Management
Analysis
& Development

MMB (MAD) Evaluation

Options for Administering Health and Human Services Regulations

July, 2013

Minnesota Management & Budget, 203 Administration Building, 50 Sherburne Avenue, St. Paul, MN 55155
Telephone: 651-259-3800 Fax: 651-797-1311 Website: www.mad.state.mn.us

Project Team

Ralph Brown
Laura Iversen

Division director

Bill Clausen

Assistant division director

Kristin Batson

Contact information

Telephone:	651-259-3800
E-mail:	Management.Analysis@state.mn.us
Fax:	651-797-1311
Website:	http://www.mad.state.mn.us/
Address:	203 Administration Building 50 Sherburne Avenue St. Paul, Minnesota 55155

Copies of this report

For more information or copies of this report, contact **Minnesota Management & Budget**.

Management Analysis & Development

Management Analysis & Development is Minnesota government's in-house fee-for-service management consulting group. We are in our 29th year of helping public managers increase their organization's effectiveness and efficiency. We provide quality management consultation services to local, regional, state and federal government agencies, and public institutions.

Table of Contents

Overview

Introduction

Management Analysis & Development (MAD), a division of Minnesota Management and Budget (MMB), has prepared this evaluation on behalf of the MMB commissioner. Laws of Minnesota 2012, chapter 247, article 2, section 9, addresses service issues of the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH). The section includes:

(2) the commissioner of management and budget, in consultation with the commissioners of health and human services, must evaluate and recommend options for administering health and human services regulations. The evaluation and recommendations must be submitted in a report to the chairs and ranking minority members of the health and human services legislative committees no later than August 1, 2013, and shall at a minimum:

> *(i) identify and evaluate the regulatory responsibilities of the Departments of Health and Human Services to determine whether to reorganize these regulatory responsibilities to improve how the state administers health and human services regulatory functions, or whether there are ways to improve these regulatory activities without reorganizing;*
>
> *(ii) describe and evaluate the multiple roles of the Department of Human Services as a direct provider of care services, a regulator, and a payor for state program services; and*
>
> *(iii) for long-term care regulated in both departments, evaluate and make recommendations for reasonable client risk assessments, planning for client risk reductions, and determining reasonable assumptions of client risks in relation to directing health care, client health care rights, provider liabilities, and provider responsibilities to provide minimum standards of care.*

Context

This evaluation includes three distinct studies, each with a discretely defined purpose. All of the studies address issues within the scope of providing care and services to people with significant frailty, disability or need of substance abuse or mental health treatment. The development, delivery and regulation of such services are vast topics, and ultimately involve much more state responsibility and participation than the three studies cover. For example, the Department of Commerce is involved in this larger world through its regulation of the insurance industry, and the Department of Veterans Affairs is involved through its operation of nursing facilities. The studies, however, are limited to the agencies, the roles and the purpose as statutorily specified. Each, in effect, is like a pinpoint on an expansive chart.

Each study is complete by itself, and includes self-contained recommendations. And yet, the placement of the studies in one report does influence the final aggregate of recommendations. One example is particularly clear. The first study examines the regulatory role of DHS in the context of its relationship with the regulatory role of MDH; it recommends an array of improvement options, both with and without structural reorganization. The second study also examines the regulatory role of DHS, but this time in the context of its relationship with other service-related roles of DHS. Instead of improvement options, it recommends avoidance of conflict of interest, and narrows the first study recommendations to reorganization only. In some instances, by focusing on risk issues, the third study is illustrative of regulatory tensions and the need for DHS and MDH collaboration as discussed in the first study.

Sequels and prequel

None of the studies are viewed as reports written in isolation. The first two studies are treated as sequels, following closely behind reports from other sources, and the third is treated as a prequel, preparing the way for inevitable work to come.

- The first study is an extension to a February 2012 MDH report to the Legislature, Evaluation of Health and Human Services Regulatory Responsibilities. That evaluation called for continuing examination of interagency regulation issues, which this study provides, within the scope of the legislative request.
- The second study was conducted in approximately the same timeframe as a February 2013 Office of the Legislative Auditor report, *State-Operated Services*. That evaluation examined residential and inpatient services provided by DHS and explored service alternatives, but excluded consideration of structural changes. This study does consider structural changes to state-operated services, in the context of reviewing DHS role relationships.
- The third study was conducted as the State Quality Council (SQC) was preparing a 2014 legislative report that includes risk examination, and as a Governor's sub-cabinet team was drafting an Olmstead Plan to guide the state's service provision to people with disabilities in integrated settings, to help ensure meaningful choice and opportunities. Risk is a key element in determining meaningful choice. This study reviews state progress and proposals for resolving risk issues in anticipation of new efforts that likely will stem from Olmstead, the SQC or related initiatives.

The first two studies are intended to emphasize organization issues along with policy options, while the third study is intended to emphasize policy issues along with organization options. The first two studies are built upon the foundations of earlier reports and try to minimize repeating the data they collected, while the third study is intended to be the foundation for future work, and provides an information compilation that will be needed as Olmstead or related processes continue.

Methodology

Data gathering for the studies included a review of relevant statutes and laws; recent legislative reports and internal reports by state agencies and offices; website information from state agencies, national professional associations and federal agencies; and a general literature review. In addition to web-based information on other states, interviews were conducted with ten employees representing health and human service agencies in three Midwestern states and one comparable state on the East Coast.

MAD consultants conducted interviews with 60 Minnesotans representing DHS, MDH, other state agencies, service provider associations, private service facilities, consumer advocacy groups, ombudsman offices, legislative staff and other involved parties.

Interviewees were offered the opportunity to discuss all three study areas. While some chose to focus on one or two studies, most offered comments on all. The three study areas encouraged people to look at the same topic from multiple perspectives. MAD conducted its research between June 2012 and July 2013.

Recommendations summary

Study 1: Regulatory responsibilities

There is not one single way to improve regulatory administration in MDH and DHS. From the perspective of this study, bringing the DHS Licensing Division and the MDH Compliance Monitoring Division into the same organization makes sense. Rather than offer one recommendation, following are four recommended options. In this sequence, they involve escalating levels of reorganization.

1. ***Take action regardless of reorganization decisions***. The following steps have value, with or without any structural reorganization.
   A. ***Expand and accelerate the current course***. The agencies deserve credit for initiating an effort to improve cross-agency collaboration. The scope can be expanded—there are provider and advocate issues that are not yet incorporated. The current interagency planning group should consider sub-groups to focus on areas such as an integrated professional development program.
   B. ***Emphasize improved communication***. MDH and DHS have focused on web linkages as a useful first step, and it has helped in identifying out-of-date or broken connections. The agencies could approach providers and advocates about priorities from their perspectives. Interpersonal skills training could be of value for frontline and high-level staff.
   C. ***Involve stakeholders in the effort***. At least yearly, the agencies should gather service providers and consumer advocates who work with both agencies to discuss change initiatives and other concerns. A component would be the opportunity for everyone to identify and respond to what they see as important issues affecting regulation. For both agencies and service providers, participants should include frontline staff as well as high-level representation.
   D. ***Report to the legislature.*** Every year, the regulatory units should be required to submit a combined annual legislative report, identifying key issues and the steps taken to address them. Annual reports are often easily dismissed but, by requiring agencies to identify and respond to issues, they provide stakeholders with an opportunity to address elected officials if they believe issues have been ignored or inadequately addressed.

2. ***Identify a chief interagency regulatory coordinator.*** MDH and DHS can and have worked well together, but overall coordination tends to be on an ad hoc basis. A continuous effort to pull together quality initiatives and procedural changes should have someone identified as being in charge. Similar to (but not replacing) the DHS Office of Inspector General position in its emphasis on coordinating across divisions, a "supra" role could cover regulatory work in both agencies. To the extent both agencies formally recognize that the position has some authority with their staff, it represents quasi-reorganization.

3. ***Place the regulatory divisions in the same agency—eventually.*** Regulatory activities can be improved without reorganization. However, the steps the agencies should take to coordinate their regulatory activities are, in effect, the same steps that would blend cultural differences. If the agencies are culturally capable of coordinating and communicating and collaborating, the arguments against merger become mostly moot. Over time, without offsetting obstacles, the advantages of merger become more obvious.

4. ***Announce now that both regulatory divisions will be in the same agency***. Given that the administration of regulatory functions can and should work better together, and given that doing so removes key disincentives for merger, then perhaps the agencies shouldn't wait until more cooperative efforts have been explored before making a merger decision. Little would be lost, and a lot of direction would be gained, by simply announcing now that, after an extensive transition phase, the two primary regulatory divisions are moving to the same agency.

Study 2: Multiple DHS roles

Reorganization can help DHS address two issues identified among its payor, regulator and direct service provider roles: inherent conflict of interest between the regulator and provider roles; and agency complexity compounded by the extent of agency operations.

1. ***Move the DHS Licensing Division to MDH.*** Study 1 recommended an array of options to improve regulatory issues that, directly or indirectly, involve both state agencies with service provision to frail elderly, people with disabilities and people in need of substance abuse or mental health treatment. The recommendation of this study, however, is that a move or merger of licensing operations to MDH is the preferred approach, because it has the additional benefit of removing a troubling conflict of interest environment within DHS.

2. ***Continue the current DHS restructuring effort.*** DHS leadership is well aware of the policy and program issues that the agency faces, and both the current and previous administrations deserve credit for attempting to address them through structural, operational, personnel and role revisions for at least the past five years. During the past two years in particular, a number of changes have been made, and it makes sense to track them to determine how effective they are in improving agency practices. Current leadership, in its response to the OLA report recommendations, makes clear that it is

committed to a continuous improvement process. That approach should be acknowledged and encouraged.

3. ***Develop a transition strategy for a new service agency.*** The DHS direct care and treatment programs could be removed from the rest of the agency and recast as a service-specific agency of its own. In the course of this evaluation, interviewees frequently suggested this notion as the simplest and clearest way to address an array of long-standing concerns. Almost as frequently, the notion was dismissed as close to frivolous because surely the state would never make such a major change.

   Perhaps it won't. There are many questions that would need resolution: reorganization costs, any new ongoing expenses, reporting relationships, potential new policies and rules, and implications for other state agencies need consideration. Although transferring programs to a new agency doesn't inherently affect the number of jobs or job security, assurances would be sought. Even how the issue is phrased and framed – the creation of a new large agency versus the slimming of an even larger agency – needs more thought. There are good reasons why the state might not consider such a major change at this time.

   Yet the possibility deserves further consideration. The agency does have internal conflicts, potential and real, in housing its varied roles. The agency has a complexity that isn't well understood by many, and it inhibits the quality of the agency's work as leadership's focus is forced to go in many divergent directions. And costs, though real, may be worthwhile, and the potential may be there to offset expenses with efficiencies from an undistracted leadership.

   It is recommended that the Legislature direct DHS to develop a transition strategy, a plan of action outlining how the direct care roles would become a separate agency, what the actual costs would be, and what steps the agency would take to promote its own policy development, budget processes and service efficiencies to improve its effectiveness in the future. The preparation of a transition strategy would not require the Legislature or the agency to necessarily implement the strategy, but it would enable an informed and thought-out decision to later be made. The agency should be given at least 18 months to complete a transition strategy.

Study 3: Risk issues

Risk assessment and planning have historically been conducted to eliminate or reduce threats to a person's health and safety. Tensions can arise when an individual's personal choices and autonomy are restricted—or potentially restricted—because an agency, provider or others limit choices due to safety, liability or other concerns. Stakeholders involved in these decisions need to develop a more common and holistic view of risk issues, including new and continuing MDH and DHS collaboration to improve risk strategies at both the policy and individual level.

