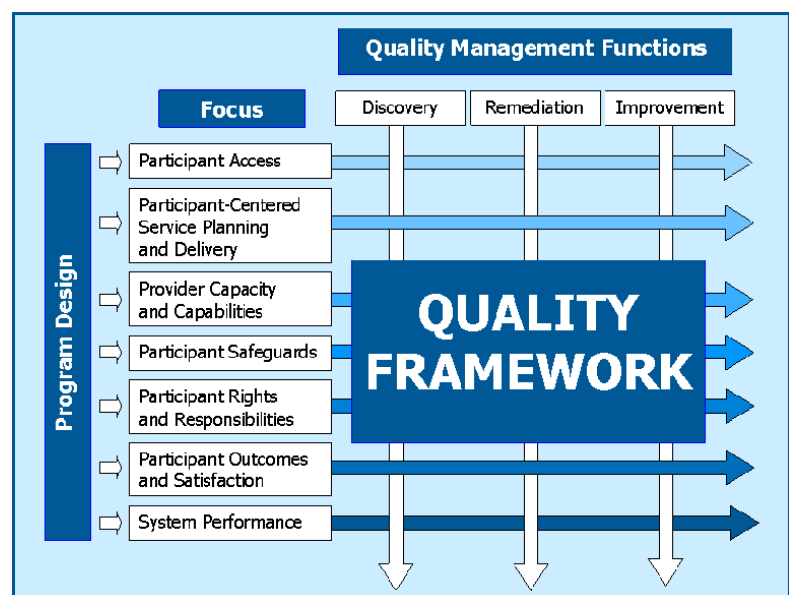
1. A set of HCBS Quality System Practices, and;
2. A set of HCBS disability waiver provider standards

The HCBS Quality System Practices are presented in Section III. The HCBS disability waiver provider standards are detailed in Section IV.

### III. Minnesota's HCBS Quality System Practices

This section will provide a summary of the Quality System Practices. The recommended statutory language for these standards is attached in Appendix D. The Quality System Practices address the quality of the entire HCBS system. They will serve as the *core set of quality standards* for Minnesota's HCBS system. The Standards take into account a number of sources:

- The Center for Medicare & Medicaid Services (CMS) Quality Framework (shown at right and detailed further in Appendix E);
- A list of principles submitted by a stakeholder group convened to help shape the Quality Outcome Standards (Appendix L);
- The six division goals of the DHS Disability Service Division (Appendix H) and;
- The Domains of a Meaningful Life adopted by Continuing Care Administration within DHS (Appendix H)



The QOS legislation required DHS to shape home and community based services to become more person-centered. The standards below will direct the system in this effort. The MN HCBS Quality System Practices will tie the quality initiatives described in Section IV and Appendix A together, defining the effects they will have on the system. The five quality system practices will govern:

- Participant Access
- Participant Choice
- Service Standards
- Service Outcomes
- Service Review

## Quality System Practice #1: Access

---

Potential and current recipients of HCBS will have ready access to information regarding eligibility for services and providers of available services in order to give them the opportunity to make an informed choice.

Shaping the HCBS system to become more person-centered requires, above all else, a focus on participant choice. Quality System Practice #1 provides the right to informed choice. "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives, to:

- A. select a preferred alternative from a number of feasible alternatives;
- B. select an alternative which may be developed in the future; and
- C. refuse any or all alternatives<sup>13</sup>.

Since informed choice requires access to information regarding feasible alternatives, to create an optimum level of choice DHS recommends: 1) creation of a public list of service providers, and; 2) creation of an 'HCBS Provider Report Card' that allows the public to compare service providers based on quality indicators. This will enable possible participants and their support team to make an informed choice when selecting a service provider.

## Quality System Practice #2: Choice

---

Potential candidates for waiver services have the right to freedom of choice. Recipients of HCBS will choose the services they receive and decide their desired outcomes of service delivery.

This standard continues to provide for participant choice. Added to the right to Informed Choice in Quality System Practice #1 is freedom of choice. "Freedom of choice" is a federal requirement providing people the choice of waiver or institutional services. System Practice #2 goes farther to ensure that, should a person choose waiver services, they choose the services they will receive from among the services they are eligible for. Should the person have a guardian, the guardian will make the final decision on behalf of the person.

Quality System Practice #2 will further provide for freedom of choice by ensuring that:

- i. An HCBS recipient's case manager then facilitates the recipient's choice of service providers; identified by the public list in Quality System Practice #1: Access.
- ii. Recipients of HCBS have a person-centered Coordinated Service and Support Plan (CSSP) created with the facilitation of their case manager. The CSSP will direct the services they receive and the outcomes expected from services.

## Quality System Practice #3: Service Standards

---

DHS will create a single set of standards governing HCBS providers. The standards will provide for the proper care, health, treatment and safety of the individuals served. All services offered through the HCBS waiver will meet the definition of person-centered services.

System Practice #3 reiterates the QOS legislation requirement to create a single-set of standards for providers of HCBS. It further goes on to require that all services meet the definition of Person-Centered

---

<sup>13</sup> This definition is included in Appendix D.

## Quality Outcome Standards: A Report to the Minnesota Legislature

Services. This standard defines person-centered services as “services that are important for the person to meet individual support needs as assessed through a person-centered assessment of needs as well as what is important to the person with regard to preferences for the delivery of such supports.”

Section IV describes the work to create a single-set of standards. DHS has developed a person-centered assessment, MnCHOICES. Appendix A describes this assessment.

### Quality System Practice #4: Service Outcomes

---

Providers of HCBS will assist the people they serve reach their goals.

System Practice #4 is, perhaps, the most important. While the other practices provide access, choice and standards, System Practice #4 will assist a person to meet their goals. This is the reason a person accesses waiver services. To ensure that providers assist people they serve reach their goals, System Practice #4 also requires the following:

- i. Providers of HCBS will create a service delivery plan that complements the Coordinated Service and Support Plan and the person-centered directed outcomes the consumer wishes to accomplish through the accepted service.
- ii. Providers of HCBS will report to the participant and their support team the participants’ progress annually, at minimum. The participant, their representative and the case manager shall determine the frequency of progress reports. If the recipient has not made progress toward their goals at the time of a progress report, it should be determined whether strategies used to accomplish goals require modification or whether the participant requires other services that will better assist them in progressing toward their stated goals. It is possible to change intended goals at any time should the participant or their representative deems it fit to do so.
- iii. Goals and outcomes should be dynamic, reflecting changes in the recipients’ priorities and life experiences.

### Quality System Practice #5: Service Review

---

DHS shall monitor the quality of the waiver-based service delivery system and develop quality improvement plans to increase the quality of the HCBS system

DHS can assess HCBS system quality in a number of ways, including:

- i. Regular Participant Experience Surveys measuring participant outcomes associated with HCBS.
- ii. Outcomes related to provider workforce stability. Outcomes possibly included in this indicator:
  - a. retention of staff employed at least six months;
  - b. staff salaries and benefits;
  - c. staff opportunities for advanced training;
  - d. staff promotions to higher-level positions within the agency.
- iii. Substantiated reports of maltreatment, including abuse, neglect or financial exploitation
- iv. Violations of licensing requirements or Participant Rights
- v. Complaints and appeals regarding service delivery, client interaction and operational management
- vi. Licensing actions resulting in correction orders, licenses being made conditional, or the issuance of sanctions up to and including license revocation

## Quality Outcome Standards: A Report to the Minnesota Legislature

In addition to creating quality improvement plans, DHS recommends establishing an HCBS Report Card. Experiences with past report cards<sup>14</sup> have shown that publicly reporting quality outcomes and statistics can improve the system.

The MN HCBS Quality System Practices purposely mirrors the CMS HCBS Quality Framework (Appendix E) to aid Minnesota in responding to increasing federal quality requirements. This is also consistent with outcome (7) of the QOS legislation. In essence, the HCBS Quality System Practices ensures that:

- A person in need of services has access to services needed to meet their needs and goals
- Persons in need of services choose their service and provider
- Providers adhere to standards for service
- The people closest to the person are contributing to their care and treatment
- Services support the goals of the persons receiving services

The Quality System Practices will not just meet federal and state mandate, they will direct the system to deliver services in a person-centered manner. In addition to the creation of these standards, DHS has a number of initiatives working to support and enforce them. Section IV describes the provider standards. Appendix A describes additional initiatives that support the Quality System Practices. Table A (next page) shows how the HCBS Quality System Practices address each criteria of the QOS legislation. Table A also shows the quality initiatives that will support each of the Practices.

**Table A: Quality System Practices and Quality Initiatives Satisfying the QOS legislation**

QOS Legislation Portion	System Practice Meeting Requirement	Initiative Meeting Requirement
(a) The commissioner of human services shall... develop a single set of standards, to be referred to as "quality outcome standards," governing services for people with disabilities receiving services under the home and community-based waiver services program to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the [PMUC]	#3	Waiver Provider Standards Residential Support Services (Community Residential Setting) Quality Outcome Standards
(1) enable optimum consumer choice;	#1 & #2	Waiver Provider Standards MnCHOICES Disability Waivers Rate System Participant Experience Survey Disability Linkage Line HCBS Provider Report Card
(2) be consumer driven;	#1, #2, #3, #4 & #5	Waiver Provider Standards MnCHOICES Participant Experience Survey Disability Linkage Line Provider Standards
(3) link services to individual needs and life goals;	#1, #2, #4 & #5	MnCHOICES

<sup>14</sup> See the [Minnesota Nursing Home Report Card](#)

## Quality Outcome Standards: A Report to the Minnesota Legislature

QOS Legislation Portion	System Practice Meeting Requirement	Initiative Meeting Requirement
		Waiver Provider Standards Disability Linkage Line Participant Experience Survey
(4) be based on quality assurance and individual outcomes;	#1, #2, #3, #4 & #5	Waiver Provider Standards HCBS Provider Report Card Participant Experience Survey MnCHOICES
(5) utilize the people closest to the recipient... in conjunction with the recipient's risk management plan to assist the recipient... in making decisions that meet the recipient's needs in a cost-effective manner and assure the recipient's health and safety;	#1, #2, #3, & #5	MnCHOICES Waiver Provider Standards Disability Waivers Rate System
(6) utilize person-centered planning;	#1, #2, #4 & #5	MnCHOICES Waiver Provider Standards Participant Experience Survey
(7) maximize federal financial participation.	#1, #2, #3, #4 & #5	Waiver Provider Standards Disability Waivers Rate System Quality System Practices

### IV. HCBS Waiver Provider Standards

---

The Quality System Practices will govern the HCBS system, but do not provide specific service standards. System Practice #3 requires the creation of a single set of provider standards, in compliance with the Quality Outcome Standard Legislation. The central effort of the QOS initiative has been the consolidation of provider service standards into a single set. Home and Community-Based Service waivers have been constantly changing since they began in 1983. Many standards are in existence, spread between statute and rule. Most waiver services have their own licensing standards, which evolved separately from the others. This has created a complexity in the existing rules and practices in Minnesota that often leads to confusion for providers offering more than one service or who serve people on different waivers.

The QOS legislation intended to streamline the many rules and shift the emphasis of HCBS review from provider compliance to participant outcomes. The QOS initiative is, however, just one of several initiatives trying to resolve inconsistencies within HCBS. The following initiatives are working to create uniform provider standards:

- The Quality Outcome Standards (QOS) initiative (provider standards portion)
- The Residential Support Services (RSS) and Community Residential Setting standard project
- The Provider Enrollment and Provider Standard Initiative (PEPSI)
- Rule 40/METO Settlement Advisory Committee

The QOS initiative has a global scope, while the other initiatives focused on specific services within HCBS. RSS seeks to create a set of standards for the services provided in corporate foster care. PEPSI seeks to develop enhanced provider standards and eliminate county contracts. The Rule 40 Advisory Committee seeks to promote positive behavioral practices as well as standards for use of restraints and seclusion for people with disabilities. To avoid inconsistencies in the final standards, these projects recently combined

## Quality Outcome Standards: A Report to the Minnesota Legislature

into one initiative, the HCBS Waiver Provider Standards (WPS). The merger of these initiatives has created a more concise product for all the initiatives. Described below is the provider standards' integration effort and plan for implementation.

### Residential Support Services and Quality Outcome Standards Stakeholder Group

The Residential Support Service (RSS) is a new service replacing corporate foster care. 'Corporate foster care' refers to situations in which a foster home is not the license holder's primary residence. Currently in Minnesota, either families in their own home or corporate owners provide foster care. The same rules (Minnesota Rule 203) govern families and corporate foster care providers<sup>15</sup>. Though they follow the same rules and have the same license, the services are very different. Corporate providers often use shift-staff to monitor and assist the people living there. In addition, the BI, CAC and CADI waivers rely only on the foster care standards, while those who serve people on the DD Waiver need an additional service license<sup>16</sup>. These differences can create confusion when serving more than one population and can lead to inconsistent service-delivery.

Minnesota heavily relied on corporate foster care to achieve the closure of institutions. The Legislature placed a moratorium on new corporate foster care development in 2009. To manage statewide foster care capacity, legislation<sup>17</sup> was passed requiring a separation of family foster care from settings that were not the primary residence of the license holder. The Residential Support Service will create separate standards for corporate foster care providers and consolidate population-specific standards. The service setting identified in statute is the Community Residential Setting (CRS)<sup>18</sup>. When implemented, provider homes will be licensed as a Community Residential Setting and they will provide Residential Support Services.

The QOS legislation required the creation of a single set of standards for all HCBS, which includes the Residential Support Service. In June of 2010, the QOS and RSS projects merged so that the standards created by each project would not conflict or overlap with the other. Per the requirements of the QOS legislation, DHS convened a stakeholder group to assist with the creation of the standards. The group met twice a month between September 2010 and June 2011<sup>19</sup>. At the conclusion of their meetings, the group submitted their recommendations for QOS & RSS standards (Appendices I, J, K & L).

### Provider Enrollment and Provider Standards Initiative

In December 2008, CMS reviewed the Community Alternative Care (CAC) Waiver renewal application and determined that Minnesota was out of compliance with the Code of Federal Regulations<sup>20</sup>. At that time, DHS had been delegating the development of provider contracts to lead agencies (individual counties, tribes and health plans). CMS stated that the use of lead agency contracts and potential variation in the standards to which providers must adhere, could result in participant access issues. During subsequent waiver renewals, CMS raised the same concerns with the other disability waivers. Minnesota's response to these concerns was to agree to eliminate the use of county and tribal contracts for all HCBS disability waivers and implement consistent and equitable HCBS provider standards.

<sup>15</sup> [Minnesota Rule 9555](#) governs adult Foster Care. [Minnesota Rule 2960](#) governs Child Foster Care.

<sup>16</sup> DD services are governed by Minnesota Statute §245B

<sup>17</sup> Minnesota Statutes §245A.11, Subd. 8; Minnesota Statutes §256B.092, Subd. 11; and Minnesota Statutes §256B.49, Subd. 22. Both Statute §256B.092, Subd. 11 & §245A.11, Subd. 8 are reprinted in Appendix C for reference purposes

<sup>18</sup> §245A.11, Subd. 8

<sup>19</sup> A list of stakeholder members, their organization affiliation, is listed in Appendix I

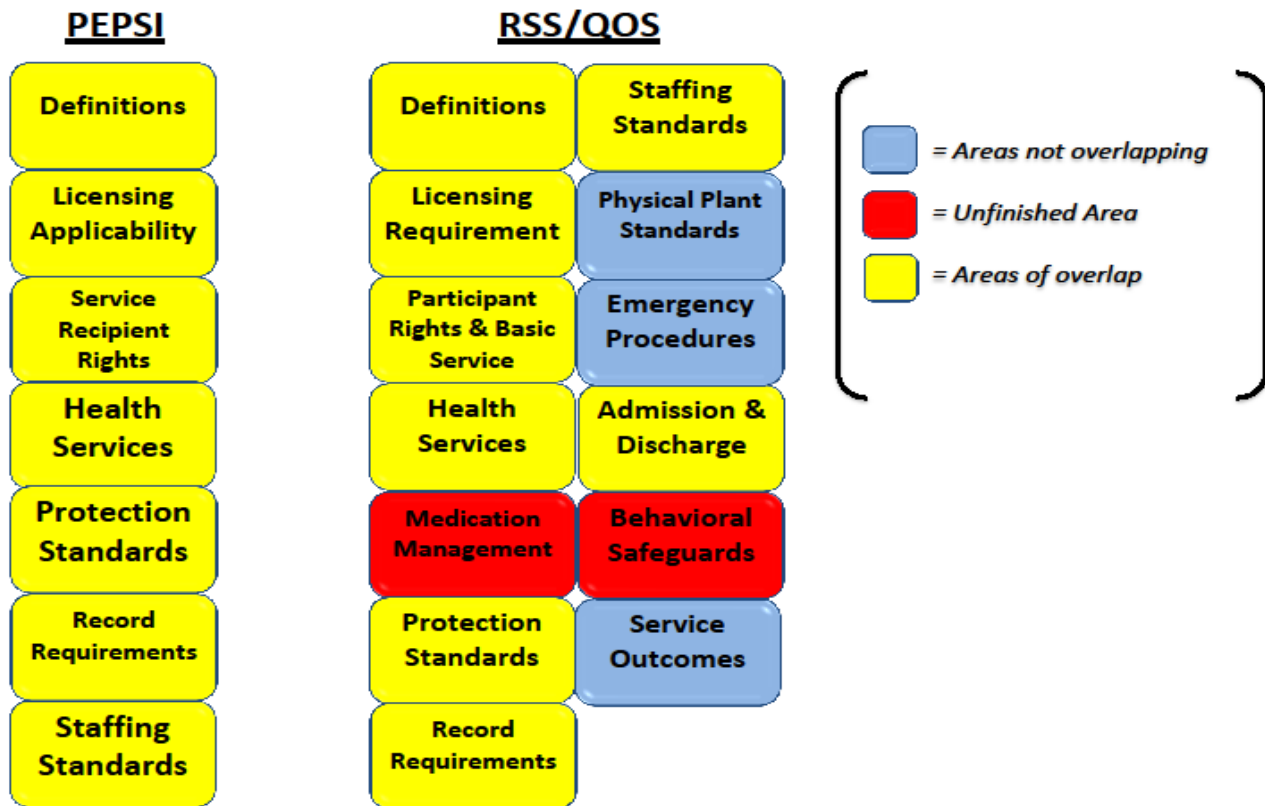
<sup>20</sup> CFR title 42, chapter VI, part 431, section 51.

## Quality Outcome Standards: A Report to the Minnesota Legislature

In 2009, the Minnesota Legislature authorized the Provider Enrollment and Provider Standards Initiative (PEPSI) to coordinate the elimination of county and tribal contracts. County and tribal contracts contained the rate of pay and the service standards for each provider. Shifting provider management to the state required a single-set of standards and uniform rates for service providers. The PEPSI Initiative handled the task of creating statewide standards, while the Disability Waivers Rate System (formerly Rate-Setting Methodologies Initiative) handled the creation of uniform payment structures. (Appendix A)

A stakeholder group consisting of community members, providers, advocates, lead agencies and DHS staff worked to draft PEPSI's set of standards. PEPSI created standards for several previously unlicensed services. DHS-licensed services had a set of standards, but many waiver services did not require a license. Unlicensed service providers previously entered into a contract that negotiated service and standard parameters. Without county and tribal contracts, the state needed to set service standards for these unlicensed providers.

After the PEPSI stakeholder group<sup>21</sup> concluded their effort, it was determined the standards that had been sculpted would best be implemented through a DHS license. CMS requirements for quality management<sup>22</sup> necessitate the State to have means to detect, investigate, remediate and improve service issues. The DHS licensing process provides this type of oversight. Comparison to the standards created by the RSS/QOS group found that the products of each stakeholder group had many similarities. The diagram below illustrates the areas of overlap between the standards created by each initiative:



<sup>21</sup> Appendix M & N contain participation lists on the PEPSI stakeholder group

<sup>22</sup> Appendix E



## Quality Outcome Standards: A Report to the Minnesota Legislature

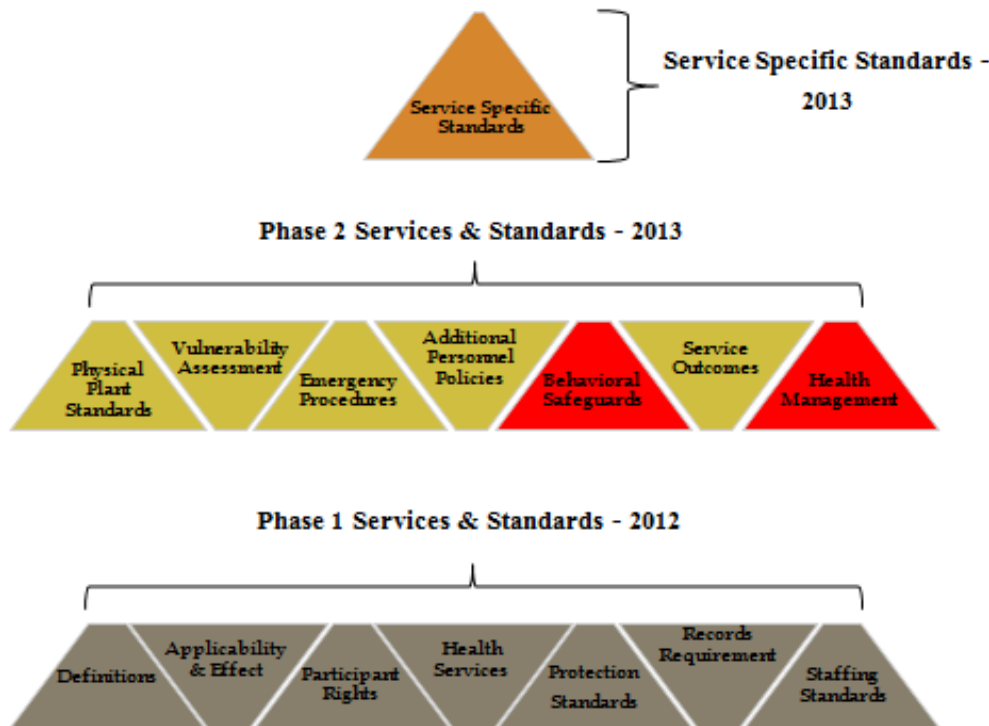
PEPSI's standards applied to a wider set of services than RSS/QOS standards and were more general. The RSS/QOS group had a number of service-specific standards not considered by PEPSI. To prevent any overlap between the resulting standards, RSS/QOS & PEPSI initiatives combined to determine the final set of provider standards.

### HCBS Waiver Provider Standards: The Combination of Initiatives

To meet the legislative intent to devise one set of standards, the PEPSI, QOS & RSS initiatives combined into one initiative: the HCBS Waiver Provider Standards (WPS). WPS will integrate the RSS/QOS & PEPSI standards into one 'single set of standards'. WPS has created a work plan that will propose the single set of provider standards to the 2013 legislature. The work plan drafted for WPS meets compliance with the previously, CMS-approved corrective action plan completed through PEPSI.

The most challenging task within the plan is the licensing and/or *re*-licensing of services under the new standards. There are over 3,500 HCBS providers in Minnesota, making the licensing of all services at one time impracticable. To make this process manageable, WPS has divided home and community-based services into two groups and proposed provider standards to the legislature in two phases. DHS proposed a set of provider standards in 2012, which comprise Phase 1 standards. Phase 1 service standards are universal standards, eventually applied to all services. Phase 2 standards are more comprehensive than Phase 1 services as they may include habilitative goals, a physical plant, daily supervision and health maintenance needs (for example, medication management, medication administration, psychotropic medication monitoring). The Residential Support Service is one example of a Phase 2 service. Below is a diagram illustrating the 'phased' concept and implementation plan<sup>23</sup>:

### Waiver Provider Standards Implementation Plan



<sup>23</sup> A complete list of services included in each 'Phase' is outlined in [Appendix F](#)

## Quality Outcome Standards: A Report to the Minnesota Legislature

Due in large part to the work of PEPSI and RSS/QOS stakeholder groups, the provider standards for Phase 1 were proposed in 2012 in a new chapter within Minnesota Statute, chapter §245D, for HCBS provider standards. The standards proposed in House File 2456 and Senate File 2234 of the 87<sup>th</sup> Legislative Session contain the standards DHS considers ‘Phase 1’. The Phase 1 standards will apply to 14 services. [Appendix F](#) lists the services included in each phase. DHS intends to introduce Phase 2 Standards as an amendment to §245D in the 2013 Legislative session.