In the recommendations, "risk issues" refers not to risk, but rather to the whole package of issues surrounding client risk assessment, planning and determining "reasonable" risk levels in relation to other factors, as described in the legislative directive for this report (i.e., health care, *client health care rights, provider liabilities and provider responsibilities to provide minimum standards of care).*

1. **To build a more evidence-based and multi-faceted understanding of risk issues across stakeholders, the state should assure there is an ongoing forum for discussing risk issues, addressing policy and practical concerns, and developing consensus**. This forum could be a new group or existing group, such as extensions of the State Quality Council or Olmstead Subcabinet with broader representation from all stakeholders. The forum should be a place to provide, discuss and receive information. The role of this group and its deliverables should be well documented and publicized, with strong project management and effective mechanisms to assure the group's mission is accomplished (e.g., change in statute, use of interagency agreements, annual reports to the legislature).

2. **To build MDH and DHS capacity on risk issues, the agencies should embed organizational, staff and service performance systems with risk-related expectations, standards and measures.** For instance, MDH and DHS should embed a focus on risk issue information into: policy manuals, staff and provider training and standards, and related documents; ongoing review of MDH and DHS statutes, policies and communications to identify where a consistent state policy related to risk issues could be stated or clarified; and MDH and DHS quality initiatives (with a goal of a holistic, consistent perspective related to basic risk issues).

3. **MDH and DHS should work together to address priority areas of concern, respond to provider questions and implement other strategies for improving cross-agency problem solving, collaboration and communication on risk issues.** Specifically DHS and MDH should work together to plan and implement initiatives to address key areas of risk, such as assisted living. In these efforts, each agency should understand and articulate its roles and responsibilities, such as whether they are serving in an advisory or equal-partner role. It is also recommended that the agencies develop a single point of entry for providers who have licensing and risk issue questions, track provider issues and consider ways to assess and communicate to stakeholders about how changes in policy and funding affect state and provider capacity to address risk issues and related outcomes.

4. **To help resolve risk issues at the individual level, MDH and DHS should use multidisciplinary teams to develop solutions and create a system for tracking and sharing risk issue knowledge and strategies.** Specifically, MDH and DHS should use multidisciplinary, joint teams to respond to individual situations and identify the real and priority issues in the situations, The agencies should develop systems to track and share information between DHS and MDH on patterns of provider and client risk issues. MDH and DHS should share and incorporate what has been learned from teams into quality initiatives, training and informational materials.

5. **MDH and DHS should jointly develop and use practical tools to assist stakeholders in addressing and resolving risk issues at the individual level.** Specifically, DHS and MDH should develop or continue to develop: tools such as up-to-date, clear, user-friendly websites and manuals; checklists for how and when it is appropriate, legal and advisable to set limits; specific training on risk issues, and associated risk communications; use of risk/harm/abuse reduction and prevention plans, rather than risk management plans; and use of the assessment and service contracting process to specify what all parties agree to regarding reasonable risk, in compliance with state and federal standards.

6. **DHS and MDH should continue to examine and implement the most promising alternatives to traditional tort reform.** Per recommendations from the State Quality Council and Olmstead Planning Committee, DHS and MDH should examine the relationships among the Americans with Disabilities Act, Vulnerable Adults Act and liability and insurance laws and practices, calling on legal and other expertise to determine if there are inconsistencies in the state's approach. It is recommended that MDH and DHS do not pursue additional, traditional tort reform, but instead continue to expand use of tort reform alternatives such as evidence-based practices. The agencies should also explore the expanded use of insurance risk pools, alternative dispute resolution and provider and client education and technical assistance.

Study 1: Regulatory Responsibilities

Summary

Study 1 evaluates how to improve the regulatory responsibilities of MDH and DHS, either through reorganization or other ways. It is a follow-up to an earlier MDH report that concluded there was no jurisdictional overlap between the agencies and no need for reorganization, and recommended multiple approaches to improve related operations. This report found stakeholders, including private service providers and consumer advocates, define overlap differently and see a more expansive need for coordination. The two agencies have begun making progress on a closer working relationship; however, this report concludes that more work needs to be addressed. The study identifies advantages and disadvantages to reorganization; a key disadvantage being organizational culture differences. It concludes that the two agencies need to do more, but there are options available to pursue.

Recommendations

There is not one single way to improve regulatory administration in MDH and DHS. From the perspective of this study, bringing the DHS Licensing Division and the MDH Compliance Monitoring Division into the same organization makes sense. Rather than offer one recommendation, following are four recommended options. In this sequence, they involve escalating levels of reorganization.

1. ***Take action regardless of reorganization decisions***. The following steps have value, with or without any structural reorganization.
    A. ***Expand and accelerate the current course***. The agencies deserve credit for initiating an effort to improve cross-agency collaboration. The scope can be expanded—there are provider and advocate issues that are not yet incorporated. The current interagency planning group should consider sub-groups to focus on areas such as an integrated professional development program.
    B. ***Emphasize improved communication***. MDH and DHS have focused on web linkages as a useful first step, and it has helped in identifying out-of-date or broken connections. The agencies could approach providers and advocates about priorities from their perspectives. Interpersonal skills training could be of value for frontline and high-level staff.
    C. ***Involve stakeholders in the effort***. At least yearly, the agencies should gather service providers and consumer advocates who work with both agencies to discuss change initiatives and other concerns. A component would be the opportunity for everyone to identify and respond to what they see as important issues affecting regulation. For both agencies and service providers, participants should include frontline staff as well as high-level representation.

D. **Report to the legislature.** Every year, the regulatory units should be required to submit a combined annual legislative report, identifying key issues and the steps taken to address them. Annual reports are often easily dismissed but, by requiring agencies to identify and respond to issues, they provide stakeholders with an opportunity to address elected officials if they believe issues have been ignored or inadequately addressed.

2. ***Identify a chief interagency regulatory coordinator.*** MDH and DHS can and have worked well together, but overall coordination tends to be on an ad hoc basis. A continuous effort to pull together quality initiatives and procedural changes should have someone in charge. Similar to (but not replacing) the DHS Office of Inspector General position in its emphasis on coordinating across divisions, a "supra" role could cover regulatory work in both agencies.. To the extent both agencies formally recognize that the position has some authority with their staff, it represents quasi-reorganization.

3. ***Place the regulatory divisions in the same agency—eventually.*** Regulatory activities can be improved without reorganization. However, the steps the agencies should take to coordinate their regulatory activities are, in effect, the same steps that would blend cultural differences. If the agencies are culturally capable of coordinating and communicating and collaborating, the arguments against merger become mostly moot. Over time, without offsetting obstacles, the advantages of merger become more obvious.

4. ***Announce now that both regulatory divisions will be in the same agency***. Given that the administration of regulatory functions can and should work better together, and given that doing so removes key disincentives for merger, then perhaps the agencies shouldn't wait until more cooperative efforts have been explored before making a merger decision. Little would be lost, and a lot of direction would be gained, by simply announcing now that, after an extensive transition phase, the two primary regulatory divisions are moving to the same agency.

Introduction

This is the first study in an evaluation, *Options for Administering Health and Human Services,* conducted by Minnesota Management & Budget (MMB), Management Analysis & Development. The Legislature directed MMB to complete the following:

> *Identify and evaluate the regulatory responsibilities of the Departments of Health and Human Services to determine whether to reorganize these regulatory responsibilities to improve how the state administers health and human services regulatory functions, or whether there are ways to improve these regulatory activities without reorganizing. (Minnesota Session Laws 2012, chapter 247, article 2, section 9)*

This first study is an extension, or sequel, to an earlier legislative report. In February 2012, the Minnesota Department of Health (MDH) provided a report to the Legislature, *Evaluation of Health and Human Services Regulatory Responsibilities* (The executive summary is Appendix P of this report). Written in response to a legislative request, the report focused on possible organizational restructuring of regulatory responsibilities within MDH and the Minnesota Department of Human Services (DHS). Specified options included a merger of responsibilities into one or the other agency, or the possible creation of a new, separate agency. With a programmatic scope set in the legislative directive, that report looked at an array of regulatory responsibilities where any overlap between the agencies might occur, primarily regulation involving the DHS Licensing Division and the MDH Compliance Monitoring Division (and in the area of board and lodging licensing, the MDH Environmental Health Division).

The 2012 report made no structural recommendations, but it included four recommendations to improve working relationships involving the two agencies, the regulated service providers and consumers. In addition, a fifth recommendation was made for continuing examination of interagency regulation issues. This new report is the response to the fifth recommendation.

About 60 people representing state agencies, service providers, consumer advocates and informed observers were interviewed for this study. Together, the interviews projected a collectively held premise that the state does not have a deficient system that needs to be elevated to a level of adequacy. As it now is, the system addresses its regulatory obligations as specified under statute, rule or contract. Interviewees in all the stakeholder groups identified areas where change was strongly encouraged in order to improve regulatory functions. Interviewees—particularly private service providers and consumer advocates—defined regulatory overlap differently, seeing a more expansive need for coordination. This study, following the legislative language, looks at improvement opportunities both with and without reorganization.

Background

The purpose of government regulation is to protect the public by enforcing minimum standards set in federal law or state statute or administrative rules. Regulation has some common themes such as: setting minimum entry qualifications; reviewing and approving applications for credentials; enforcing laws including prohibited conduct; conducting inspections and audits; investigating complaints; taking enforcement actions and monitoring conduct for compliance; communicating to regulated parties and consumers; and providing due process rights concerning action taken by the regulatory agency. Service provider credentials are often licenses but also can include registrations, certifications or other credentials.[1]

In this sense, and for the purposes of this study, regulation refers to the scope of activities provided by the DHS Licensing Division and the MDH Compliance Monitoring Division (and the MDH Environmental Health Division for board and lodging licensing) in those service areas where the regulatory functions intersect. These service areas involve the frail, elderly, people with disabilities and people with substance abuse or mental health conditions. In addition to their own staff, state agencies utilize expertise and data in other state and local agencies to carry out their regulatory responsibilities through delegations, contracts and other interagency relationships. For example, while the Compliance Monitoring Division conducts quality audits of health maintenance organizations, the division contracts with the state Department of Commerce to conduct HMO financial solvency analyses on its behalf. DHS delegates some licensing functions to counties and private agencies, and has some relationships with tribal authorities. The

MDH Environmental Health Division also delegates inspections to county and city agencies. DHS and MDH both have some unique functions or activities; for examples, MDH monitors education requirements for professional licenses and DHS informs local jurisdictions when a program seeks a license in their area. However, Table 1 lists many functions that the two agencies have in common.

Table 1. Regulatory Functions Common to Both MDH and DHS

- Evaluates license (or other credential) applications to determine whether standards and qualifications are met
- Provides technical assistance and feedback to applicants
- Issues license (or other credential) to providers who meet the requirements
- Evaluates whether license (or other credential) applicants have had previous sanctions or background study disqualifications that would prohibit them from being credentialed
- Assures proper zoning, building and fire inspections are completed
- Conducts inspections to evaluate compliance with applicable standards
- Takes complaints from the public and conducts investigations
- Issues correction orders following licensing reviews and investigations, as applicable
- Issues sanctions/enforcement actions in follow-up to licensing reviews and investigations, as applicable
- Provides due process to providers related to correction orders, sanctions and enforcement actions, including reconsiderations, administrative hearing and other proceedings provided in law
- Monitors compliance with orders, including settlement agreements
- Evaluates variance requests (called waivers in MDH) and issues when appropriate
- Maintains a website that includes information on programs reports sanctions and correction orders
- Maintains data related to licensing and investigative actions for public and other reports
- Provides public alerts on trends to increase compliance and improve service delivery and proactively address health and safety issues
- Enforces Maltreatment of Minors Act and Vulnerable Adults Act, including related investigations, determinations and reports
- Conducts reconsiderations requested of individuals who are disqualified by a background study and conducts preponderance of evidence reviews
- Monitors and responds to emergencies in health facilities such as fire, tornadoes, floods and health provider work stoppages and strikes
- Works with various internal and external stakeholder groups
- Provides training/information to providers, for DHS this includes training to providers, counties and private child placement agencies regarding delegated functions
- Responds to legislative inquiries and initiatives
- Responds to public and media requests

Source: Minnesota Department of Health, “*Evaluation of Health and Human Services Regulatory Responsibilities*,” February 2012.