The refinement of service standards for HCBS meets federal requirements and the requirements of the QOS legislation. The WPS provider licensing process will also add to the public list of HCBS service providers available on [www.minnesotahelp.info](http://www.minnesotahelp.info). This list will help potential persons in need of waiver services to find appropriate services near their homes. This will fulfill two additional legislative goals: create better access to services for individuals in need by enabling optimum consumer choice<sup>24</sup>, and; link services to individual needs and life goals<sup>25</sup>. The products of the WPS initiative will greatly affect the quality of service delivery to persons in need of services in Minnesota.

Two areas within the WPS standards are in the process of revision: Behavioral Safeguards, traditionally called Rule 40 guidelines, and the monitoring of psychotropic medications. Current Rule 40 guidelines<sup>26</sup> only address the service needs of persons with developmental disabilities. For a ‘single set’ of standards to be created, guidelines for the use of controlled procedures will have to be revised to better suit the needs of all of the individuals served, including those receiving services through the CAC, CADI and BI waivers. The same condition applies to the monitoring of psychotropic medication; current guidelines only address the needs of individuals with developmental disabilities, leaving those who receive BI, CAC and CADI waiver services with different standards. Neither the PEPSI nor the RSS/QOS group handled these areas, as a separate advisory group assembled for that purpose.

### Rule 40 Changes/Jensen Settlement Agreement

---

Though not officially merged into the Waiver Provider Standards initiative, the Rule 40 revisions affect the provider standards timeline. As stated above, Behavioral Safeguards have not yet been included in the new provider standards. There are two factors for this: CMS HCBS Waiver Requirements and The METO Settlement.

#### **CMS HCBS Waiver Requirements**

Every HCBS waiver must have safeguards in place to protect the people it serves<sup>27</sup>. CMS requires that for every waiver, Minnesota identify if it allows the “use of restraints and/or restrictive interventions”. *If they are allowed*, “The state must specify the safeguards that is has established concerning their use and how the state ensures that such safeguards are followed.” When permitted, types of allowed and prohibited restraints need to be identified. For each type of restraint allowed, the safeguards need to address:

1. Requirements concerning the use of alternative approaches to avoid the use of restraints and seclusion;
2. Methods for detecting the unauthorized use or misapplication of restraints;

---

<sup>24</sup> Outcome (1) of MN Law 2009, chapter 79, article 8, section 81, paragraph (a).

<sup>25</sup> Outcome (3) of MN Law 2009, chapter 79, article 8, section 81, paragraph (a).

<sup>26</sup> Rule 40 guidelines refer to Minnesota Rules parts 9525.2700 to 9525.2810

<sup>27</sup> CMS requires each state to have safeguards assuring the health and welfare of waiver participants. CMS specifically requires safeguards addressing: 1. Responses to Critical Events or Incidents; 2. Safeguards Concerning Restraints and Restrictive Interventions, and; 3. Medication Management and Administration. The CMS Application for a §1915(c) Home and Community-Based Waiver can be viewed at [http://www.dads.state.tx.us/providers/waiver\\_instructions/cms\\_waiver\\_instructions.pdf](http://www.dads.state.tx.us/providers/waiver_instructions/cms_waiver_instructions.pdf)

## Quality Outcome Standards: A Report to the Minnesota Legislature

3. The procedures that must be followed when restraints or seclusion are used (including the circumstances when their use is permitted and when they are not) and how their use is authorized;
4. The practices that must be employed in the use of a restraint or seclusion to ensure the health and safety of individuals;
5. Required documentation (record keeping) concerning the use of restraints or seclusion; and,
6. The education and training requirements that provider agency staff must meet who implement restraints or seclusion.<sup>28</sup>

Minnesota has a set of behavioral safeguards for persons with developmental disabilities, outlined in Minnesota Rule 40<sup>29</sup>. Rule 40 guidelines are nearly thirty years-old and have had few changes since introduction. National movement surrounding behavioral safeguards since that time has focused on:

- The promotion of positive behavioral approaches
- Person-centered thinking and planning
- Consistent guidelines and safeguards across all populations
- Emphasis on the reduction of physical restraint and seclusion
- Assuring that mental health needs are addressed

To better meet the needs of Minnesotans, behavioral safeguards that apply the above concepts are in development. To comply with the Quality Outcome Standard Legislation, Minnesota will need a single-set of behavioral safeguards for persons receiving CAC, CADI, BI & DD waiver services.

### **The Jensen Settlement**

Any behavioral safeguards created for the single-set of provider standards will also need to comply with the settlement terms of The Jensen Settlement Agreement. In the agreement, DHS agreed to modernize Rule 40 to reflect current best practices including positive and social behavioral supports.

The settlement agreement, CMS guidelines, QOS legislation and current positive behavior approaches require that Minnesota revise its Behavioral Safeguards. A task force created per the terms of The Settlement Agreement to assist with Rule 40 revisions held its first meeting on January 30, 2012. The group will address positive behavioral practices as well as restrictions on the use of controlled procedures for people receiving home and community-based services. The implementation plan in Section V considers this process. Current updates on the project can be found at the [Rule 40 advisory committee's website](#).

## **V. Timeline for Implementation & Recommendations**

DHS has centered the comprehensive implementation plan for the provider standards and Quality System Practices on the federally approved PEPSI timeline. The universal provider standards (Phase 1) were adopted by the Minnesota Legislature during the 2012 Legislative session. A proposal to address future fees to implement the universal provider standards will be brought to the legislature during the 2013 session, so that implementation can begin in 2014. This will be a significant effort for the DHS Licensing Division as well as some 1,300 previously un-licensed providers. House File 2456 and Senate File 2234 contain DHS' proposed Licensing Statute for Phase 1 Home and Community Based Services.

<sup>28</sup> Page 231 *Instructions: Version 3.5 HCBS Waiver Application*

<sup>29</sup> Minnesota Rules 9525.2700 to 9525.2810

## Quality Outcome Standards: A Report to the Minnesota Legislature

As detailed in Section IV, Phase 2 and RSS standards are near ready except for standards pertaining to behavioral safeguards and psychotropic medication administration. Because those standards will be developed using a different process (See the section on Rule 40 for more information) they require more time for completion. The goal is that Phase 2 standards are ready for submission to Minnesota Legislators in 2013, along with the HCBS Quality System Practices.

The Quality System Practices will not be included in the recommended licensing language. The System Practices have a wider scope than the provider standards, affecting DHS delivery of HCBS components. DHS will propose language for the Quality System Practices in 2013. The standards will complement each other and, together, create the set of standards that govern all aspects of HCBS.

### **Other laws affecting HCBS providers**

The QOS legislation required that all or portions of laws including data practices, background studies, reporting of maltreatment of minors and reporting of maltreatment of vulnerable adults be replaced by the new quality outcome standards. Each of those laws is in a particular statute because they affect a variety of service sectors. HCBS is just one part of social and human services in Minnesota. The data practices and maltreatment laws govern all Minnesota social and human service program. To replace them would affect services not included in the scope of the QOS legislation. To change them to suit HCBS purposes would affect all the other departments. To create versions solely for HCBS may eventually create conflicting standards when funding sources overlap. The QOS effort has not attempted to change these areas, but has worked to eliminate duplication or conflicting requirements within its standards in regards to these areas.

The implementation plans for DHS' quality initiatives are:

#### **2012 Legislative Session**

- WPS Phase 1 provider standards submitted to legislature; House File 2456/Senate File 2234
- The five Quality System Practices in Appendix D submitted to MN Legislators

#### **Throughout 2012**

- Obtain legislative authority to implement Phase 1 provider standards
- Phase 2 standards continue to be vetted through stakeholder meetings and internally within DHS
- Rule 40 Advisory Group works on behavioral safeguards, psych med administration
- DHS begins licensing service providers under statute §245D, based on legislative authorization
- Participant Experience Survey sampling
- Provider licensing information used to update listings within [www.minnesotahelp.info](http://www.minnesotahelp.info)
- Develop population-specific certifications for service providers
- Develop plan for elimination of county/tribal contracts and transition to state administered provider system
- Develop training modules for providers and waiver program administrators

#### **January 2013**

- WPS Phase 2 provider licensing standards submitted to 2013 legislature (including RSS/CRS)
- DHS Licensing completes licensure of Phase 1 service providers

#### **Throughout 2013**

- DHS begins licensing Phase 2 service providers
- Design, develop and test Routine Provider Review and Data Management Process

#### **2014**

- Develop and administer Routine Provider Review training with local agencies
- Implement Routine Provider Reviews

## Quality Outcome Standards: A Report to the Minnesota Legislature

- All county contracts with providers end per Waiver Provider Standards Initiative

The standards listed above, supported by the initiatives described in Appendix A, will meet both federal and state requirements. The HCBS Quality System Practices will effectively put any person in need of waiver services in the driver seat when determining their services and living a meaningful life (Appendix H). The improved system will give assurances that services will meet their needs and be provided with the utmost concern for the individual's health, safety, welfare and goals.

## Appendices

---

### Appendix A: Quality Initiatives that Support the Quality Outcome Standards

---

In addition to the Waiver Provider Standards initiative, many DHS projects will help fulfill the goals of the HCBS Quality System Practices. The initiatives that will improve the quality of Minnesota's HCBS System are:

- MnCHOICES Initiative
- Disability Waiver Rate Setting Initiative
- The Participant Experience Survey
- The formation of a State Quality Council
- Disability Linkage Line
- HCBS Provider Report Card

#### MnCHOICES

---

MnCHOICES seeks to create a set of standards and protocol to assess the needs of persons for long-term care services. DHS currently uses a variety of assessment and screening documents to determine if persons are eligible for long-term care services. MnCHOICES will be a comprehensive assessment able to replace the following documents:

- Developmental disability screening
- Long-term care consultation assessment
- Personal care assistance assessment
- Private duty nursing assessment

MnCHOICES is developing a web-based tool that utilizes a person-centered planning approach to:

- Simplify and standardize face-to-face assessments
- Determine eligibility for level of care and programs and services for all ages and disabilities
- Allow for timely consideration of support options beyond what is reimbursed through Medical Assistance long-term care programs
- Combine long-term care assessment processes
- Provide additional data to evaluate outcomes
- Streamline support plan development

The 2009 Minnesota Legislature approved funding for DHS to implement MnCHOICES. MnCHOICES includes standards, protocols and a common data collection tool that reflect stakeholder recommendations. Once operationalized, MnCHOICES will provide a comprehensive person-centered assessment of individuals' strengths, needs and service options based on individual outcomes. When determining need, the assessment will recognize available informal caregivers and supports.

## Quality Outcome Standards: A Report to the Minnesota Legislature

The QOS legislation requires that each individual served in HCBS receive a person-centered plan. The MnCHOICES assessment will do just that. The MnCHOICES assessment will create a support plan with service options. When coupled with the public list of providers, an individual will be able to choose from that list a provider that meets their service needs. This process will assist in allowing for an optimum level of choice to a person in need of home and community-based services.

---

### Disability Waivers Rate System Initiative

---

As reported in Section IV, CMS requires Minnesota to create a more consistent and equitable HCBS structure. This mandate created both the Provider Enrollment and Provider Standards Initiative and the Disability Waiver Rate System Initiative. The Disability Waiver Rate System will create an equitable payment structure for services across the entire state. Currently, DHS gives lead agencies (counties and tribes) permission to negotiate rates for waiver services with each service provider. This has predictably led to varying rates throughout the state, and even in the same cities, for similar services. The initiative will build rates for services based on components within each waiver service and the persons assessed need for those components within each service. This will ensure that the rates created are fair and consistent across the state.

Rate structures were developed with the assistance of an advisory committee and are currently complete. Full implementation is planned for January of 2014. Beginning in January 2012, an initial payment structure research system will operate alongside the current payment rate-setting system. This research system will provide for analysis of the proposed payment rates and will provide information on the impact of the rates prior to implementation. The determined rates for services will not go into effect until January of 2014; lead agencies will continue to determine rates until that time. During 2012, the research system will help determine what the impact is on individuals, providers, counties and the state. This research period will create an opportunity for the rate system users to provide feedback before full operation commences.

---

### The Minnesota Participant Experience Survey (MN PES)

---

2007 Minnesota Legislation required DHS to develop an annual survey of service recipients in order to determine the effectiveness and quality of disability services<sup>30</sup>. In response, DHS worked with stakeholders to develop the Minnesota Participant Experience Survey (MN PES). A trained interviewer conducts the MN PES face-to-face interview with a participant enrolled in a waiver service<sup>31</sup> or their proxy, should they need one to communicate. The survey consists of 112 questions for adults and 61 questions for minors and assesses a participants' experience in the following domains:

- Case Management and Service Plan Development
- Health, Welfare and Safety
- Important Long-term Relationship
- Quality of Life

The survey for adults gauged experiences in four additional domains (thus the additional questions):

- Own Home/current living situation
- Community Membership

---

<sup>30</sup> Minnesota Statute §256B.096, Subdivision 3 (Later moved to subdivision 5 of the same Statute)

<sup>31</sup> Additionally, Medical Assistance for Employed Persons with Disabilities (MA-EPD) as well as individuals receiving personal care assistance (PCA) experiences was explored.

## Quality Outcome Standards: A Report to the Minnesota Legislature

- Daily Activities/Employment
- Experience with Congregate Housing

The Participant Experience Survey will obtain the participant's view of their experience regarding their supports and services. This information will be an excellent indicator of the effectiveness and quality of disability services. Like any business, consumer satisfaction should play a role in system design. Results from the MN PES will give DHS consumer satisfaction information with which it can tailor the system to better meet the needs of those it serves.

During a statewide test of the MN PES in 2010, 825 interviews were conducted. 51% (422) of the interviewees were participants on the CADI waiver and 15% (124) of the interviewees coming from the other disability waivers (BI, CAC & DD). The remaining 34% (279) of respondents were on two other Medical Assistance programs: MA-EPD and PCA. Approximately 90% of all respondents reported that the support they receive through these programs has made their life better than before they received waiver-based services<sup>32</sup>. This data illustrates how important HCBS services are to the people who receive them. The first set of surveys provided crucial information about HCBS services. A second survey will be conducted with a small sample of participants by June 30<sup>th</sup>, 2012. Future surveys could give validity to the numbers obtained and provide indicators regarding changes within the system.

When implemented annually, the survey will:

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

The MN PES is a valuable tool to ensure persons with disabilities have a voice. It is unique in that it seeks to determine the performance of the HCBS system through the perspective of its participants'. The MN PES will aid DHS in complying with the requirements of the Quality Outcome Standard legislation in a number of ways: the MN PES is consumer driven<sup>33</sup>; creates a unique indicator of quality assurance and individual outcomes<sup>34</sup>; and provides information regarding participant experience that CMS routinely requests. When DHS seeks to determine whether the HCBS system meets the demands of the QOS legislation, the results from the Minnesota Participant Experience Survey will surely provide some of the most important indicators.

The Minnesota Participant Experience Survey's creation, initial test and second sample were paid for with one-time funding. At the time of this report, there are no ongoing appropriations to implement the MN PES annually. The estimated cost of implementing the survey is roughly \$250,000/year. It is DHS' intention to seek on-going funding for this project so that it can continue obtaining feedback of the HCBS system from the perspective of the participants it serves.

---

<sup>32</sup> A detailed report accounting the complete set of results obtained by the PES will be released by DHS within the upcoming months

<sup>33</sup> Goal (2) of MN Law 2009, chapter 79, article 8, section 81, paragraph (a)

<sup>34</sup> Goal (4) of MN Law 2009, chapter 79, article 8, section 81, paragraph (a)



## Quality Outcome Standards: A Report to the Minnesota Legislature

### Disability Linkage Line® (DLL)

---

The Disability Linkage Line® (DLL) is an information and referral service available at no charge to help people with disabilities and their representatives connect to community services. The line is already in operation<sup>35</sup>. Common requests include information and referrals on disability benefits programs, home modifications, assistive technology, personal assistance services, transition services, accessible housing, employment, social activities and disability rights. DLL® Resource Specialists can provide one-to-one assistance to help people learn about their options and connect with the supports and services they choose.

The DLL® is a partner in the statewide resource database found at [www.minnesotahelp.info](http://www.minnesotahelp.info). The website gives another access point to those in need. The DLL and the online resource database help connect persons in need of or already-receiving services connect with the services they are eligible to receive. This highly visible medium enables optimum consumer choice, is consumer driven and links services to individual needs and life goals; three requirements of the QOS legislation<sup>36</sup>.

### HCBS Provider Report Card

---

The HCBS Provider Report Card is recommended to be the public reporting tool for provider quality. The report card would combine information from many sources, consolidating indicators in one location. The use of provider performance measures in the form of an HCBS Report Card can:

- Educate persons in need of services about differences among HCBS services, service providers and costs. This can facilitate better decision making, or, informed choice.
- Contribute to DHS' response to federal waiver program assurances regarding access, choice, and system improvement
- Support HCBS providers in targeting improvements in their services

As reported in 2011 to Legislature<sup>37</sup> the proposed provider performance measures includes:

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

---

<sup>35</sup> The line is available at 1(866)333-2466

<sup>36</sup> MN Law 2009, chapter 79, article 8, section 81, paragraph (a), outcomes (1), (2) & (3).

<sup>37</sup> "Quality Management in HCBS 2011: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services", Disability Services Division Legislative Report, February 2011  
Minnesota Department of Human Services  
September 2012

## Quality Outcome Standards: A Report to the Minnesota Legislature

The HCBS Report Card is currently in design but lacks the funding for further development. If finished, it will give persons in need of services and their support team a robust tool for comparing services and service providers against one another. When combined with the results of MnCHOICES and the list of available service providers from [www.minnesotahelp.info](http://www.minnesotahelp.info), persons in need of services will have independent access to service options, service choices and quality information regarding those options and choices. This initiative could satisfy many expectations of the QOS legislation as it:

- Enable optimum consumer choice (QOS legislation expectation #1),
- Is consumer driven (2),
- Links services to individual needs and life goals (3),
- Is based on quality assurance (4),
- Utilizes person-centered planning (6), and
- Ensures that Minnesota's system of quality assurance maximizes federal financial participation by meeting federal requirements (7).

The value the HCBS Report Card would bring has made its development a priority to DHS.

### The State Quality Council

---

The 2011 Legislative Special Session<sup>38</sup> enabled DHS to assemble a State Quality Council. The State Quality Council will:

- Conduct community-based person directed quality reviews
- Create a system for incident reporting, investigation, analysis and follow-up
- Define regional quality councils
- Establish council assignments
- Promote consumer-directed services

Members shall include representatives from the following groups: 1) disability service recipients and their family members; 2) during the first two years of the State Quality Council there must be at least three members from the Region 10 stakeholders; 3) disability service providers; 4) disability advocacy groups; and 5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

The State Quality Council will play a key role in ensuring the fulfillment of the Quality Outcome Standards. While each of the quality initiatives *creates* opportunities to improve the quality of the system, the State Quality Council will enforce and maintain the quality outcome standards. The SQC will drive the promotion of consumer-directed services in HCBS, an essential aspect of the Quality Outcome Standard legislation.

The State Quality Council had its first meeting on March 30, 2012. Information regarding the activities of the Council can be found on the [State Quality Council DHS website](#).

---

<sup>38</sup> Minnesota Special Session Laws 2011, Chapter 9, Section 23 created Minn. Stat. §256B.097. Minn. Stat. §256B.097 is included as Appendix G of this report  
Minnesota Department of Human Services  
September 2012

### Appendix B: A Walk-Through of Minnesota's HCBS Quality System

---

#### **ACCESS**

A person in need of a home and community-based service will have many ways to access information about services and service providers. The Disability Linkage Line (DLL) and [www.minnesotahelp.info](http://www.minnesotahelp.info) provide information about eligibility and services in Minnesota. Both resources offer information regarding how to connect with counties for additional information, assessments and/or case management.

The first step towards enrolling in waiver services is to request an assessment. Once operational, MnCHOICES will provide a universal assessment tool. MnCHOICES will assess a persons' need for long-term service and eligibility for publicly funded services. The MnCHOICES assessment process will create a Community Support Plan identifying which services a person can use. Once appropriate services are identified through the assessment, [www.minnesotahelp.info](http://www.minnesotahelp.info) then provides a list of service providers in their area. The person will be able to find information about those providers with the HCBS provider report card on [www.minnesotahelp.info](http://www.minnesotahelp.info).

The case manager then creates a Coordinated Service and Support Plan with the person and the people closest to them, based on the services and goals the person identifies as needs and/or wants. The decision to begin a service will be up to the person and their team. If one is decided on, the case manager initiates the intake process with the provider based on the client's decision of possible providers.

*MN HCBS Quality System Practices #1 and #2 enable access to the system and Choice of services. It supports the Quality Outcome Standard Laws paragraph (a) requirements #(1) enabling optimum consumer choice, (2) be consumer driven, (3) linking services to individual needs and life goals, (4) based on quality assurance and individual outcomes, (5) utilizes the people closest to the participant, and (6) utilizes person-centered planning.*

#### **PROVIDER PLANNING**

When the waiver recipient comes to the provider, an intake meeting occurs. A service delivery plan is created that supports the Coordinated Service and Support Plan. The service delivery plan includes the list of goals the consumer and provider will work towards during service delivery. The plan also identifies indicators of progress towards those goals. Copies of the Coordinated Service and Support Plan and Service Delivery Plan are available to the recipient, their guardian and the case manager. This allows everyone to be on the same page.

*This intake process supports MN HCBS Quality System Practices #2 and #3. It supports the Quality Outcome Standard Laws paragraph (a) requirements #(1) enabling optimum consumer choice, (2) be consumer driven, (3) linking services to individual needs and life goals, (4) based on quality assurance and individual outcomes, (5) utilizes the people closest to the participant, and (6) utilizes person-centered planning.*

#### **SERVICE DELIVERY**

The focus of service delivery is on assisting the participant reach their goals and meeting their needs. The person may have one or several providers delivering services to them depending on their needs. To ensure that the proper goals and indicators have been identified a service review can be held at any time. Provider standards specify that a review be conducted once per year. During a review, the person and/or their legal

## Quality Outcome Standards: A Report to the Minnesota Legislature

representative is able to reflect on their choice of providers and determine if the provider is satisfactorily meeting their needs & goals.

The provider should regularly check in with the recipient to report their progress towards their goals. The provider should notify the recipient and the Case Manager if they are not progressing. Any deficit in meeting the recipient's needs is not necessarily the fault of the provider. The provider is responsible for providing the agreed-to service and notifying the person and their team when that service does not seem effective. The needs of the recipient will change over time, which will change the need for services. There are times when the recipient requires a different type of service or delivery. The HCBS Quality System Practices ensure the freedom to select a new provider or service.

HCBS providers will have a concise set of standards to hold them accountable. The standards ensure that the participants are safe, secure and working towards their goals. The provider will be subject to routine licensing reviews. The participants will yearly have a MnCHOICES assessment to gauge their need and their satisfaction with service. After the MnCHOICES, the Community Support Plan may be updated to reflect developing/waning needs. Licensing reviews and participant surveys will help determine the quality of services given, along with the service delivery reviews.

*This type of review is required under MN HCBS Quality System Practices #3, #4 and #5. It supports the Quality Outcome Standard Laws paragraph (a) requirements #(1) enabling optimum consumer choice, (2) be consumer driven, (3) linking services to individual needs and life goals, (4) based on quality assurance and individual outcomes, and (6) utilizes person-centered planning.*

### **SERVICE DELIVERY REVIEW**

Service Delivery Review is completed minimally once per year. During the review, the provider and the recipient convene to determine the effectiveness of service delivery. The people supporting the person, as well as the case manager or any member of the public can additionally check on the quality of the service provider through the future HCBS provider report cards. If at any point the participant chooses an alternative services or an alternative provider, the case manager can facilitate that transition. If at any point the participant determines that their condition has changed, the tools within the ACCESS step can be repeated.

The provider will be rated through the HCBS provider report card; they are also audited routinely to ensure they meet the DHS Licensing Standards and comply with their service standards

*MN HCBS Quality System Practices #3, #4 & #5 support this review. It supports the Quality Outcome Standard Laws paragraph (a) requirements #(1) enabling optimum consumer choice, (2) be consumer driven, (3) linking services to individual needs and life goals, (4) based on quality assurance and individual outcomes, (5) utilizes the people closest to the participant, and (6) utilizes person-centered planning.*

### **CONCLUSION**

In the end, the services a participant receives are chosen by the participant with the help of their team; reviewed by a participant and their team, and; meet the quality standards created by the Waiver Provider Standards (WPS) initiative. Participant interviews, licensing reviews and service delivery reviews gauge the quality of services given. The result is that a person receiving services is able to live a meaningful life that they have helped define.