In general conversation, regulation is sometimes used to refer to other related activities. When DHS policy divisions contract for service delivery, they include conditions of payment and Medicaid standards that service providers are required to provide. Medicaid fraud is investigated by DHS under its Office of Inspector General (OIG) and by the state Attorney General's office. Concerns raised by consumers and their advocates are handled by several ombudsman and information services as well as by the MDH Office of Facility Complaints.

The 2012 MDH report examined regulation of entities—programs and facilities (and some individual professionals)—that provide ongoing care to frail elderly or people with significant disabilities. The MDH Compliance Monitoring Division and the DHS Licensing Division identified a total of 51 types of entities that require a license, certification, registration or similar designation from one of the two divisions (Table 2). Each entity is unique in the activities that it covers, and in this regard there is no duplication. However, a service provider may need a license for a particular facility plus one or more licenses for the programs conducted inside the facility, including a license for the professional staffing involved. For each license or similar designation, a service provider may have separate inspections.

Table 2. Regulated Entities/Service Types by Agency and Number

DHS Regulated	**Number**	**MDH Regulated**	**Number**
Adult Day Centers	145	Ambulatory Surgical Centers	56
Adult Foster Care	4,767	Assisted Living Settings (*a subset of Housing with Services*)	-
Chemical Dependency Treatment*	342	Audiologists	406
Child Care Centers	1,587	Birth Centers	4
Child Foster Care	3,489	Boarding Care Homes	28
Child Placing Agencies	45	Body Art Technicians and Establishments	850
Children's Residential Facilities*	82	Clinical Laboratories	3,456
Crisis Respite Services	18	County Based Purchasers	3
Day Training and Habilitation	276	Crematoria	54
Detoxification Services*	23	Doulas	4
Family Child Care	11,222	End Stage Renal Disease Facilities	95
Independent Living Assistance for Youth	4	Essential Community Providers	73
Mental Health Centers and Clinics	70	Freestanding Outpatient Surgical Centers	59
Psychopathic Personality Treatment*	2	Funeral Establishments	561
Residential Facilities for Adults with Mental Illness*	52	Health Interpreters (*spoken language*)	2,857

DHS Regulated	**Number**	**MDH Regulated**	**Number**
Residential Habilitation Services for People with Developmental Disabilities (*generally serving four people in one home*)	899	Health Plans	8
Residential Program and Services for Physically Disabled*	4	Hearing Instrument Dispensers and Dispenser Trainees	206
Residential Services for People with Developmental Disabilities	229	Home Care Providers	1,517
Semi-Independent Living Services	127	Hospice Providers and Residential Hospices	95
Supported Employment Services	94	Hospitals	146
		Housing with Services Establishments	1,631
		Intermediate Care for the Developmentally Disabled (*ICF/DDs are federally certified SLFs*)	214
		Morticians	1,282
		Nursing Assistant Registry	60,693
		Nursing Homes	379
		Occupational Therapists	2,957
		Occupational Therapy Assistants	931
		Speech-Language Pathologists	1,377
		Supervised Living Facilities (SLFs) (*Also require a DHS license to oversee the services provided*)	309
		Unlicensed Complementary and Alternative Health Practitioners	2,700

Notes

- Includes entities regulated by the DHS Licensing Division and the MDH Compliance Monitoring Division, but not the MDH Environmental Health Division.
- Includes entities where some licensing functions are delegated to counties or private agencies.
- *Asterisked service types licensed by DHS also require an MDH license if they provide residential services.
- Data is not revised to include any 2013 Legislative changes.

Source: Minnesota Department of Health, “Evaluation of Health and Human Services Regulatory Responsibilities,” February 2012.

Some providers have complained that the overall process results in multiple site visits that are redundant in looking at the same documentation and physical plant components. Some have suggested that the two divisions be restructured, possibly merged, as both a first step and as a strong message to eliminate any duplication or overlap in their work. The 2012 report was written in response to these concerns, and concluded “There may be some public perception that there is overlap in the requirements between MDH and DHS in the oversight of these entities; however the scope of each license, registration, or certification is distinct.” Service providers interviewed for this study agreed that the scopes are distinct, but suggested that the processes for carrying out those scopes do not always appear so distinct, particularly when one license covers a facility and another license covers a service within the facility and another covers a person providing the service.

Organizational structure in other states

There is no singular, common model of state regulation. A DHS internal scan conducted in 2012 compiled how all the states have organized their health and human services policy agencies, their regulatory functions and their array of state-operated services. While states tend to be similar in what they do, and tend to be similar in how they do it, no two states provide exactly the same licensing functions and state-operated services in exactly the same organizational structure.

State agency organizational structures tend to be the result of historical development. Since Minnesota first ventured into the field of care and support services to people with disabilities 150 years ago, states have continuously evolved. Using the “Modified Bell” typology (a standard tool for state structure comparisons), states have moved in different paths from a traditional model with a large number of small agencies to an agency cabinet model with a moderate number of larger agencies, and some have evolved to a secretary model with small number of much larger agencies. For example, the responsibilities Minnesota has organized into two agencies (MDH and DHS), South Dakota has kept spread into three agencies and Wisconsin has consolidated into one agency.

It should not be surprising that each state has its own structural characteristics. During the past 100 years, Minnesota alone conducted 17 major reorganization and reform efforts, each of which resulted in some changes and many more proposed changes. Both MDH and DHS have undergone major organizational changes outside of the major reform efforts; most individuals interviewed for this report presume structural change will continue.

For this report, officials in four other states were interviewed to learn what advantages might accrue from their structures, as well as good practices not dependent upon structure. Their responses are incorporated into other sections of this report.

Mission-based regulatory roles

DHS and MDH have mission statements that are different but compatible. The DHS mission is “… [DHS], working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.” The MDH mission is “Protecting, maintaining and improving the health of all Minnesotans.” The regulatory work connected to these missions is identified in statutes and procedurally refined in regulatory rules. Several descriptors are used to differentiate each agency's coverage area (health services vs. support services, Medicaid consumers vs. all consumers, facilities vs. programs) but all have exceptions—each agency's collection of licenses and other designations is also a matter of historical decisions.

Culture as a distinguishing characteristic

For numerous agency staff, service providers and consumer advocates interviewed for this study, the primary distinguishing characteristic between the two agencies is their organizational culture—their values and behaviors and how they are reflected in their regulatory work. There is a popular sense, propped by anecdotal incidents, that MDH has long been guided by health care-background management and DHS by social work-background management, in keeping with their respective missions. Over time, this has imbued distinctive philosophies, perspectives and operating styles, even among staff that didn't have health care or social work backgrounds.

Neither agency necessarily agrees with the following generalizations that were repeatedly shared. Some service providers and agency staff have described MDH as having more of a yes-no, right-wrong approach to determining regulatory infractions, being more stringent with firm due dates for correction and less willing to discuss proposed solutions until after a service provider has formally submitted a correction plan. On the other hand, they described DHS as being more flexible, more open to negotiation and more willing to provide possible solutions to problems. MDH was described as less willing to support consumer choice if injury was a possible consequence and DHS as more willing to support it, provided that it really represented consumer choice. However, it must be noted that this was not necessarily seen as a criticism of MDH. Service providers observed that MDH regulators frequently work on behalf of federal agencies such as the Centers for Medicare and Medicaid Services (CMS) and have little or no discretionary authority in determining whether federal standards have been met. DHS regulators also have CMS requirements, but they also frequently evaluate whether a service plan for a consumer is optimal, which tends to involve negotiation and discretion. Consumer advocates, while often wanting MDH to have more of a consumer choice perspective, complimented the agency for not compromising on consumer safety.

In terms of this study, the relevant question regarding culture is whether the differences between the agencies preclude gaining any benefit from reorganization. Managers who have transferred from one agency to the other insist that the cultural differences can be breached or blended, but acknowledge that it requires time and energy. Former agency leaders acknowledged that, in the past, some potentially beneficial reorganization plans were not implemented because the cultural change required was judged as precluding any short-term payoff. Based on their experience, when state agencies—as well as organizations in general—have had success in bringing together units with strong cultural differences, it required lengthy pre-work to diminish differences and build familiarity, and an ongoing transition management effort to create a new culture for the new organization. Elements noted as contributing to successful reorganization included a phased structural process, a transition management plan, a strong communication effort and continuing close leadership involvement.

2012 Findings Framework

The earlier MDH report included inventories of the regulatory activity of the DHS Licensing Division and MDH Compliance Monitoring Division based upon types of regulated entities, basic regulatory functions, interagency relationships and staffing. As already noted, the two agency divisions regulate 51 types of entities or services (30 by MDH, 21 by DHS). The licenses themselves have no overlap to the extent that each type is for a particular setting or service specified in statute or rule.

However, the report identified situations in which a service provider needs a facility license from MDH and a program license from DHS. According to the 2012 report, these involve four types of facilities.

Supervised living facilities are residential, homelike settings providing meals, lodging, housekeeping, health services and treatment for people who are developmentally disabled, mentally ill, chemically dependent or physically disabled. MDH regulators conduct regular onsite inspections to ensure that sanitation, nutritional requirements, medication handling procedures and health care practices are safe and effective. In order to provide the people with treatment services, however, the service provider is required to have a DHS license specific to the needs of the residents. DHS regulators ensure that people are receiving the appropriate treatment for chemical dependency, adult mental illness, developmental disabilities or physical disabilities.

Intermediate care facilities for developmentally disabled (ICF/DD) are federally certified supervised living facilities where CMS has delegated its regulatory authority to MDH. The MDH role includes reviewing the outcomes of the DHS licensed treatment program to ensure services are provided as required.

Nursing facilities are licensed by MDH; there are four in the state that include DHS licensed services for people with physical disabilities.

Board and lodging establishments are licensed by MDH and sometimes include DHS licensed programs inside them.

Together, these two-agency-license situations involve roughly 700 facilities. A key conclusion of the earlier study is that since this represents a small percentage of licenses (DHS Licensing Division issues about 23,000 licenses), it perhaps precludes the need to consider organization restructuring and instead suggests finding new ways to manage the regulatory activities that involve more than one license. The report dismissed the question of whether the activities of the two divisions should be restructured into one organization—either MDH or DHS or some new entity. Instead, the report recommends taking action on ways to improve working relationships.

Additional findings within the framework

Within the framework of the 2012 MDH report, this study adds some additional findings. Beyond what was identified in the 2012 report, there are a few other situations in which a MDH regulated facility also must have a DHS service license or registration. For example, there is one Rule 36 mental health program licensed under DHS that also has an MDH boarding care license. The biggest example, however, relates to people who live in "housing with services" (HWS) establishments where they rent the housing and then obtain health services from the HSW establishment or through another licensed home care agency.

- The legislatur**e enacted the HWS law in 1995.**[2] HWS is a registration, not a license, and includes housing types such as apartment building, corporate adult foster care an**d board and lodging facilities.** HWS is not a **health care requirement;** it applies to rental buildi**ngs and is governed by landlord–**tenant law.