*This system complies with federal mandate, MN Quality Outcome Standard Law (MN Law 2009, chapter 79, article 8, section 81), DHS Guiding Principles and the Goals of the Disability Services Division.*

Appendix C: RSS and CRS Statutory Authority

---

**Minn. Stat. §245A.11, Subdivision 8:**

**Subd. 8. Community residential setting license.**

(a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, 2011.

(b) Providers licensed under chapter Minn. Stat. chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minn. R. 9555.5105 to 9555.6265, or child foster care under Minn. R. 2960.3000 to 2960.3340; and meeting the provisions of Minn. Stat. §256B.092, subd. 11(b), must be required to obtain a community residential setting license.

**§256B.092, Subd. 11:**

**Subd. 11. Residential support services.**

(a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in Minn. Stat. §245A.11, subd. 8.

(b) Residential support services must meet the following criteria:

- (1) providers of residential support services must own or control the residential site;
- (2) the residential site must not be the primary residence of the license holder;
- (3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;
- (4) the provider of residential support services must provide supervision, training, and assistance as described in the person's community support plan; and
- (5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009.

Appendix D: HCBS Quality System Practices

---

**Definitions**

Def. 1. Feasible Alternatives. The types of waiver services that may be available to an individual who is a candidate for entrance to the waiver (e.g., meets requirements for entrance such as the need for a level of care specified in the waiver). During the waiver entrance process, a person must be informed of the feasible alternatives under the waiver so that the person may exercise freedom of choice between waiver and institutional services.

Def. 2. Freedom of Choice. The right afforded an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in §1915(c)(2)(C) of the Act and in 42 CFR §441.302(d).

Def. 3. Informed choice. "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives, to:

- select a preferred alternative from a number of feasible alternatives;
- select an alternative which may be developed in the future; and
- refuse any or all alternatives.

Def. 4. Person-Centered Planning. An assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.

Def. 5. Person Centered Services. "Person Centered Services" means services that are important for the person to meet individual support needs as assessed through a person-centered assessment of needs as well as what is important to the person with regard to preferences for the delivery of such supports.

HCBS Quality System Practices

In the interest of complying with Center for Medicaid and Medicare Services (CMS) guidelines regarding quality of Home and Community Based Services (HCBS) funded through the Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), and Developmental Disability (DD) waivers, as well as Minnesota Law 2010, Chapter 352, Article 1, Section 24 regarding quality outcome standards, the Minnesota Department of Human Services (DHS) has established the following quality outcome standards that formalize the goals of the Disability Service Division of DHS which provides oversight for Minnesota's Medicaid waivers:

**Quality Practice #1: Potential and current recipients of home and community-based service waivers will have ready access to information regarding eligibility for services and providers of available services in order that they may be provided with the opportunity to make an Informed Choice as defined in Subdivision 4.**

## Quality Outcome Standards: A Report to the Minnesota Legislature

- a. As Informed Choice requires having access to information regarding feasible alternatives and having a system to compare the feasible alternatives, to create an optimum level of choice DHS will: 1) create a public list of service providers, and; 2) create an ‘HCBS Provider Report Card’ that allows the public to compare service providers based on Quality Indicators.
  - i. All providers of Home and Community-Based Services must register with The Department. Upon application, The Department will then add the provider to the public list of Home and Community-Based Providers
  - ii. DHS will identify quality indicators for providers of home and community-based services. DHS will create a public reporting system that will enable possible participants and their support team to make an informed choice when selecting a service provider based on those indicators

### **Quality Practice #2: Potential candidates for entrance into waiver services will be afforded the right to Freedom of Choice as defined in subdivision 3. Recipients of home and community-based services will choose the services they receive and will decide their desired outcomes of service delivery.**

- i. Recipients of waiver based services will have a person-centered individual support plan created with the facilitation of their case manager that will dictate the services they receive and the outcomes expected from those services.
- ii. All recipients of home and community-based services will be assessed for service eligibility and appropriateness. The recipient’s case manager will facilitate the recipient’s choice of service providers, identified by the public list in Quality Practice #1a.i., which will meet their assessed needs.

### **Quality Practice #3: DHS will create a single set of standards governing providers of home and community-based services. Providers of HCBS will adhere to those standards providing for the proper care, health, treatment and safety of the individuals they serve. All services offered through the Home and Community-Based Service waiver services will meet the definition of Person-Centered Services as defined in definition 5.**

### **Quality Practice #4: Providers of home and community-based waiver services will assist the recipients of home and community-based services they serve reach their goals.**

- i. Providers of waiver-based services will create a service delivery plan that complements the individual support plan and the person-centered directed outcomes the consumer wishes to accomplish through the accepted service.
- ii. Providers of waiver-based services will report to the consumer and their community support team the participants’ progress annually, at minimum. The frequency of progress reports will be determined by the recipient or their representative, and the case manager. If the recipient has not made progress toward their goals at the time of a progress report, it should be determined whether strategies used to accomplish goals require modification, whether the participant requires other services that will better assist them in progressing toward their stated goals. It is

## Quality Outcome Standards: A Report to the Minnesota Legislature

also possible to change intended goals at any time should the participant or their representative deems it fit to do so.

- iii. Goals and outcomes should be dynamic, reflecting changes in the recipients' priorities and life experiences.

### **Quality Practice #5: The State of Minnesota shall monitor the quality of the waiver-based service delivery system and quality improvement plans to increase the quality of entire waiver-based system.**

- a. Quality will be assessed in the following ways:
  - i. Regular Participant Experience Surveys<sup>39</sup> measuring participant outcomes associated with HCBS.
  - ii. Outcomes related to provider workforce stability. Outcomes possibly included in this indicator:
    - a. retention of staff employed at least six month;
    - b. staff salaries and benefits;
    - c. staff opportunities for advanced training;
    - d. staff promotions to higher-level positions within the agency.
  - iii. Substantiated reports of abuse, maltreatment, neglect
  - iv. Violations of Participant Rights
  - v. Complaints and appeals regarding service delivery, client interaction and operational management
  - vi. Licensing actions resulting in corrective actions, fines and or suspensions.
- b. Areas of low quality will be encouraged to improve either through the free market (providers with low-quality usually suffer due to loss of clientele and/or small entrance numbers); or under the auspices of The State of Minnesota.

---

<sup>39</sup> See [Appendix A](#)



Appendix E: HCBS Quality Framework

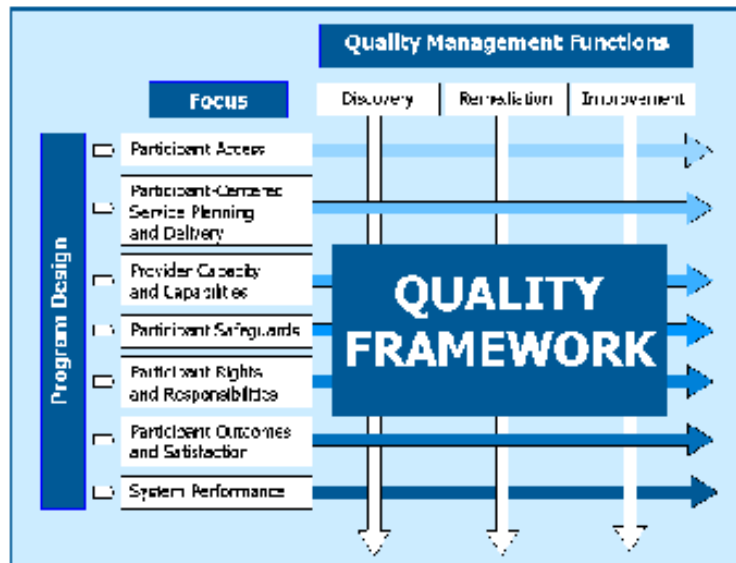
## HCBS QUALITY FRAMEWORK<sup>1</sup>

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

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

Quality management encompasses three functions:

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



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

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

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

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

<sup>1</sup> This reference sheet has been adapted from a reference sheet used at the Michigan Long-Term Care Conference Workshop on Defining and Achieving Quality

## STAGE 1

### Home and Community Based Waiver Provider Standards

#### 245D Licensed

*LICENSING STANDARDS: Staffing Standards, Record Retention, Policies and Procedures, Background Checks, Participant Rights, Participant protection reporting/management*

*SERVICE SPECIFIC STANDARDS: Professional license/certification/degree, additional training, experience*

Companion  
Services

Homemaker  
(excluding MDH  
licensed and  
Cleaning Only)

Housing Access  
Coordination

Respite

24-Hour  
Emergency  
Assistance

Behavioral  
Programming

Specialist  
Services

Night  
Supervision

Personal  
Support

#### INTERIM STAGE ONE SERVICES

Structured Day

Supported  
Employment

Prevocational  
Services

Independent  
Living Skills

## STAGE 2

### Home and Community Based Waiver Provider Standards



**Minn. Stat. §256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.**

**Subdivision 1. Scope.**

(a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under Minn. Stat. [§256B.092, subdivision 4](#), or Minn. Stat. [§256B.49](#), including traumatic brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care;

(2) home care services under Minn. Stat. [§256B.0651](#);

(3) family support grants under Minn. Stat. [§252.32](#);

(4) consumer support grants under Minn. Stat. [§256.476](#);

(5) semi-independent living services under Minn. Stat. [§252.275](#); and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under Minn. Stat. [§256B.0951](#); and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

**Subd. 2. Duties of commissioner of human services.**

(a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to Minn. Stat. [§245A.16](#) to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under Minn. Stat. [§256B.0951, subd. 3](#), at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

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

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

**Subd. 3. State Quality Council.**

(a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

## Quality Outcome Standards: A Report to the Minnesota Legislature

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

- (1) disability service recipients and their family members;
- (2) during the first two years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;
- (3) disability service providers;
- (4) disability advocacy groups; and
- (5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

- (1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota; and
- (2) establish state quality improvement priorities with methods for achieving results and provide 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.

(e) The State Quality Council, in partnership with the commissioner, shall:

- (1) approve and direct implementation of the community-based, person-directed system established in this section;
- (2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;
- (3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;
- (4) establish variable licensure periods not to exceed three years based on outcomes achieved; and
- (5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

### **Subd. 4. Regional quality councils.**

(a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

## Quality Outcome Standards: A Report to the Minnesota Legislature

- (1) disability service recipients and their family members;
  - (2) disability service providers;
  - (3) disability advocacy groups; and
  - (4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.
- (b) Each regional quality council shall:
- (1) direct and monitor the community-based, person-directed quality assurance system in this section;
  - (2) approve a training program for quality assurance team members under clause (13);
  - (3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;
  - (4) make recommendations to the State Quality Council regarding the system;
  - (5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;
  - (6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;
  - (7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;
  - (8) disseminate information and resources developed to other regional quality councils;
  - (9) respond to state-level priorities;
  - (10) establish regional priorities for quality improvement;
  - (11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;
  - (12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and
  - (13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.
- (c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under Minn. Stat. [§245.825](#); Minn. Stat. [§245.91](#) to 245.97; Minn. Stat. [§245A.09, subd. 2](#), (c), (2) and (5); Minn. Stat. [§245A.12](#); Minn. Stat. [§245A.13](#); Minn. Stat. [§252.41, subd. 9](#); Minn. Stat. [§256B.092, subd. 1b\(7\)](#); Minn. Stat. [§626.556](#); and Minn. Stat. [§626.557](#).
- (d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.
- (e) The regional quality councils may charge fees for their services.
- (f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.
- (g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under Minn. Stat. chapter 245A.

## Quality Outcome Standards: A Report to the Minnesota Legislature

### Subd. 5. **Annual survey of service recipients.**

The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

### Subd. 6. **Mandated reporters.**

Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in Minn. Stat. §[626.556, subd. 3](#), and Minn. Stat. §[626.5572, subd. 16](#).

### **History:**

[1Sp2011 c 9 art 7 s 23](#)

### **Continuing Care Administration Mission Statement**

The Continuing Care Administration strives to improve the dignity, health and independence of the people we serve.

### **Continuing Care Administration Vision Statement**

Minnesotans will:

- Live as independently as possible
- Enjoy health, with access to quality to health care
- Have safe, affordable places to live
- Be contributing and valued members of their communities
- Participate in rewarding daily activities, including gainful employment

### **Continuing Care Administration Values Statement**

In supporting this vision, we value:

- Self-determination
- Personal responsibility
- Integrity
- Diversity
- Partnerships
- Accountability

### **Disability Services Division Goals**

- Goal 1: Improve service and administration to increase access, consistency, transparency and accountability
- Goal 2: Provide access to the right service at the right time
- Goal 3: Provide accountability to/and improve quality
- Goal 4: Strengthen partnerships and collaboration
- Goal 5: Foster a shared vision and a culture of innovation
- Goal 6: Make person centered assessment and decision making the foundation of the service system

### **Disability Services Division Adopted “Domains of a Meaningful Life”**

Community Membership;  
Health, wellness and safety;  
Own place to live;  
Important Long-term relationships;  
Control over supports, and;  
Employment earnings and stable income.



## Quality Outcome Standards: A Report to the Minnesota Legislature

### Appendix I: RSS/QOS Stakeholder Workgroup Participants

---

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

---

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

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

---

##### **Additional participants Organizations/Stakeholders represented**

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

##### **Project Staff**

---

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

Appendix J: RSS/QOS Stakeholder Recommendations for Community Residential Setting License and Residential Support Services Standards

---

**Purpose.**

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

**Scope.**

The licensing standards in this section as well as quality outcome standards must be met to obtain and maintain a community residential setting license to provide residential support services. For the purposes of this section, residential support services must meet the following criteria:

- (1) providers of residential support services must own or control the residential site;
- (2) the residential site must not be the primary residence of the license holder;
- (3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;
- (4) the provider of residential support services must provide supervision, training, and assistance as described in the person's community support plan; and
- (5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

Residential Support Services refers to the services defined in Minn. Stat. §256B.092, subd. 11

Adult foster care license holders providing residential support services under their foster care license on [INSERT DATE HERE, 1/1/2013?], shall be permitted to continue providing these services with no additional requirements until their adult foster care license is due for renewal. At the time of relicensure, an adult foster care license holder will transition to provide residential support services upon demonstration of compliance with this section.

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

Adult foster care variances issued prior to [INSERT DATE HERE 1/1/2013?] are grandfathered in as variances to Community Residential Setting License standards.

**Definitions.**

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

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

Applicant. "Applicant" has the meaning given in Minn. Stat. §245A.02, subd. 3

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

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

Communicable Disease "Communicable Disease" means a contagious or infectious disease or condition as specified in Minn. R. 4605.7000 to 4605.7800.

## Quality Outcome Standards: A Report to the Minnesota Legislature

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

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

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

Health Authority. "Health Authority" means the designated representative of the board of health as defined in Minn. Stat. §145A.02 subd. 2, to enforce public health codes.

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

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

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

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

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

License Holder. "License holder" means that which is defined in Minn. Stat. §245A.02, subd. 9.

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

Minnesota State Building Code. "Minnesota State Building Code" means those codes and regulations adopted by the commissioner of administration under Minn. Stat. chapter 1300 and Minn. Stat. §326B.101.

Minnesota State Fire Code. "Minnesota State Fire Code" means those codes and regulations adopted by the fire marshal under Minn. Stat. §299F.011 and Minn. Stat. chapter 7511.

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

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

## Quality Outcome Standards: A Report to the Minnesota Legislature

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

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

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

**Supervision.** "Supervision" means: a) oversight by a caregiver as specified in the community support plan/individual service plan and daily awareness of a person's needs and activities; and b) the presence of a caregiver in the residence during normal sleeping hours or the presence of alternative overnight supervision through the compliance of Minn. Stat. §245A. 1, subd. 7, 7a, and 7b.

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

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

### **Applicable state and local code compliance.**

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

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

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

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

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

## Quality Outcome Standards: A Report to the Minnesota Legislature

### **Notification to local agency.**

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

### **Capacity.**

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

### **Physical Examination of a person receiving services.**

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

### **Emergencies.**

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

- a non-coin-operated landline telephone that is not cordless, an operable battery operated radio, and an operable flashlight are located within the residence;
- the phone numbers of each person receiving services' primary emergency contact representative, primary medical professional, emergency mental health provider, if applicable, and dentist are readily available for emergency personnel;
- the universal emergency phone number 911 and the home's address is posted by the telephone;
- each person receiving services is informed of a designated area where they can take shelter during severe storms or tornadoes and a drill is conducted annually;
- fire drills are conducted at least once every three months;
- a written fire escape plan and a log of quarterly fire drills are on file in the residence;
- the fire escape plan is initially reviewed by the fire marshal and includes the following on the floor plan: occupancy assembly point, exits, primary evacuation routes, secondary evacuation routes, enclosed exit stairs (if any), accessible egress routes (if any), areas of refuge (if any), manual fire alarm boxes (if any), portable fire extinguishers, smoke detectors, fire alarm enunciators and controls (if any). Fire escape plans are readily available for staff and persons receiving services;
- the house number is located on the outside of the house, in a prominent location that is visible from the street, to ensure that emergency vehicles will be able to easily locate the home in case of an emergency.

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

### **Common area requirements.**

Each person receiving services must have use of and free access to common areas in the home, unless it is documented as contraindicated for that person. The dining area is furnished to accommodate meals shared by all people receiving services. The living area shall be provided with an adequate number of

## Quality Outcome Standards: A Report to the Minnesota Legislature

furnishings for the usual functions of daily living and social activities. These furnishings shall be in good repair and functional to meet the daily needs of the people receiving services in the home.

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

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

### **Medications.**

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

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

Goods provided by the license holder.

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

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

### **Water.**

Potable water from privately owned wells must be tested annually by a Minnesota Health Department certified laboratory for coliform bacteria and nitrate nitrogens to verify safety. Retesting and corrective measures may be required by the health authority if results exceed state water standards in Minnesota Rules, chapter 4720 or in the event of a flooding or incident which may put the well at risk of contamination.

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

### **Food.**

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

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

### **Bedrooms.**

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

## Quality Outcome Standards: A Report to the Minnesota Legislature

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

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

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

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

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

### **Personal possessions.**

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

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

### **Pets and service animals.**

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

### **Weapons.**

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

### **Variations.**

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

### Minnesota Statutes, Laws and Rules

#### **Purpose.**

To develop a single set of standards governing services for people with disabilities receiving services under the home and community-based waiver services program to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the psychotropic medication checklist.

#### **Scope.**

(List identified services) under the BI, CAC, CADI and DD home and community-based waiver services program

#### **Definitions.**

**Annual or Annually.** “Annual” or “annually” means to be prior to or within the same month of the subsequent calendar year.

**Case manager.** "Case manager" means the individual designated by the county board under rules of the commissioner to provide case management services as delineated in Minn. Stat. §256B.092 or successor provisions.

**Change to health service needs.** “Change to health service needs” is defined as a change in the needs of an individual receiving services which would require new or additional care or services.

**Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

**Coordinated Service and Support Plan.** “Coordinated Service and Support Plan” has the meaning given in (to be added when determined)

**Demonstration of competency.** “Demonstration of competency” means documentation which demonstrates the understanding of the training content and ability to meet the license holder’s standard level of performance in the defined area.

**Direct service.** "Direct service" means, for a person receiving services, one or more of the following: supervision, assistance, or training.

**Health assessment.** “Health assessment” means the evaluation of the health status of an individual by performing a review of a person’s medical history, and gathering and analyzing the characteristics of the person’s health to determine the health care needs of the individual.

**Health care plan.** “Health care plan” means documented strategies designed to guide staff involved with care based on the specific health care needs of that individual.



## Quality Outcome Standards: A Report to the Minnesota Legislature

**Health services professional.** “Health services professional” means a registered nurse, nurse practitioner, physician's assistant, or medical doctor.

**Immediately.** "Immediately" means as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received.

**In writing.** “In writing” means written on paper or electronic form.

**Legal representative.** "Legal representative" means the parent or parents of a person receiving services who is under 18 years of age or a guardian, conservator, or guardian ad litem authorized by the court or other legally authorized representative to make decisions about services for a person receiving services.

**License holder.** "License holder" has the meaning given in Minn. Stat. §245A.02, subd. 9.

**Mandated Reporter.** “Mandated Reporter” has the meaning given under Minn. Stat. §626.5572 subd. 16.

**Medical and assistive equipment.** “Medical and assistive equipment” means medical, assistive, adaptive, and rehabilitative equipment or devices used by individuals with disabilities in order to perform functions that might otherwise be difficult or impossible.

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

**Other licensed caregiver.** “Other licensed caregiver” means another provider licensed under this chapter/section

**Persistent emotional distress.** “Persistent emotional distress” means a behavioral or emotional/psychological change observed in the person that is not brief in duration and persists so that the person is not restored to his/her previous state after intervention by staff people or after 24 hours if there is no intervention.

**Person Centered Services.** “Person Centered Services” means services that are important for the person to meet individual support needs as assessed through a person-centered functional assessment as well as what is important to the person with regard to preferences for the delivery of such supports.

**Person receiving services.** "Person receiving services" means an individual who has been determined eligible to receive and is receiving services or support licensed under this chapter/section

**Qualified source for first aid and cardio pulmonary resuscitation.** “Qualified source” means a person who by determination of the commissioner is licensed, registered or certified as appropriate to train in First Aid and/or Cardio Pulmonary Resuscitation.

**Qualified source for medical and assistive equipment training.** “Qualified source” includes a health services professional or an individual who provides training on such equipment.

**Service.** "Service" means care, supervision, activities, or training designed to achieve the outcomes assigned to the license holder.

## Quality Outcome Standards: A Report to the Minnesota Legislature

**Service outcome.** "Service outcome" means the behavior, action, or status attained by the person that can be observed, measured, and can be determined reliable and valid. Service outcomes are the equivalent of the long-range goals and short-term goals referenced in Minn. Stat. §256B.092, and any rules promulgated under that section.

**Support team.** "Support team" means a team composed of the person, the case manager, the person's legal representative, the person's advocate, if any, other people chosen by the person receiving services, and representatives of providers of the service areas relevant to the needs of the person as described in the Coordinated Service and Support Plan.

**Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to persons served by the license holder.

### **Data on file.**

The license holder must maintain the following information for each person:

- (1) identifying information that includes date of birth, legal representative, history as available, and the name of the primary emergency contact person;
- (2) health information, including medications, individual medication administration and monitoring information, diagnosis, allergies, medical appointment referrals, medical equipment used, and health care providers as required to meet the Coordinated Service and Support Plan responsibilities as assigned;
- (3) the person's current Coordinated Service and Support Plan or a letter to the case manager's supervisor requesting the most current copy;
- (4) copies of requested assessments;
- (5) documentation of service delivery;
- (6) progress reports as determined by the person, legal representative, if any, and case manager;
- (7) incidents involving the person as required under [insert section for "Incidents"];
- (8) and when service coordination is required, record of other license holders serving the person that includes a contact person, telephone numbers, and services being provided.

### **Access to records.**

The license holder must ensure the following people have access to the information in [insert section for "Data on file"]:

- (1) the person, their legal representative, and case manager;
- (2) staff providing direct services to the person and staff monitoring services unless the information is not relevant to carrying out the Coordinated Service and Support Plan or;
- (3) other individuals authorized by the person, or their legal representative, if any.

### **Environment.**

The license holder must:

- (1) ensure that services are provided in a hazard-free environment free of conditions that would create an immediate danger or threat to the health and safety of persons when the license holder is the owner, lessor, or tenant of the service site. When the license holder is not the owner, lessor or tenant of the service site the license holder shall inform the person or their legal representative and case manager about any environmental safety concerns in writing;
- (2) lock doors only to protect the safety of people and not as a substitute for staff supervision or interactions with persons;
- (3) follow procedures that minimize the person's health risk from communicable diseases; and

## Quality Outcome Standards: A Report to the Minnesota Legislature

(4) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in reliable working condition.

### **Health.**

The license holder is responsible for meeting the health needs of the person as assigned in the Coordinated Service and Support Plan and for bringing changes to health service needs to the attention of the person, their legal representative and Case Manager within 24 hours of the license holder having knowledge of the change in needs. If assigned in the Coordinated Service and Support Plan, the license holder will conduct a health assessment and develop a health care plan for the person. The license holder is required to maintain documentation on how the person's health needs will be met as applicable to the person.