- However, a provider must have both HWS registration and other licenses to provide certain programs or service types. For example, adult foster care homes can provide household or home health services to people unable to live independently. These facilities require a DHS Rule 203 license for adult foster care. If they provide a health related service, or two or more support services for elderly residents, they must also have a MDH HWS registration and obtain an MDH home care license.

- A HWS establishment can offer services labeled as "assisted living" if they meet the requirements of Minn. Stat. 144G (e.g., provides a minimum standard set of health-related services). People receive home care through the HWS establishment or other home care provider. In either case, the home care provider must be licensed. Stakeholders in the current study almost universally cited AL regulation as complicated, confusing and/or redundant. A 2013 legislative study noted that services in HWS are governed by home care regulations and "must comply with all applicable building, fire, rental facility (if applicable), board and lodging, and corporate foster care licensure regulations, among others. Given this complexity of regulations, consumers and providers share the challenge of understanding and complying with them."[3]

  In addition, if a HWS establishment has people who are receiving home and community-based services via MA waivers, these services must meet the new ("245D") HCBS licensing standards. (Study 3 in this report provides more detail on the new standards established by the 2012-2013 legislature). More broadly, DHS does not issue a home services license but it does have requirements (conditions of payment) for providers who receive Medical Assistance (Medicaid) payments.

Overlap issues outside the framework

While service providers rarely mentioned overlap issues in terms of license or certification coverage, they were quick to mention that they often find the licensing process to be confusing and frustrating, sometimes to the detriment of their ability to serve consumers. Providers as well as consumer advocates suggested that the scope of overlap and confusion issues is more expansive than what was covered in the 2012 report. Specifically:

The involvement of local agencies. Providers also deal with local public agency staff, who work on behalf of, in cooperation with or independent of state agencies. County case workers and other social work staff are viewed as extensions of DHS. City and county inspection staff often work with delegated authority from MDH. City and county building inspectors sometimes conduct multi-housing inspections with no connection to state agency regulation. While the roles of local agencies are not technically duplicative, service providers say the involvement with multiple staffs contributes to a sense of confusion.

The involvement of other state agency units. The Office of Health Facility Complaints (OHFC) in the MDH CM Division; the Ombudsman for Long-Term Care, a Board on Aging program located in DHS; and other ombudsman offices and program policy divisions are viewed as having additional roles in resolving regulatory issues. If a service provider submits a corrective action plan for a deficiency noted by OHFC, but has not heard back from that office before its next MDH Compliance Monitoring surveyor inspection, it can be cited again for the same deficiency which will appear on its publicly-viewed state report card (MDH notes that any new citation would be under the same tag number and would need to document different residents or circumstances).

Communication coordination. Service providers said the state agencies are very good in providing telephone and web-based contacts for questions or concerns. Sometimes it is problematic understanding which helpline or call desk is the right one, but it is perhaps better to have too many than too few options. Consumer advocates, on the other hand, are more concerned that consumers and their families are frequently confused about who to contact about regulatory concerns: their options include the licensing divisions, OHFC, ombudsmen offices, a county case manager, a managed care organization coordinator or other sources such as the Disability Senior Linkage Line. This is a particular concern if a consumer has been informed of something soon to take place such as a transfer to another facility or program. State agency staff who have family members in care settings confided they have the same concern. If the agencies are reworking their websites to ease contact for providers, advocates recommend the same should be done for consumers.

Information sharing. Consumer advocates suggested that not enough overlap, rather than too much overlap, may be a bigger issue. They cited examples where they contend multiple regulators inspected a facility and found different issues, yet never shared their information with each other. Had it been shared, the preponderance of citations would have made regulators aware of a serious situation. At the same time, service providers suggested a negative consequence of how information is now shared: they contended that when one regulator issues a citation, every other regulator looking at that same facility or service has a need to cite the same issue so that it won’t appear that they missed something.

Internal dissension perception. Some service providers observed that, in work groups, DHS policy staff and regulatory staff did not always appear to work well together, or with providers, on developing the new system of HCBS licensing and home care standards. At the same time, some agency staff cited this as an example of a new era in coordination. In other settings, some service providers observed that MDH Compliance Monitoring staff and Environmental Health staff appeared to have turf issues when working together on board and lodging license issues involving assisted living and memory care units; a perception not accepted by MDH. While outside the scope of this study, providers expressed concern that internal difficulties in the agencies ultimately affect relationships with providers.

High-level cooperation. Service providers suggested that, through its facility inspections, MDH is aware of physical plant needs that impact their ability to serve their consumers, but doesn't share that information with DHS staff involved in setting payment rates that could address physical needs. More to the point, some service providers argued that MDH and DHS, with its pooled information, should be making a stronger case to the legislature about the correlation between funding levels and service levels. At the same time that the agencies are well positioned to regulate service providers, the agencies are well positioned to advocate for providers to benefit consumers. It also should be noted that state agency policy managers shared different but similar concerns. They gave examples of policy reports written in one agency with no involvement of policy experts in the other agency, and contended it resulted in poorer reports.

Field-level cooperation. While this may be the least of the concerns identified by service providers, it may be the issue that creates the most annoyance for frontline service provider staff. They claimed that often field-level regulators tend not to know, or even appear to care, who else has been in the facility or when others have conducted inspections. Some state agency managers expressed similar concerns, observing that high-level commitments sometimes are diluted by the time they reach field-level staff.

2012 recommendations and progress

The 2012 MDH report was based on a premise that organizational change probably wasn't needed, but that the affected agencies should take other steps to improve regulation. Besides further study, the MDH report included four non-structural recommendations to address the scope of perceived overlap that the report identified. Following are brief summaries of the recommendations and action taken so far.

Recommendation: Blend regulatory activities for facilities licensed by MDH with DHS license programs. For supervised living facilities, intermediate care facilities and nursing facilities, it was recommended that the DHS Licensing Division and the MDH Compliance Monitoring and Environmental Heath divisions work together to reduce inspection and investigation impact on the facilities where possible. This could mean conducting visits together, or some alternate schedule, whichever would reduce disruption. The divisions could meet and work together to develop better practices and procedures.

The agencies have begun convening a regular, ongoing set of interagency meetings with assigned staff from each affected program. The meetings have begun with introductory overviews to enhance a mutual understanding of each program's roles, prepare for later consideration of how to jointly schedule inspections or use each other's documentation and explore joint enforcement actions. At this point, the agencies are still coming to a management-level understanding of what each other do. As that understanding improves, managers will be able to see how their work can blend or otherwise be coordinated.

Recommendation: Clearly inform providers and the public about MDH and DHS regulatory responsibilities. It was recommended that each division's website be improved to include information and updates from the other divisions so that service providers and the public can find all relevant regulatory information in one place. This would include providing links between the departments' websites.

Linked websites are now a legislative requirement. Chapter 247 of the 2012 session laws, Article 2, Section 9: "The commissioners of health and human services must update, revise and link the contents of their Web sites related to supervised living facilities, intermediate care facilities for the developmentally disabled, nursing facilities, board and lodging establishments, and human services licensed programs so that consumers and providers can access consistent clear information about the regulations affecting these facilities." In supporting the law, MDH's recommendation noted "The website revisions and updates should include all the divisions' responsibilities related to health regulation. Members of the public and providers often want to see information about health regulations in one place, versus having to know where to go to get information."

Progress is being made. The Office of Enterprise Technology (MN.IT) is guiding the multi-agency project, which has gathered relevant process data, tracked existing interagency connections, identified incomplete or inaccurate web links both within and between agencies. The project charter calls for creating a virtual path for consumers and providers through website links and a virtual flowchart to help guide people—a website navigation system.

A further goal is to create a consistent set of fact sheets for each type of regulated facility or integrated service setting. In its preliminary steps, the interagency planning group is addressing differences that can contribute to confusion, such as terminology and whether regulations apply to all facilities or only facilities using a particular source of payment. Ultimately, each fact sheet should be a summary of the licensing the provider needs at the end of an iterative web-based process that asks providers key questions guiding them to the right fact sheet. Key questions may include: what type of services do I intend to provide; what the intended service population is (and how large a population); where the services will be provided; and what payment sources are available to me and what are those standards?

Recommendation: Cross train MDH and DHS staff. It was recommended that the divisions hold regular staff meetings to cross train each other about their regulatory areas. The meetings also could be used to compare practices for inspections, investigations and enforcements. Other approaches for joint training and information sharing should be explored. So far, each of the three involved divisions has presented a brief information session for staff from the other divisions.

Cross training on a staff level has only been perfunctory in the past year, as initial emphasis has been on improving management-level understanding. Although written from the perspective of service providers, the iterative fact sheets under development are viewed as training tools for agency staff as well, so that a consistent understanding develops among providers and regulators.

Recommendation: Establish linkages between MDH CM Division and DHS Office of Inspector General (OIG). When MDH has enforcement action involving providers who are reimbursed with public funds, it shares that information with DHS staff involved with payments. It was recommended that MDH share investigation and enforcement information with the DHS Office of Inspector General. This is a relatively new position in DHS, giving one person oversight over both licensing and public fund fraud protection. It was also recommended that the information be shared faster electronically.

Some steps have been taken to improve communication. As already noted, an inventory of existing links exist between agencies was prepared. Management and staff involved in the interagency planning group also were involved in the successful 2013 legislative efforts to integrate home care licensing (Chapter 144A) with waiver service licensing (Chapter 245D) so that home care entities would not need two licenses. The same people are addressing how to improve interagency communication when analyzing the impact of legislative or policy proposals on regulation.

While communication is seen as improving, there has not been a particular effort to exploit opportunities to use the still-evolving OIG position to expand communication and interaction in innovative ways.

2013 stakeholder suggestions

Outside of structural reorganization, providers, regulators, consumer advocates and others interviewed for this study have suggested other options for improving regulatory coordination. Some of these are consistent with, and others are divergent from, the current thinking of the interagency planning team. The recommendations fall into four categories: expanded communication, greater staff development, closer cooperation and new regulations.

Expanded communication

- **Bring providers and advocates into the process**. While value is seen in having management-only planning meetings to identify and resolve interagency concerns, value also is seen in a formal planning process that includes both service providers and consumer advocates. One suggested option is an annual session to review interagency regulatory issues and explore non-agency perspectives on potential changes.
- **Report to the legislature.** As an adjunct to expanded interagency planning, an annual report to the legislature has been proposed, but with a caveat. Such a report presumably would identify current and evolving issues in regulation, the action that could be taken to address those issues, and any progress on the action. It was suggested that annual reports tend not to be illuminating, and as long as all parties are satisfactorily invested in a planning process, the report would tend to go unread. The caveat is that the real value of the report would emerge only when service providers or advocates believed that issues were not being adequately addressed. At that point, the required report would be a tool they could use to keep their concerns from being dismissed.
- **Work together informally.** Regulatory staff in other states recommended increasing the participation of state staff on ongoing industry and advocate committees, and increasing provider and advocate participation on ongoing state agency committees. In other states the intent has been to have individuals develop connections with each other in interactive settings that don’t involve controversy or win–lose conditions, so that they may be better able to communicate and cooperate when resolving contentious issues.

Greater staff development

- **Accelerate and expand cross training**. Cross-training is sought for those areas where regulators from multiple agencies or units may be involved. While a deliberative approach to cross training staff has value, non-regulatory interviewees expressed concern that a too-slow process may never impact field-level staff. In addition to field-level employees of the two agencies, it has been suggested that cross training also needs to reach local agency staff as well: city and county staff with MDH delegated authority and county case managers working with DHS licensed programs.
- **Institutionalize cross training**. Beyond required attendance at cross training presentations, the knowledge, skills and abilities component of senior regulatory staff position descriptions could be modified so that future promotions would require a basic understanding of intra- and interagency regulation.
- **Create interdisciplinary positions.** A basic question of some service providers is why one inspector cannot be capable of handling a wider range of regulatory functions, so that one person can handle inspections for multiple licenses or registrations. One response from agency staff is that the work is so complex and difficult that it would be asking too much for one person to have all those skill sets (some knowledge of social work, public health and building codes). The pushback from providers is that in smaller facilities, a service provider manager is required to master all those skill sets in order to meet regulatory requirements.

Closer cooperation

- **Link together all inspections at the same site**. The divisions have identified this as something to explore, beginning with more study. This approach already is done in some states. In South Dakota not only are there joint inspections in which both agencies participate, but the agencies also have joint reports so that any concerns found by one agency is in the file of the other agency as well. This addresses a concern raised by some advocates that while agencies are aware of issues their own staff members have found, they may be ignorant of issues found by other agencies. In situations where joint inspections may not be helpful, designated inter-agency teams for each facility may help coordination.
- **Discuss philosophy.** Given that DHS and MDH are seen has having different perspectives and approaches to their work, interviewees both in and out of the agencies suggested a more extensive conversation among regulators to identify and understand their differences, if any, and to develop a framework of cooperation that acknowledges differences yet minimizes any contradictions that may inhibit interagency effectiveness.

New regulations

- **Update statutes and rules**. There is a belief among some providers, regulators and others that the core issues in regulatory effectiveness have little to do with organizational structure or even operating processes, but instead stem from outmoded statutes and rules. The State’s experience this past year in setting new statewide HCBS waiver regulations and in streamlining home care licensing is seen as demonstrating that updated regulations can prevent redundant licensing and lead to additional simplification and clarity not achievable through any agency reorganization. Only when regulations reflect or anticipate contemporary service delivery models, it is argued, can state organizational structures enable form to follow function. A proposed next step for continued updating is a broader regulatory structure to encompass evolving models of assisted living and memory care. Some interviewees caution that this approach alone cannot be sufficient unless state agencies allow a much higher level of participation by service providers and consumer advocates.

- **Replace statutes and rules.** Going beyond the immediacy of current regulatory practices, some industry and agency staff contend the basic rules-based model may not be adequate for physical structures (if a complaint-based approach can replace ongoing inspections), and definitely not adequate for programmatic licenses. For the future, they propose a more quality-driven approach similar to hospital regulation that emphasizes root cause analyses when problems are identified, resulting in business function best practices. If so, then it may be better to invest energy in creating a new system rather than in patching an old system.

In summary, there was a sense that the 2012 MDH report set appropriate recommendations—now being addressed by the agencies—but that the report scope did not fully capture the extent of concerns regarding regulatory coordination, and that additional action would be helpful.

Reorganization options

As noted, the 2012 MDH study recommended coordination, communication and cross-training to improve regulatory activities, and rejected reorganization options to merge responsibilities into one or the other agency or possibly creating a separate agency. This 2013 study is directed to relook at the issue, to "determine whether to reorganize these regulatory responsibilities to improve how the state administers health and human services regulatory functions, or whether there are ways to improve these regulatory activities without reorganizing."

Context

There are two factors that help set a context for looking at possible reorganization. The first factor, noted earlier, is that there is no "default" or commonly recognized national model for organizing state-level regulatory responsibilities. There is much variety among states, and interviews with regulators in five states (including Minnesota) suggest that structure is as much a consequence of local historical development as anything else.

A second factor is that there are several reorganization options. When asked to consider the possibility of organizational reform in Minnesota, people interviewed for this study were divided about whether combined regulatory activity should be placed within DHS, within MDH or in a freestanding entity. However, even among those who said they would want the DHS culture or perspective to dominate in a merged operation, there was some presumption that a mission- or role-driven decision would more likely result in regulators being placed in MDH. DHS is viewed as the primary agency for setting and delivering services and MDH is viewed as the agency for regulating those services.

There are other factors, outside the scope of this study, that also point to the likelihood of MDH as a reorganization location. The second study of this report looks at the multiplicity of service roles that DHS performs—policy, payment, provision and regulation—and recommends greater role separation as a matter of transparency and public confidence. Should regulatory reorganization take place, this second study recommends that regulatory activity move out of DHS, in order to help achieve role separation. While some sentiment was expressed for moving merged operations to a new strictly-regulatory agency, the option was generally considered to be too complex at this time, requiring further study to consider governance issues and possible involvement of other regulatory activities conducted by additional state agencies. For purposes of this study, it is presumed that any merged regulatory activities would be located within MDH. However, if merger is to be pursued, the home location could be reconsidered at that time.

Finally, it should be noted that most people interviewed for this report—regulators, providers and advocates—viewed reorganization as a dilemma. Reorganization is not viewed as a day-and-night issue; rather, there is value both gained and lost in any change. The basic approach considered was whether or not to merge regulatory operations. Another approach proposed in interviews was to somehow capture the value of reorganization without actually doing it: take steps to create a sort of quasi, partial or virtual merger. A third approach was, in effect, to ignore the immediate question and instead to look alternatively at more strategic changes.

Reasons for reorganization

Common purpose, common culture. Stakeholder arguments for reorganization begin with the premise that regulatory functions need to be as coordinated, up-to-date, streamlined and unobtrusive as possible. Ultimately, this presumes that having one entity, or having multiple entities under single leadership, is required. A merger today makes the point that state regulators—regardless of how many statutes and rules are on the books—are expected to work together in common purpose. Rather than worrying about whether an MDH culture or a DHS culture predominates, a merger is the first step in moving toward a new, common culture that redefines regulation.

Accelerated communication improvement. Historically, agencies have not always had excellent coordination and communication, a point bolstered by the need to start new coordination and communication initiatives last year. Placing the regulators under shared leadership doesn't guarantee better coordination, but presuming that leadership is good, it inherently accelerates the improvement process.

Accelerated common inspections. For the service facilities that now have multiple regulatory inspections, a move to single inspections may be a long time in coming as long as two state agencies are involved. With all inspecting staff working for a single agency, the decision and especially the implementation would likely happen much sooner. Finally, if single inspections are ultimately determined not to be an improvement, at least the service providers would have a single regulatory agency to contact.

Simplified chain of command. Other changes that may have value as regulation evolves, such as blended staff roles, presumably can happen much faster—as well as be adjusted or revised as needed—if only one agency is involved. Shifting staff responsibilities between multiple agencies involves two human resources offices, two chains of command, two final approvals and could require memorandums of understanding or interagency agreements. Even though such change is possible, the paperwork and bureaucracy involved can slow improvement to a crawl.

Greater change flexibility. It is commonly accepted that service provision delivery models will continually change. The state is receiving applications for new variations, such as non-licensed lodging sited on a hospital complex which allow licensed health professionals to provide post-surgery care in a non-licensed facility. State regulation needs to adapt accordingly to keep up. Given this, keeping regulators divided by unnecessary organizational walls keeps the state lagging behind industry change and consumer preferences.

Better DHS role clarification. Presuming that any merged regulation unit would be located in MDH, some observers suggest an incidental benefit: that state regulation would become further unattached from the DHS units involved with setting service standards or policy, and with setting and making payments for service. One of the suggested issues to be addressed was a lack of clarity on the distinction between licensing regulation and the enforcement of program standards—items included in state contracts with service providers. In disagreements with DHS, some service providers said they aren't sure if they are being cited for a regulatory violation or for a contract misinterpretation. It was argued that having regulation functions in one agency and policy and payment functions in another would result in improved role clarification for both regulators and service providers.

As noted earlier, the second study in this report looks at the DHS regulatory and payor roles from a different perspective; it considers whether they are appropriately housed in an agency that also directly delivers some of the services that it pays for and regulates. While that perspective may seem outside the scope of this first study, the two studies do intersect in influencing each other's conclusions and recommendations. While the practical effect of role clarification issue noted above may be nothing more than minor irritation—a cost of doing business—for providers, there is a philosophical question about whether these roles should be located in the same agency when organizational alternatives are available.

Reasons against reorganization

Weakened OIG role. At the same time that some see value in more separation of service regulation and service policy and payment roles, others see more separation as a missed opportunity. It would weaken or eliminate one of the reasons why DHS created the position of the Office of Inspector General (OIG).

Several years ago, after trying various internal organizational approaches, DHS created a new Inspector General position to renew an emphasis on effective regulation. The position was given a highly visible, central position in the agency. A key power was management authority over both the Licensing Division and the Medicaid Fraud and Financial Abuse Investigation unit, providing a stronger coordination between two units that investigated the same facilities for different reasons. An apparent outcome has been better information sharing that is helpful to both operating units.

The opportunities opened by creating the OIG role are still emerging, and a stated objective is to improve communication and coordination. It was for good reason that MDH specified working more closely with the OIG in its 2012 report recommendations, and presumably this will happen more in the near future. However, DHS also anticipated that the OIG role will improve internal communication, by serving as a liaison between licensing and policy divisions. The position is viewed as one that can be working with policy divisions in program development, advising them on what is practical in terms of regulation, and working with licensing, advising them on the program outcomes and concerns of policy staff. If the regulation functions are merged and placed in MDH, then the OIG may not have the same effectiveness as when working with policy and regulatory staff in the same agency.

No assurance of improvement. A more basic argument against a merger is that it can be another case of “just moving boxes” on an organizational chart with no real difference in outcomes. While there may be advantages in theory, in practice it may not result in better communication or coordination. While the move itself might be bold and send an initial strong message, there are too many other factors involved, such as leadership ability and cultural change capacity, to presume that any real differences will result from reorganization.

Even service providers generally positive about potential advantages of reorganization cautioned that recent issues regarding board and lodging regulation illustrated that simply placing similar units in the same agency does not ensure that coordination will improve. As they see it, the MDH Compliance Monitoring Division has responded to inadequate regulatory standards for assisted living facilities, particularly memory care units, by requiring facilities to get lodging licenses from the MDH Environmental Health Division—licenses originally intended for boarding houses and other antiquated lodging concepts not involved with services. MDH also has expressed concern about current law and an interest in updating standards for memory care settings. So far, the issues have generated acrimonious conversation but remain unresolved. While the issues are complex and involve numerous factors, there is a provider contention that the controversy demonstrates that having two units in the same agency doesn’t mean they work well together.

Cost considerations. Cost is another factor in any reorganization. Should a specific proposal be considered, a detailed cost analysis would need to be done. As a rough indicator, in its 2012 report MDH estimated that reorganization can cost $1,000 per person for physical relocation. The DHS Licensing Division has about 107 employees; if all functions reorganized, relocation to MDH could cost about $107,000. While costs can perhaps be minimized or phased, cost remains an obstacle. In its report, MDH suggested that the potential gains from reorganization may be overshadowed by its cost.

It should be noted that any change option, such as increased communication or staff training, also has initial costs that would need to be assessed once a specific proposal is developed. Presumably change options such as communication or training would bring eventual cost savings that also would need assessment.

Transition difficulties. A greater cost, perhaps, is not monetary but productivity. Both the DHS Licensing Division and the MDH Compliance Monitoring Division are generally considered competent, functioning units. While a merger might improve their effectiveness, it also might reduce it (at least short term) by requiring the divisions to meld distinctly different operating styles. Mergers frequently achieve success only after a disruptive period in which all the informal processes of an organization—internal and external communication, operating procedures, leadership style, leadership expectation and institutional values—undergo a transition. State employees who have managed in both agencies caution that if two units that haven't necessarily coordinated well in the past are simply placed together without advance preparation, the merger is as likely to hurt as help their collaboration. Should a merger happen, it was recommended that it be preceded by acclimation activities, such as shared planning (including vision and goals) and shared operations (including joint responsibilities and documentation).