License holders serving children in a residential setting will comply with [link to be added to Child Foster Care appropriate health services]

### **Funds.**

The license holder must ensure that persons served retain the use and availability of personal funds or property unless restrictions are justified in the person's Coordinated Service and Support Plan.

The license holder must ensure separation of funds of persons served from funds of the license holder, the program, or program staff.

The license holder shall not handle the funds of a person without first receiving written authorization annually from the person or their legal representative. The license holder shall keep a record of expenditures to be provided on an agreed regular basis to the person, legal representative and case manager.

License holders and program staff must not:

- Borrow money from a person served by the license holder;
- Require a person served by the license holder to purchase items for which the license holder is eligible for reimbursement; or
- Use funds of persons served by the license holder in a manner that would violate Minn. Stat. §256B.04, or any rules promulgated under that section.

Unless otherwise addressed in the person's written authorization or Coordinated Service and Support Plan, per the preference of the person or the person's legal representative, the license holder and program staff must not:

- Purchase personal items from a person served by the license holder; or
- Sell merchandise or personal services to a person served by the license holder.

### **Incidents.**

When an incident occurs during service provision the license holder must maintain documentation about and report the following incidents to the person's legal representative, other licensed caregiver when service coordination is required, and case manager within 24 hours of the occurrence, or within 24 hours of an employee of the license holder receiving information that the incident has occurred unless the license holder has knowledge that the incident has been reported by another license holder. Notification to the person's legal representative or case manager does not need to be given if the legal representative or case manager is involved in the incident:

- (1) serious injury as determined by Minn. Stat. §245.91, subd. 6;
- (2) death of a person;

## Quality Outcome Standards: A Report to the Minnesota Legislature

- (3) any medical emergencies, unexpected serious illnesses, or accidents that require physician treatment or hospitalization;
- (4) unauthorized absence of a person as identified in their vulnerability management plan;
- (5) any fires or other events that require the relocation of services for more than 24 hours, or circumstances involving a law enforcement agency or fire department related to the health, safety, or supervision of a person;
- (6) physical or verbal aggression by a person receiving services against another person receiving services that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;
- (7) any sexual activity between persons receiving services involving force or coercion as defined under Minn. Stat. §609.341, subd.3 and 14; or
- (8) a report of child or vulnerable adult maltreatment under Minn. Stat. §626.556 or Minn. Stat. §626.557.

When the incident involves more than one person receiving services, the license holder must not disclose personally identifiable information about any other person receiving services when making the report to each legal representative, other licensed caregiver, if any, and case manager unless the license holder has the consent of a person receiving services or their legal representative.

Death or serious injury of a person must also be reported to the Department of Human Services Licensing Division, and to the ombudsman for mental health and developmental disabilities when required under Minn. Stat. §245.91 and Minn. Stat. §245.94, subd. 2(a).

The quality outcome coordinator shall review incident reports, identify incident patterns, and implement corrective action as necessary to reduce occurrences.

### **Maltreatment Reporting.**

The license holder shall report child or vulnerable adult maltreatment in compliance with Minn. Stat. §626.556 and Minn. Stat. §626.557. The license holder shall inform and train staff in their responsibilities as a mandated reporter.

Within 24 hours of reporting maltreatment as required under Minn. Stat. §626.556 or Minn. Stat. §626.557, the license holder must inform the person, the person's legal representative and case manager of the report unless there is reason to believe that the legal representative or case manager is involved in the suspected maltreatment. The information the license holder must disclose is the nature of the activity or occurrence reported, the agency that receives the report, and the telephone number of the Department of Human Services Licensing Division.

### **Medication Management.**

If the license holder is responsible for the administration and/or monitoring of medication, the license holder shall ensure the following:

1. A written statement from the prescriber stating the name of the medication prescribed and whether the person is capable of taking the medication without assistance
2. Written permission from the person or the person's legal representative to administer the medication
3. A person who is not capable of self-administering the medication will have medication administered by a staff in accordance with the written instructions from the prescriber, if the written permission has been obtained from the person or the person's legal representative.
4. Each person receiving medication assistance must have a medication record containing the prescriber's order; purpose of the medication; notations when a medication is started, changed,

## Quality Outcome Standards: A Report to the Minnesota Legislature

discontinued, or administered; side effects; and consequences if the medication is not administered as prescribed. Side effect information must be available onsite to all staff administering the medication.

5. Ensure a report to the prescriber of any adverse medication reaction and as specified by the prescriber, the person's refusal or failure to take medication as prescribed
6. The license holder must immediately report to the legal representative and case manager whenever the prescriber is notified because medication is not taken as prescribed and the prescriber determines that the refusal or failure to take medication as prescribed creates an immediate threat to the person's health or safety or the health or safety of other persons receiving services.
7. Over the counter medications not requiring a prescription must be administered according to manufacturer's instructions. Written permission for administration must be obtained from the person or the person's legal representative.

Injectable medications may be administered under one of the following circumstances:

- The staff is a registered nurse or licensed practical nurse with a current Minnesota license
- A supervising registered nurse has delegated the administration of injectable medication to staff. The staff must receive training on the administration of injectable medication from a licensed health care professional. Or
- There is an agreement signed by the license holder, the person's physician, the person and the person's legal representative specifying what injections may be given, when, how, and that the physician shall retain responsibility for the staff giving the injections. A copy of the agreement must be placed in the person's record. The staff must receive training from a licensed health care professional on the administration of injectable medication.

### **Rights of people receiving services.**

The license holder must provide services in a manner which protects and promotes individual rights for all persons receiving services. The license holder shall provide the person receiving services and the person's legal representative, if any, a copy of the rights on the day that services are initiated and annually thereafter. Individual rights will be provided and explained in a manner which facilitates understanding of the rights by the person receiving services and their legal representative, if any. A signed acknowledgement of receipt of this document shall be kept in the person's file.

People receiving services have the right to:

- (1) all human, legal, equal and civil rights afforded under federal and state laws
- (2) assert these rights personally, or have them asserted by the person's family or legal representative, without retaliation;
- (3) receive services which are designed and delivered based on personal needs and individual preference;
- (4) self-determination and freedom of choice to direct services to the person's fullest capability including the right to engage in chosen activities and the right to refuse or terminate services;
- (5) know, in advance, limits to the services available from the license holder;
- (6) receive licensed services from individuals who are competent and able to perform their job duties, and who have professional certification or licensure, when required, and who meet additional qualifications identified in their Coordinated Service and Support Plan;
- (7) the opportunity to undergo typical developmental experiences even though such experiences may entail an element of risk; provided safety and well-being are not unreasonably jeopardized;
- (8) confidentiality of personal, financial, service, and medical information;
- (9) access records and recorded information;
- (10) freedom from maltreatment;

## Quality Outcome Standards: A Report to the Minnesota Legislature

- (11) be treated with courtesy, dignity, compassion, and respect;
- (12) voice grievances, and receive timely responsive services to address grievances;
- (13) access to their legal representative, self-help and advocacy support services for additional information or assistance;
- (14) give or withhold written informed consent to participate in any research or experimental treatment;
- (15) reasonable access to a telephone and to make and receive confidential phone calls;
- (16) receive and send uncensored, unopened mail and electronic correspondence;
- (17) associate with persons of their choice; and
- (18) personal privacy, including privacy expressing sexuality, and including the opportunity whenever possible to be provided privacy within living, sleeping, and personal care space.

Children receiving services will be afforded the rights in Minn. R. 2960.0050.

### **Vulnerability and assessment planning.**

Based on the Coordinated Service and Support Plan, and in coordination with the person, the person's legal representative, if any, and case manager, the license holder shall assess the person's vulnerabilities in relation to the services to be provided by the license holder and develop and document a plan to mitigate the vulnerabilities identified. Based on the assessment, the individual and support team can choose not to create a plan for identified vulnerabilities that do not rise to the level of self neglect, maltreatment and violations of law if the team accepts the vulnerabilities as a part of the person's quality of life. If such a decision is made the team must document the vulnerability and the decision made by the person, their legal representative and case manager to not create a written plan. The assessment and plan shall be created and on file upon the initiation of services, reviewed within 45 days of service initiation, updated annually, and as needed when vulnerabilities change.

The license holder shall train staff on the vulnerability assessment plan for each person before the staff provides direct service provision.

License holders licensed under this chapter are exempt from Minn. Stat. §245A.65, subd. 2, and Minn. Stat. §626.557, subd. 14, if the requirements of this subdivision are met.

The following areas are included in, but are not limited to, the assessment:

a) **Health and Wellness:** *Allergies, Seizures, Medications/Treatments & other health needs, Choking, Special Diet Needs, Vision, Hearing, Communication, Preventative Screening, Level of Cognition or Capacity to Understand*

b) **Personal Safety:** *Risk of Falling/Mobility Level, Physical Abuse, Emotional Abuse, Any type of Exploitation, including Financial Exploitation, susceptibility to neglect and abuse, Sexual Abuse, other safety needs*

c) **Behavior Related:** *Self-Injurious, Substance Abuse, Law Breaking Behaviors, Aggressive Behaviors, Other Unsafe Behaviors*

d) **Environment:** *Unsanitary/Unsafe Housing, Unsafe Neighborhood/Service Site, Multi-Person Service Site, physical environment that may impact safety*

## Quality Outcome Standards: A Report to the Minnesota Legislature

### **Service outcomes.**

When services are initiated, the license holder shall meet with the person receiving services, their legal representative, if any, and case manager to determine the services to be provided and the outcomes of those services. Service outcomes must be developed within 45 days of service initiation. Service outcomes will include the person's definition of success, the action steps to reach the outcome, timelines for accomplishment of the outcome and the responsible person or position for providing support for the service outcome.

In addition, frequency of meetings to review services and the frequency and types of reports shall be determined with the person, the person's legal representative, if any, and case manager. Written reports and meetings to review services must occur at least annually.

The license holder shall maintain a copy of the person's current Coordinated Service and Support Plan and provide services consistent with the plan. If the license holder does not receive a Coordinated Service and Support Plan, prior to initiation of services, the license holder shall send a letter to the case manager requesting a copy. If the license holder does not receive an updated Coordinated Service and Support Plan annually, the license holder shall send a written request to the case manager's direct supervisor.

### **Training of direct support staff.**

#### **Orientation training**

The license holder shall assure that staff providing direct support:

Complete 20 hours of orientation training, including demonstration of competency, related to the services provided within 60 days of hire date including

- Person centered services
- Medication administration if it applies to the person receiving services, from a training curriculum developed by a licensed health care professional.

Orientation training required within 72 hours of direct contact must include:

- Rights of persons receiving services
- Explanation of responsibilities related to Minn. Stat. §245A.65; Minn. Stat. §626.556 and Minn. Stat. §626.557, governing maltreatment reporting and service planning for children and vulnerable adults.

Orientation training required before the staff is unsupervised by the license holder must include:

- license holder policies and procedures,
- each person's vulnerability management plan
- each person's Coordinated Service and Support Plan
- topics identified in the person's Coordinated Service and Support Plan
- first aid, unless service provision to the person is less than 1 hour per person per shift, then first aid training must be completed within 60 days of hire date
- medical and assistive equipment used by the person receiving services
- cardio pulmonary resuscitation if directed by the person, their legal representative or the person's physician
- symptoms and effects of disabilities, health conditions, and positive behavioral supports and interventions as identified in the Coordinated Service and Support Plan

## Quality Outcome Standards: A Report to the Minnesota Legislature

First aid and cardio pulmonary resuscitation training must be provided by a nationally recognized source or a qualified source as determined by the commissioner. Medical and assistive equipment training must be provided by a qualified source.

The license holder must ensure that volunteers who provide direct services to persons receive the training and orientation necessary to fulfill their responsibilities.

### **Annual training**

The license holder shall assure that staff providing direct support completes at least 5 hours of training annually including vulnerability management plans, emergency plans, Coordinated Service and Support Plans, and explanation of responsibilities related to Minn. Stat. §245A.65; Minn. Stat. §626.556 and Minn. Stat. §626.557, governing maltreatment reporting for minors and vulnerable adults.

The training will be documented and maintained in the personnel files for each direct support staff.