Try smaller steps first. The merger of state units can be considered a major, even dramatic change. Given that some initiatives are underway and other opportunities for improvement have been identified, perhaps the strongest argument against reorganization is that other approaches should first be given the opportunity to succeed. If an improved regulatory function doesn't result, reorganization always remains an option.

Quasi-reorganization options

The Legislative directive "to determine whether to reorganize these regulatory responsibilities" is not limited to simply bringing the regulatory division together. Options that "virtually" reorganize or somehow bring the regulatory units together short of a full merger are possible, and were frequently noted by people interviewed for this study. Without making any changes in basic organizational structure, regulatory units could project a sense of closer cohesion through actions such as: creating a single website for service providers, cohosting regular meetings for service providers and consumer advocates, publishing a combined annual report on regulation activities, and establishing single primary contacts for facilities or programs that require more than one license or other certification.

However, creating the illusion of a combined organization doesn't actually cause improvement. The real element of change is creating a mechanism or a position that has some authority within both state agencies. A model is the evolving OIG role in DHS. As described by senior staff, the OIG role is not just to manage licensing (a division manager does that) or just to provide oversight for both licensing and fraud (a deputy commissioner does that). The role is intended to be a liaison with others to see that proposed policies and procedures are compatible with licensing and that licensing changes are compatible with policy goals. Just as DHS has intended the OIG position to coordinate operations between different units in one agency, the intent of a new office or position would be to coordinate operations between different units in the two agencies. This sort of "supra-OIG" position would be located in one agency, but would be given authority and responsibility in the other agency as well through an interagency agreement or memorandum of understanding.

At a minimum, a trans-agency role would have the authority to call multi-agency meetings, to write an annual progress report, and represent multi-agency regulatory activity in policy settings and would have the responsibility to not only advise MDH and DHS, but also the other public agencies involved in providing and regulating services. If the position did not have the authority to make shifts in resources and agency roles, it at least would have the responsibility for proposing changes when appropriate.

The position could be located in either agency. The other agency might be expected to be cautious about sharing its traditional authority with another agency, particularly when it still is held accountable for proper regulation. But there are examples of interagency agreements sharing power between agencies that can serve as templates. All agencies have transferred internal IT staff and responsibilities to centralized MN.IT control. There are agencies that jointly hire managers who report to both. There are agencies that meet staffing needs by contracting with employees in other agencies.

An alternative approach would be to have this role served not by an individual but by a recently formed body: the MDH/DHS Integrated Licensing System Framework – Leadership Steering Committee. Both agencies provide the committee with deputy commissioner sponsorship and three high level managers. On one hand, the committee spread responsibility over six people instead of one; on the other hand, it may have more authority and ability to make changes.

In general, the presumed advantage of a less-than-merger reorganization is that it keeps agencies in their traditional roles, but it increases the likelihood and speed of enhanced coordination by identifying who is responsible for taking the initiative for change.

Multi-scenario analysis

Having three organizational directions offers consideration of a multi-scenario analysis. This a tool used in strategic planning to help organizations take into account different environmental factors and make action plans regardless of whether the probable factors ever emerge. MDH and DHS management can look at each of the three options and ask: If our intent is to improve our regulatory function, and this is our structural decision, then what would we do during the next year or so?

Certainly, some unique activities would appear under each option or scenario. But there are a variety of recommendations offered by stakeholders that could be judged by management as appropriate under any scenario. These might include: identifying central leadership responsibility and authority; initiating a regular stakeholder forum; publishing an annual progress report; incorporating cross-training in position descriptions; further linking related agency webpages (or developing a cross-agency webpage); or developing legislative proposals for assisted living facilities regulation reform.

These activities represent a useful action plan regardless of any reorganization decision. And if the decision is to delay reorganization consideration until a later time, the action plan still has value in improving regulatory administration.

Conclusions

In the provision of continuing care to people with significant disabling conditions, including disabilities, mental illness and frailty, change is a constant. Responding to an environment being transformed by new federal laws and requirements and by technological and medical advancements, service providers are seeking innovation in how they deliver health care and support services. State agencies, in turn, are attempting to reflect the change, both by changing their regulatory processes and by proposing changes in statute.

As service providers innovate with new service models, MDH and DHS find themselves lagging behind, but they have tried to keep up with some regulatory simplification and through improved communication among its regulatory staff. The progress made on the MDH 2012 report recommendations has been slow, but the agencies haven't had much time to implement new policies and they have many other priorities. Nevertheless, more change is possible, and is expected by the other stakeholders involved in chronic care.

There is no single course of action that the agencies can follow. This legislative directive requests options around reorganization, and there are three basic directions the agencies can follow: full reorganization—such as transfer the DHS Licensing Division to MDH; no reorganization—just encourage the agencies to continue their effort at a faster pace; and between those poles, a form of quasi-reorganization—formally bring together the regulatory leadership without transferring the entire regulatory staff.

There are multiple arguments in favor of each direction. Perhaps the strongest reason for full reorganization is that it would result in the quickest pace of change, with shared management, one chain of command. Perhaps the strongest argument against reorganization is that it does avoid cultural change conflict that may slow down any regulatory improvement effort. Perhaps the strongest reason for quasi-reorganization is that it has potential for faster change, but without the cultural issues. However, the reasons for and against reorganization identified in this study also need to be taken into consideration, including the DHS role conflicts covered in the second study of this report.

Strongly ingrained cultural considerations make agencies apprehensive about reorganization, even when it is acknowledged as a unique opportunity for improvement. When there is hesitation, for any reason, agencies can still commit to immediate improvement steps that don't preclude eventual reorganization.

Recommendations

There is not a single way to improve regulatory administration in the MDH and DHS. From the perspective of this study, bringing the DHS Licensing Division and the MDH Compliance Monitoring Division into the same organization makes sense. Following are four recommended options, with escalating levels of reorganization.

1. ***Take action regardless of reorganization decisions***. As noted before, a multiple scenario analysis of the basic reorganization options (yes, no, quasi) would show there are steps that the agencies should take now if a reorganization is not intended, and should also take immediately as preliminary steps if a reorganization is intended. These steps may include:
   A. ***Expand and accelerate the current course***. The agencies deserve credit for a great start. They came together, identified issues, set a course of action and began that

action. There aren't many accomplishments yet, but the effort is just beginning. The scope can be expanded; there are provider and advocate issues that are not yet incorporated into this particular conversation. The current interagency planning group perhaps has too full an agenda to explore issues deeply. It may be well served by setting side or sub-groups to focus on areas such as institutionalizing an integrated professional development program.

B. ***Emphasize improved communication.*** Almost every organizational diagnostic report ever written, both public and private sectors, identifies a need for better communication. MDH and DHS have focused on web linkages as a useful first step, and it has helped in identifying out-of-date or broken links. While that work is progressing, the agencies could more systematically approach providers and advocates about priorities from their perspectives, which may lead to more clarity and ease of use. Communication goes well beyond websites, of course, and interpersonal skills training could be of value for frontline and high-level staff to improve the effectiveness of their interaction with service providers.

C. Involve stakeholders in the effort. The initial 2012 MDH report process was a consequence of service providers complaining directly to legislators, with some alleging that the agencies were not listening to them regarding overlap issues. There is, of course, a significant volume of interaction among the agencies, service providers, advocates and other stakeholders, much of it focused on local situations or the crises du jour. At least once a year, the agencies would be well served by gathering stakeholders working with both agencies to openly discuss change initiatives and other concerns. An important component of the meeting would be the opportunity for everyone to identify and respond to what they see as the most important issues affecting regulation. For both the agencies and the service providers, participants should include frontline staff as well as high-level representation.

D. ***Report to the legislature.*** Every year, the agencies involved in long-term or chronic care regulation should be required to submit a combined annual report to the legislature. This could be a new report or a variation on an existing one. The report should identify key regulatory issues and the steps being taken to address those issues. If it is like many annual reports, it could be easily dismissed, rather than read. However, a key value of annual reports is that by requiring agencies to identify and respond to issues, they provide stakeholders with an opportunity to address elected officials if they believe issues have been ignored or have been inadequately addressed. If all is going well, annual reports can be ignored. If all is not well, annual reports provide a reasonable starting point for policy discussion.

2. ***Identify a chief interagency regulatory coordinator.*** MDH and DHS can and have worked well together, as evidenced by the outcomes of their recent work involving home care and waivered services licenses. In both agencies, there are individuals regularly interacting with counterparts, but overall coordination tends to be on an ad hoc basis. Responsibility and authority are diffused up and down two organizational charts. A continuous effort to pull together quality initiatives and procedural changes should have someone identified as being in charge.

As noted earlier, DHS has created an OIG role to coordinate regulatory and related functions in that agency, but also to liaison with policy and payment staff also involved with the services. That position's power comes from several sources: formal authority, "bully pulpit" positioning and executive leadership support. A different but similar "supra" kind of role could cover regulatory work in both agencies. This is the person who should convene the meetings, write the reports and ensure that communication lines are open. This is the one person who would be fully aware of the myriad initiatives underway that impact regulation—for all of the recent major change effort, there are many more on the horizon. To the extent that both agencies formally recognize that the position has some authority with their staff, it represents quasi-reorganization.

3. ***Place the regulatory divisions in the same agency—eventually.*** Clearly, regulatory activities can be improved without reorganization, and reorganization entails a very real cultural change that can be difficult to address. However, the very steps that two distinct agencies should be taking to coordinate and improve their regulatory activities are pretty much the same steps that would need to be taken to blend cultural differences in anticipation of a merger. In effect, if the two agencies are truly able to work better together, then in the process they will have eliminated most of the rationale against reorganization. If the agencies are fully coordinating and communicating, the arguments against merger are mostly moot.

   Being prepared for a possible merger is important, because it could be prompted by issues outside of the scope of this study. DHS in particular could be looking moving out its regulatory function because of potential conflicts with its payor and direct service roles, as examined in the second study in this report. In addition, DHS could be looking at moving out its regulatory function simply because the massive size and range of its activities make it unwieldy. A merger of regulatory functions of the two agencies may make sense for reasons not addressed in this study.

4. ***Announce now that both regulatory divisions will be in the same agency***. Given that the administration of regulatory functions can and should work better together, and given that doing so removes key disincentives for merger, then perhaps the agencies shouldn't wait until more cooperative efforts have been explored before making a merger decision. Little would be lost, and a lot of direction would be gained, by simply announcing now that the two primary regulatory divisions are moving to the same agency. While a transition phase is needed—perhaps a couple years—before the merger is completed, the decision to begin that transition can happen now. A first step to consider is appointing a manager between the assistant commissioner and division director levels with responsibility for interdivision coordination as well as planning with other units in both agencies. To emphasize the interdepartmental role, both agencies should participate in funding the position.

   Given the scope of this study, placement within MDH is preferable to placement within DHS. In the future, a broader examination of state regulatory functions could determine that a new, independent regulatory agency has value. Should that be the case, a move now to MDH still serves as an interim step that begins transitional management and cultural change efforts.

Study 2: Multiple Roles of the Department of Human Services

Summary

Study 2 examines the multiple roles of DHS, especially those of payor, regulator and direct service provider. The 2013 OLA report, State-Operated Services, focuses on the direct service provider role; this study follows up by examining reorganization options that were outside the OLA's scope. It identifies that tension and other issues emerge between any two roles, but notes that generally these don't require a high level of concern. The study concludes there are two exceptions that could be addressed by reorganization. The first is conflict of interest between the roles of regulator and direct care provider—public confidence and transparency are affected when DHS is called upon to regulate, and at times exonerate, the activities of its own staff. The second is a question of whether the enormity and complexity of the agency precludes full engagement of the commissioner, restricts policy development and slows decision-making processes. The study concludes that the conflict of interest concern can be addressed by moving either the licensing or direct service role out of the agency. It further determines that the option of moving direct care functions to its own agency involves many unanswered questions that DHS needs to answer.

Recommendations

Reorganization can help DHS address two issues identified among its payor, regulator and direct service provider roles: inherent conflict of interest between the regulator and provider roles; and agency complexity compounded by the extent of agency operations.

1. ***Move DHS Licensing Division operations to MDH.*** Study 1 recommended an array of options to improve regulatory issues that, directly or indirectly, involve both state agencies with service provision to frail elderly, people with disabilities and people in need of substance abuse or mental health treatment. The options included placing merged regulatory units within MDH, but also included approaches without reorganization. The recommendation of this study, however, is that a move or merger of licensing operations to MDH is the preferred approach, because it has the additional benefit of removing a troubling conflict of interest environment within DHS.

2. ***Continue the current DHS restructuring effort.*** DHS leadership is well aware of the policy and program issues that the agency faces, and both the current and previous administrations deserve credit for attempting to address them through structural, operational, personnel and role revisions in the past five years. During the past two years in particular, a number of changes have been made, and it makes sense to track them to determine how effective they are in improving agency practices. Current leadership, in its response to the OLA report recommendations, makes clear that it is committed to a

continuous improvement process. That approach should be acknowledged and encouraged.

3. ***Develop a transition strategy for a new service agency.*** The DHS direct care and treatment programs could be removed from the rest of the agency and recast as a service-specific agency of its own. In the course of this evaluation, interviewees frequently suggested this notion as the simplest and clearest way to address an array of long-standing concerns. Almost as frequently, the notion was dismissed as close to frivolous because surely the state would never make such a major change.

   Perhaps it won't. There are many questions that would need resolution: reorganization costs, any new ongoing expenses, reporting relationships, potential new policies and rules, and implications for other state agencies need consideration. Although transferring programs to a new agency doesn't inherently impact the number of jobs or job security, assurances would be sought. Even how the issue is phrased and framed – the creation of a new large agency versus the slimming of an even larger agency – needs more thought. There are good reasons why the state might not consider such a major change at this time.

   Yet the possibility deserves further consideration. The agency does have internal conflicts, potential and real, in housing its varied roles. The agency has a complexity that isn't well understood by many, and it inhibits the quality of the agency's work as leadership's focus is forced to go in many divergent directions. And costs, though real, may be worthwhile, and the potential may be there to offset expenses with efficiencies from an undistracted leadership.

   It is recommended that the Legislature direct DHS to develop a transition strategy, a plan of action outlining how the direct care roles would become a separate agency, what the actual costs would be, and what steps the agency would take to promote its own policy development, budget processes and service efficiencies to improve its effectiveness in the future. The preparation of a transition strategy would not require the Legislature or the agency to necessarily implement the strategy, but it would enable an informed and thought-out decision to be made later. The agency should be given at least 18 months to complete a transition strategy.

Introduction

This is the second study conducted by Minnesota Management & Budget (MMB), Management Analysis & Development. The Legislature directed MMB to complete the following:

> *Describe and evaluate the multiple roles of the Department of Human Services as a direct provider of care services, a regulator, and a payor for state program services.*[4]

The current study is, in effect, a limited sequel to a February 2013 study of the Office of the Legislative Auditor (OLA). The OLA's *State-Operated Services* evaluation report examined the residential and inpatient services directly provided by the Department of Human Services (DHS) and explored service delivery alternatives. Most research for this MMB report was conducted around the same time as the release of the OLA report and the findings are consistent. Without repetition of the OLA report, this study provides a supplement and a limited extension of its scope by looking at the multiple roles of DHS and its impact on direct service delivery, and the implications of structural change for management capacity and public confidence.

State-operated services include an array of chronic care for people with significant frailty or disability and related conditions, covering forensic treatment services, community based services and mental health and substance abuse treatment services. “Direct care and treatment programs” refers to these state-operated services along with the Minnesota Sex Offender Program.

In addition to the OLA report, data gathering included relevant statutes and laws; website information from state agencies, national professional associations and federal agencies, and limited interviews with employees representing human service agencies in four other states. MAD consultants conducted interviews with 60 Minnesotans representing state agencies, service provider associations, private service facilities, consumer advocacy groups, ombudsman offices, legislative staff and other involved parties.

Background

OLA State-Operated Services report

The 2013 OLA report identified several key concerns and recommended a variety of changes, including a clarified mission, improved placement options for individuals ready to leave state-run facilities and additional security at some state-run hospitals. In effect, the report serves as a primer on state-run services and provides relevant history and evaluative information. The OLA summary is Appendix Q of this report, and the full report is recommended as essential background for any examination of state-run services.

The scope of the OLA report was limited to describing and evaluating the Department of Human Services (DHS) role as the direct provider of care services. It was not intended to describe or evaluate other related DHS roles. However, in setting its context, the OLA report did identify that DHS designs the care services and sets its own payment rates, and—along with MDH—regulates its own service delivery. The report limited its recommendations to its intended scope, noting:

> It will remain an ongoing challenge for DHS’s top leaders to devote the attention required by a system of direct care facilities. Organizational changes—for example, devoting a DHS deputy commissioner position solely to the oversight of state-run services, or even making State-Operated Services an agency separate from DHS—might simplify oversight and accountability. However, such organizational changes are not a panacea; proper oversight and direction for SOS will depend on what leaders do, not on what titles they hold. We offer no recommendations for structural changes.[5]

Since the OLA report was published, DHS has responded to the report recommendations with a number of organizational and management changes. These include the elimination of a state-operated services governing board, addition of key new positions, additional staff training and best practices reviews.

DHS mission and roles

The mission of DHS is a natural starting point in a role examination. In authorizing direct provision of care services, Minnesota statutes specify "services consistent with the mission of the Department of Human Services."[6] The DHS mission is "… [DHS], working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential."

Units within DHS have more specific missions. For State-Operated Services, the mission is "Partnering with others, we provide and support innovative and responsive specialty services to people with complex behavioral health needs and challenges." For the Licensing Division, the mission is "The Licensing Division, partnering with many others, helps to protect and to promote the health, safety, and well-being of people receiving human services and health care through informed, objective, and consistent enforcement of applicable regulations. We are accountable to consumers and their families, communities, caregivers, providers, our partners, and elected representatives in these public and private activities."

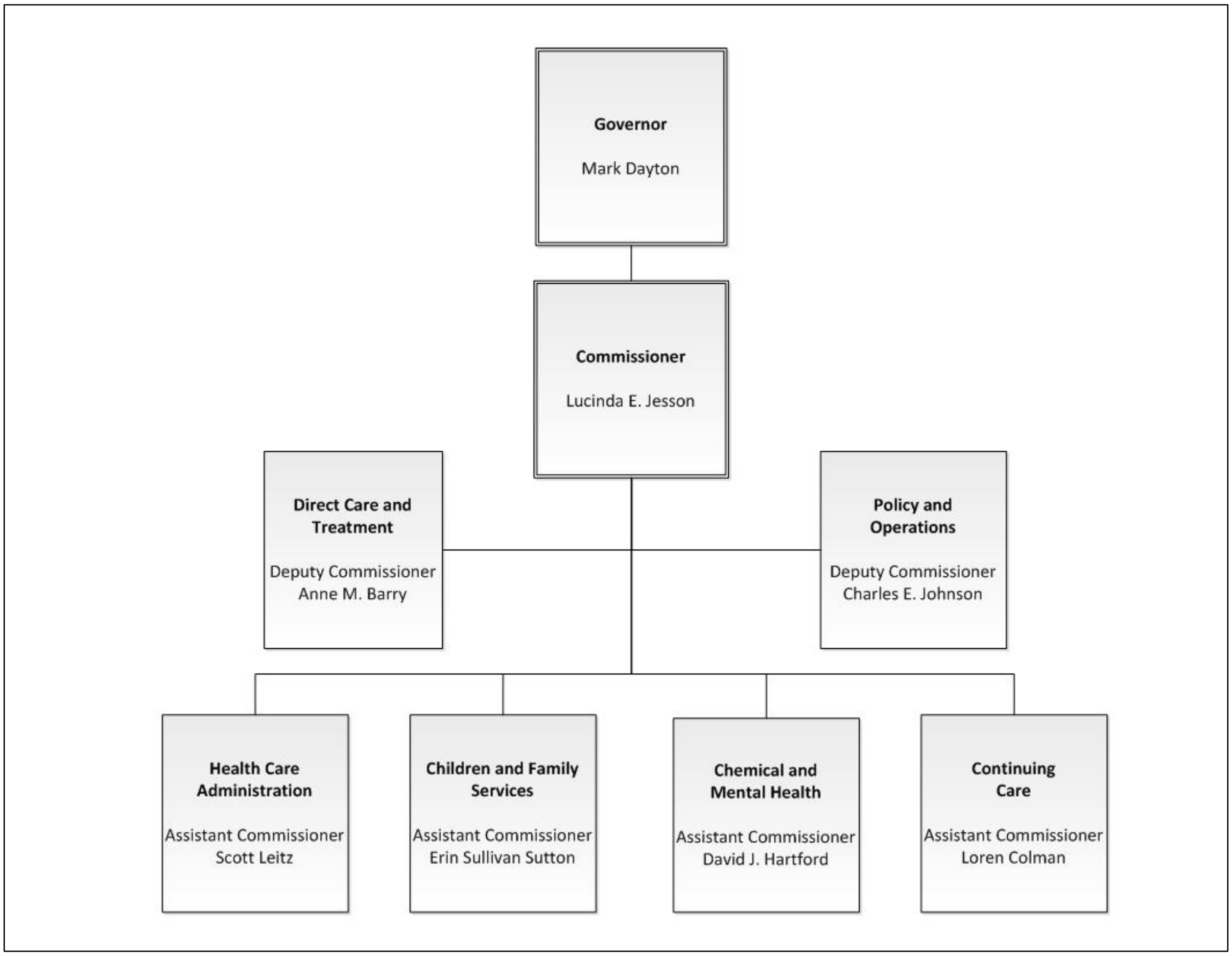
An observation is that, in the course of this evaluation, no strong challenge emerged that any particular DHS role did not fit within the DHS mission. At the same time, it was noted that other agencies have similar-sounding mission statements and arguably some roles might fit better in other agencies. As an example, DHS is the state's federally designated chemical health authority and mental health authority, roles that other states often place in their public health agencies. Another example is the Minnesota Sexual Offenders Program (MSOP) which, although it is a secure treatment program rather than a correctional program, serves what could be called a public safety role and arguably could be a better fit with the missions of other agencies.

The legislative request for this study specified three roles for examination: **payor, regulator** and **provider.** These are three basic roles for consumer service system that provides chronic or extended care. Depending upon the use of the term, the payor role is sometimes considered a component of a larger **policy** role, and sometimes viewed as a discrete role.

DHS develops program policies, guidelines and requirements, and this policy role is directly related to payor, regulatory and service provider roles. Within a federal and state framework, DHS conducts analysis and works with the governor, legislature and other stakeholders to design program services, quality assurance programs and operational procedures. Policy work results in principles set in statute and practices set in rulemaking. Policy activities are often iterative with payor activities such as contract development, with the two roles offering guidance to each other. *For purposes of this study, in keeping with the legislative directive, policy elements are included in the discussion of the payor role*.

As of July 1, 2013, the policy development role primarily resides in units under the assistant commissioners for Continuing Care and for Chemical and Mental Health. In turn, the assistant commissioners report to the commissioner. The payor role resides in units under the deputy commissioner for policy and operations, a position formerly identified as the chief financial and operating officer. The regulatory role also resides in units under the deputy commissioner for policy and operations. The direct service provider role resides in units under the deputy commissioner for direct care services. (Chart 1)

Chart 1: DHS Commissioner Organization Chart



Effective July 1, 2013

Following are brief descriptions of the roles.