### **Provider policies and procedures.**

The license holder must develop and implement the following policies and procedures:

- 1 - safety in emergency situations for people receiving services, as applicable for the environments where services are being provided, including but not limited to: fire, severe weather, medical emergency, missing person, power outage, and public emergencies;
- 2 - infection control procedures including universal precautions;
- 3 - safe transportation, when the license holder is responsible for transportation of people receiving services, with provisions for handling emergency situations;
- 4 - a system of record keeping for both persons receiving services and the organization including record retention for persons receiving services for at least five years following termination of services. When services have been terminated, a summary of the discharge shall be included and kept within the file;
- 5 - a plan for responding to all incidents, as defined in section to be added here, and reporting all incidents required to be reported under section to be added here including a system for review of incidents and emergencies, and ensuring corrective action if needed;
- 6 – health service coordination and care if it is a residential based service;
- 7 – medication administration if the license holder shall administer or assist the person to self-administer medications or treatments ordered by appropriately licensed professionals. The license holder shall have a medication administration policy with procedures that have been approved, in writing, by a health care professional (as defined in section to be added here). The medication administration policy and procedure shall address the storage of medications, the steps to be taken by staff if a medication error or medication refusal occurs and medication side effect monitoring. The license holder shall assure that before staff administers medications, they have been trained and demonstrated competency in the administration of medications as determined by the license holder’s medication administration policy and procedures.
- 8 - psychotropic medication monitoring placeholder
- 9 - data privacy, the license holder shall maintain data privacy for people receiving services, in compliance with the Minnesota Data Practices Act, Minn. Stat. chapter 13.
- 10 – grievance policy and procedure, which describes how the person and legal representative, if any, may file a grievance free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge and the timeline for a response from the license holder. The license holder will document grievances, the response, and timelines. The license holder shall offer and provide the person assistance to contact an impartial decision maker outside of the license holder agency if the grievance is not otherwise resolved.



## Quality Outcome Standards: A Report to the Minnesota Legislature

11 – criteria for admission, initiation of services, service termination, and temporary service suspension including the following requirements:

- (i) the license holder must notify the person or their legal representative and the case manager in writing of the intended termination or temporary service suspension and the person's right to seek a temporary order staying the termination or suspension of service according to the procedures in Minn. Stat. §256.045, subd. 4(a) or subd. 6 (c);
- (ii) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective;
- (iii) the license holder must provide information requested by the person, their legal representative or case manager when services are temporarily suspended or upon notice of termination;
- (iv) use of temporary service suspension procedures is restricted to situations in which
  - the person's behavior causes immediate and serious danger to the health and safety of the individual or others or
  - a significant change in the person's condition has resulted in service needs that exceed the established services to be provided and that cannot be safely met by the license holder;
- (v) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service termination or temporary service suspension; and
- (vi) during the period of temporary service suspension, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the person and others; and
- (vii) notification to the person, legal representative, if any, and the person's case manager in writing of changes to charges for services, funding source for payment of services, and any charges a private party may have to pay in advance of the change(s).

12 - quality services measured through a program evaluation process including regular evaluations of person's satisfaction including:

- The sharing the results of the evaluations with the person, legal representatives, and case managers
- Incorporation of survey feedback and results to develop improvement strategies for services.

13 – Emergency Use of Controlled Procedures according to Minn. R. 9525.2770 subp. 5 placeholder

14– VA/MOMA reporting according to Minn. Stat. §245A.65 subd. 1

15– Drug and Alcohol Prohibition according to Minn. Stat. §245A.04 subd. 1 (c)

Policies and procedures must be maintained and made available to the commissioner of human services upon request.

### **Staff qualifications.**

#### **Direct support staff**

The license holder must ensure that staff is competent through training, experience, and education to meet the person's needs and requirements as written in the Coordinated Service and Support Plan. Staff qualifications must be documented. Staff under 18 years of age may not perform overnight duties or administer medication.

The license holder must provide for adequate supervision of direct care staff to ensure implementation of the Coordinated Service and Support Plan.

#### **Quality Outcome Coordinator**

The quality outcome coordinator must meet the requirements of a Qualified Developmental Disability Professional (42 CFR 483.430) or must minimally have:

## Quality Outcome Standards: A Report to the Minnesota Legislature

- a four-year degree in a field related to service provision, and one year of full time work experience supporting people with disabilities or
- a two-year degree in a field related to service provision, and two years of full time work experience supporting people with disabilities or
- a diploma in *community-based developmental disability services* from an accredited postsecondary institution and two years of full time work experience supporting people with disabilities or
- a quality outcome coordinator certificate by successfully completing a commissioner approved quality outcome coordinator training and assessment and four years of full time work experience supporting people with disabilities

### **Quality outcome coordinator responsibilities.**

The license holder is responsible for program oversight, development, and implementation of policies and procedures. Delivery and evaluation of services provided by the license holder to a person must be coordinated by a quality outcome coordinator.

The quality outcome coordinator must provide supervision, support, and evaluation of activities that include:

- (1) oversight of the license holder's responsibilities designated in the Coordinated Service and Support Plan;
- (2) instruction and assistance to staff implementing the Coordinated Service and Support Plan areas;
- (3) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes.

The quality outcome coordinator is responsible for taking the action necessary to facilitate the accomplishment of the outcomes for each person as specified in the person's Coordinated Service and Support Plan.

### Appendix L: Stakeholder recommendations for Quality Outcome Standards

---

The below Quality Outcome Standards are built on a foundation of person-centered and self-determined beliefs in assuring a quality life and services for people with disabilities. The following principles are held:

- The person receiving services can best determine the services the person wants and needs
- For individuals with a guardian, to the greatest extent possible, the individual's wishes will be held paramount
- Each outcome is present to the degree the person receiving services desires it to be in their life
- The person defines what each outcome means to them and determines their satisfaction with the services and supports in reaching that outcome
- The person has the right to rely on a support team for input and assistance

**Community Membership** that is grounded in both participation and actual group membership.

- I am involved in cultural, ethnic, educational, social, recreational, civic, political, employment, volunteer and/or spiritual activities
- I am a valued member of my community
- I advocate for others and for causes I believe in
- I use community resources such as stores, libraries, community centers, and parks
- I participate in activities in the community with people both with and without disabilities
- I have access to the internet and other communication tools and devices

**Health, Wellness and Safety**, with an emphasis on features of communication, relationships and trust.

- I am supported to maintain health, wellness, and safety
- I have freely chosen and supportive health care professionals
- I have preventative and routine health care
- I have specialty health care to treat medical and mental health conditions
- I am listened to, understood, and acknowledged when I communicate
- I advocate for myself or have a trusted advocate or ally, as needed, who understands me
- I am provided positive behavioral supports
- I express my own identity (in dress, grooming, etc.)
- I am supported in end of life decisions

**Own Place to Live**, where people choose both the place and whomever else lives or provides support in their home.

- I have freely chosen my place to live
- I have freely chosen who I live with
- I am supported in managing and maintaining my home
- I have friends over to my home
- I have family members over to my home
- I have control of the lease or mortgage of my home
- I have access to privacy and private space
- I decide how to decorate the common areas of the home and my personal space

## Quality Outcome Standards: A Report to the Minnesota Legislature

**Important Long-Term Relationships** that are reciprocal and provide for safety.

- I have a variety of personal relationships with family, intimate companions, friends, neighbors, co-workers, fellow students, staff and others in the community
- I visit friends
- I visit family members
- I have a social support network that is nurtured

**Control over Supports** including, whenever possible, control over the funding for personal supports, housing and transportation.

- I have control over my funding, have received information to understand the resources available and can make choices based on that information and funding
- I choose supports, services, and service providers
- I identify personal outcomes which are actively created through a continual person-centered planning process
- I control the sharing of personal information
- I have input in staff hiring, retention, evaluation and review
- I have control over my daily life and have freedom to explore new experiences
- I have access to reliable transportation that enables me to be involved in the community
- I am free from arbitrary rules and restrictions
- I have the right to and choice for reasonable risk which is recognized and respected
- I have natural supports in all aspects of life
- I can access my funds in a typical way (debit card/ATM card/check book/credit card)

**Employment Earnings** - the generation of private income through typical jobs or self-employment or stable income from public or private sources.

- I choose where I work or if I am self employed
- I make minimum wage or higher
- I work to my full capacity and interest
- I have access to ongoing training and vocational opportunities for my chosen career and employment path
- I have adequate resources for daily living and find my work meaningful

Quality Outcome Standards: A Report to the Minnesota Legislature

Appendix M: Provider Enrollment Provider Standards Intensive Group Stakeholder Member List

<b>Name</b>	<b>Last Name</b>	<b>Organization</b>
Barb	Jacobson	ARRM
Sara	Schlegelmilch	Brain Injury Association
Nancy	Dahlin	Chisago County
Cindy	Guddal	Courage Center
Deanne	Skeens	Dakota County
Bud	Rosenfield	Disability Law Center
Sandy	Henry	Dungarvin
Charlotte	Strand	Hennepin County
Sarah	Keenan	Medica
Charity	Floen	Olmsted County
Carolyn	Dobis	ProAct
Connie	Menne	REM
Jon	Nelson	RSI or NE Minnesota
Julia	Wallis	Washington County

**DHS Intensive Work Group Members**

<b>Name</b>	<b>Last Name</b>	<b>Organization</b>
Jolene	Kohn	Aging and Adult Services – Policy
Libby	Rossett-Brown	Aging and Adult Services – Policy
Rebecca	Glasford	Disability Services Division – Home Care Policy
Larry	Riess	Disability Services Division - Regional Resource Specialist
Christina	Samion	Disability Services Division – Waiver Policy
Leah	Zoladkiewicz	Disability Services Division - Waiver Policy
Lori	Shimon	Health Care Operations - Provider Enrollment

\*The Intensive Stakeholder Group met from July 2009-July 2010

## Quality Outcome Standards: A Report to the Minnesota Legislature

### Appendix N: Provider Enrollment Provider Standards Expanded Work Group Members

First Name	Last Name	Organization
Gene	Leistico	ACR Homes
Jennifer	McNertney	Aging Services of Minnesota
Jan	Buck	Anoka County Social Services
Barbara	Blumer	Barb Blumer Law
Phil	Manz	Care Providers of Minnesota
Laurie	Young	Clay County
Heidi	Sandberg	Dakota County
Lisbeth	Armstrong	Hammer
Ann	Keefe	Medica
Ed	Eide	Mental Health Association of MN
Dale	Johnston	Ramsey County
Kia	Xiong	Ramsey County
Jim	Jasper	Restart Inc.
Peggy	Kraemer	Rise Inc.
Pat	Butler	White Earth

#### DHS Expanded Work Group Members

First Name	Last Name	Division /Job Title
Hal	Freshley	Aging and Adult Services Division
Sara	Myott	Aging and Adult Services Division – Quality Assurance Policy
Jay	Brunner	DHS Legal Compliance & Contracts
Karen	Erickson	DHS Licensing
Michelle	Long	DHS Licensing
Deb	Maruska	DHS Special Needs Purchasing
Ron	Nail	DHS Surveillance & Integrity Review Sections (SIRS)
Rebecca	Glasford	Disability Services Division Home Care Policy
Jason	Flint	Disability Services Division Quality Assurance Policy
Joseph	Alakija	Disability Services Division Regional Resource Specialist (Region 11NE)
Mary	Enge	Disability Services Division Regional Resource Specialist (Regions 2, 3)
Connie	Erlandson	Disability Services Division Regional Resource Specialist (Regions 1, 2SW, 4)
Annette	Guetter	Disability Services Division Regional Resource Specialist (Regions 6, 8)
Theresa	Mustonen	Disability Services Division Regional Resource Specialist (Regions 5, 7W, 7E)
Maria	Ockenfels	Disability Services Division Regional Resource Specialist (Region 11SW)
Larry	Riess	Disability Services Division Regional Resource Specialist (Regions 9, 10)
Christina	Samion	Disability Services Division Waiver Policy

## Quality Outcome Standards: A Report to the Minnesota Legislature

Paj	Thao	Disability Services Division Waiver Policy
Leah	Zoladkiewicz	Disability Services Division Waiver Policy
Lori	Dablow	Disability Services Division Waiver Policy Supervisor
Sherilyn	Moe	Office of Ombudsman for Long Term Care

The Expanded Work Group met from September 2009 to July 2010