Payor role

DHS functions as a payor for a wide range of services delivered primarily through lead agencies and private organizations. Case managers or other coordinators working on behalf of counties, tribal governments or managed care organizations help guide consumers to the services available to them through state policy and programs. The services are typically provided by private sector organizations or by local units of government. The service providers work under contract with DHS, which pays them according to the terms of the contract.

CMS sets the framework, but states have discretion. There are some limits on the state's ability to design care services: because so much of the service is provided to consumers eligible for either Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other federal programs, the framework for state policy or service design begins with requirements set by the federal Centers for Medicare and Medicaid Services (CMS) and other federal agencies. A consequence is that, at a distance, all states appear similar to each other. On closer inspection, differences appear. The first study of this report noted that a 2012 DHS internal scan compiled how all the states have organized their health and human services policy activities, related regulatory functions and their array of state-operated services, and found that no two states have exactly the same organizational structure. A contributing element in these differences is that states do have discretion in service design. Also, Minnesota and other states sometimes create services funded only by the state and subject only to state policy.

States individualize programs through waivers. A more significant element, however, is that the federal government allows states to propose new ways to deliver services as long as federal requirements or standards are met. States can request waivers, vehicles in which the regular delivery approach is replaced by a different, more flexible approach. By using waivers, states can engage in research and demonstration projects, use managed care delivery systems and support consumers in home and community settings rather than institutional settings. The waivers can combine standard medical services and non-medical services such as homemaker and personal care assistance. The Medicaid 1915(c) Home and Community-Based Services waiver program is the largest single payor of long-term care services in the country.

Once service programs are designed, DHS develops contracts and reimbursement rates to implement the programs through private organizations and local governments, as well as other DHS direct care units. In order to be paid, these service providers need to demonstrate that they have met the terms of the contracts, including federal conditions of payment.

Regulatory role

DHS provides services to help many of the state's most vulnerable citizens—people with significant frailty, disability, mental health or chemical health difficulties. DHS works to safeguard its consumers by regularly inspecting service providers and their care delivery, and by following up on consumer complaints and concerns. In addition, DHS regulates services provided by others, including those in other fields such as family childcare, childcare centers, child foster care, adult foster care and child placement agencies. DHS Licensing Division conducts maltreatment investigations similar to those of the MDH Office of Health Facility Complaints, and conducts background studies on behalf of several agencies.

An extended description of the role appears earlier in this evaluation report. The first study of this report examines the interaction of service regulation by DHS and the Minnesota Department of Health (MDH) both for service programs and the facilities that house the programs. A key point to note is that the regulatory processes are expected to be the same, regardless of whether the care service being inspected is provided by private providers or by DHS direct care units.

Direct provider of care services role

In addition to the care services delivered by private sector organizations and local units of government on its behalf, DHS itself also directly provides some services. These direct services, or state-operated services, are the focus of the 2013 OLA report, which documents the purpose, the history and the scope of the direct provider role.

In 1863, the state appropriated funds for a residential facility for the instruction of deaf and blind children. Over the years, the state created a system of large-scale institutions, called hospitals or regional treatment centers, serving a range of residential clients including people with tuberculosis and epilepsy, and ultimately with a variety of programs in the fields of chemical health, mental health, developmental disabilities and traumatic brain injury as well as people posing a risk to society.

With treatment methodologies and community values changing, by the 1980s service delivery began transforming into more of a community-based approach, and with more services provided under contract by private organizations or local government units. DHS also began operating group homes to move people with developmental disabilities into community settings, a program now known as Minnesota State Operated Community Services (MSOCS).

A major health system. Today, the services constitute a major health system—a statewide, dispersed system of specialty health services. While there is a wide range of services, most state-operated services cover forensic treatment services (including the Minnesota Security Hospital), mental health and substance abuse treatment services (including the Anoka-Metro Regional Treatment Center), seven free-standing community behavioral health hospitals and residential and vocational support services for people with developmental disabilities or acquired brain injury.

While not a part of the State-Operated Services unit, MSOP is another major direct care program, serving individuals who have been court-ordered to receive sex offender treatment. MSOP clients have completed their prison sentences and are civilly committed by the courts and placed in treatment for an indeterminate time. The program is located in Moose Lake and St. Peter.

Altogether, the programs serve about 11,000 patients per year at almost 200 sites. Table 1, a summary of licensed residential facilities run by State-Operated Services (excluding intensive therapeutic homes providing juvenile foster care) shows the range of care services directly provided.

Underlying purpose. As noted earlier, direct care services are considered within the mission of DHS. However, the OLA study included a statutory review and concluded “State law does not clearly establish the underlying purpose of the Department of Human Services’ provision of services to individuals.”[7] That underlying purpose had been clear for over a century: only the state was positioned to provide large-scale residential treatment services that were then considered the norm. Since the move to community-based services and the growth of private providers, the purpose is not clear. The state developed MSOCS and other enterprise services—programs fully funded by reimbursement from third-party payers—in order to address a legislative prohibition against closing or downsizing regional treatment centers before DHS could assure that community-based alternatives to meet program needs (found in Minnesota Statutes 2013, 246.0135 (b)). DHS met that need by creating its own community system.

Stakeholders interviewed for this study often identified the direct care provision role as being a provider of last resort, with DHS serving as a safety net for the hardest-to-serve consumers with significant care needs. Minnesota Statutes 2013 246.0136 subd. 1 specifies “Enterprise activities within state-operated services shall specialize in caring for vulnerable people for whom no other providers are available or for whom state-operated services may be the provider selected by the payer.” This refers only to enterprise services, but stakeholders frequently justified all state direct care with the “no other providers are available” provision.

Another component of underlying purpose is the reality that many clients are committed to the Commissioner for care, and much of the DHS effort in the mental health and substance abuse treatment systems is focused on those clients. This is particularly true for the Minnesota Security Hospital and the Anoka-Metro Regional Treatment Center, and to a lesser extent the community behavioral health hospitals and programs helping clients transition from skilled nursing facilities.

Table 1: Licensed Residential Facilities Run by State-Operated Services, 2012

Type of Residential Facility	**Description**	**Number of Facilities**	**Number of Licensed Beds**
Facilities for People with Mental Illness			
Minnesota Security Hospital	Secure treatment facility primarily for (1) individuals civilly committed as mentally ill and dangerous and (2) adults undergoing pre-trial evaluations	1	408
Anoka-Metro Regional Treatment Center	Psychiatric hospital providing acute care to adults with mental illness	1	175
Community Behavioral Health Hospitals	16-bed hospitals providing short-term, acute psychiatric services to adults with mental illness	7	112
Residential Treatment	Community-based facilities that provide residential treatment to five or more adults with mental illness	4	64
Facilities Primarily Serving People with Developmental Disabilities			
Adult Foster Care	Group homes providing foster care, including food, lodging, protection, supervision, and household services, to five or fewer adults	99	384
Intermediate Care	Residential facilities certified by the federal government to provide health or rehabilitation services to five or more people	15	90
Residential Services	Community-based residential facility providing developmental or rehabilitative services to five or more	1	16

Type of Residential Facility	Description	Number of Facilities	Number of Licensed Beds
	adults		
Facilities for Other Populations			
Chemical Dependency Treatment	Facilities providing chemical dependency treatment services to adults and adolescents	6	313
Forensic Nursing Home	Psychiatric nursing home for adults committed to the departments of Human Services or Corrections	1	48
Total		**136**	**1,680**

Source: Office of the Legislative Auditor, analysis of data from the Minnesota Department of Human Service, August 2012

Role relationship findings

The three DHS roles specified in this study—payor, regulator and direct service provider—are basic human service roles found in every state government, although aligned in a variety of state agency configurations. This study has examined whether the state's organizational approach has made an appreciable difference in how well the roles are performed. Following are findings in how the role relationships have affected stakeholders, in two-role configurations as well as all the roles together.

The interaction of roles in any system can result in tension, even conflict. In this study, there is no presumption that tension between roles is inherently negative. Given that tension can at times be a positive dynamic, this study primarily is concerned with any tension or conflict that may be responsible for a reduction in service performance, outcomes or consumer confidence.

Role relationships: policy/payor and regulatory

Provider concerns. Interview data indicates that from the perspective of some private service providers, the DHS policy and payor units can appear as quasi-regulators—in ensuring that providers have met federal and state contract conditions, policy and payor staff are acting similarly to regulators. When DHS staff prepare a service provider report card that will be publicly available, providers understand that, though it isn't technically regulation, they need to address it as an extension of regulation because potential consumers may view it that way. While it was hedged as a minor problem at most, service providers said they experience some frustration because they are not sure if DHS is contacting them regarding a regulatory matter or a payor matter. From a service provider perspective, a regulatory matter implies a failure on their part that potentially puts consumers at risk, while a payor matter implies differing interpretations of contract expectations, something that might be negotiable and does not potentially put consumers at risk.

Internal disagreement. Staff conflict during service redesign initiatives has been reported, both within DHS and between DHS and MDH. Service providers and some state staff described conflicting positions regarding the appropriate relationship between policy/payor and regulatory roles. This conflict emerged during the preparatory work leading to the 2013 legislative effort to integrate home care licensing (Chapter 144A) with waiver service licensing (Chapter 245D). While it was reported that the conversations revealed sharp differences in understanding, there also is general agreement that the legislative effort was successful, and that the preparatory work conversation led to a more clarified and agreed-upon understanding of the role relationships.

Emerging OIG role. The development of the DHS Office of Inspector General (OIG) position is cited as a primary effort to not only resolve potential conflicts between policy/payor and regulatory units, but to develop a synergy between the two. The OIG is a high-level position that manages regulatory-related units, but also has responsibility for connecting with policy and payor units so that the experience and insights of agency regulators can help the other units as they develop policies and practices. The position is described more fully in Study 1 of this evaluation. As that notes, the use of the position is continuing to evolve.

Long-term potential. Among both some state staff and service providers there is a hope that improved long-term interaction between DHS policy staff and regulatory staff might lead to a policy-led overhaul of the regulatory process. The hope is that it will move DHS away from a rule-infraction inspection approach to a quality based approach, similar to the root cause analysis approach used in hospitals. This approach can promote open discussion and develop functional best practices.

Role relationships: policy/payor and direct provider

Potential conflict of interest. The potential for conflict of interest in the DHS policy/payor role and the DHS direct service provider role was noted in the OLA report. Until fairly recently, one assistant commissioner was responsible for statewide policy development in chemical and mental health services, as well as overseeing state-run services in these areas. This meant that the person determining the provider payment rates that applied to state-run services also was the person responsible for those services.

That former arrangement of the agency’s organizational and reporting structures effectively set the stage for conflict of interest. This does not suggest or imply that any agency leader was ever influenced to make an inappropriate decision, but the awkwardness of the situation was known to leadership, if for no other reason than a longstanding track record of direct state care costing more than similar, private-sector services. As the OLA report noted, the cost per day at state facilities is substantial and often more than at other facilities with similar licenses.[8] Cost differences may reflect differences in the services provided by these facilities or the type of clients served—it is hard to know for sure. Substantiated examples include community behavioral health hospitals and the intensive residential treatment services for adults with mental illness.

Heightened structural walls. The structural source of the potential conflict of interest was addressed last year when DHS initiated a high-level reorganization. In 2012, the commissioner elevated oversight of all direct care and treatment by assigning responsibility to the deputy commissioner and assigning all policy/payor roles elsewhere. The move at least dampened conflict of interest concerns while elevating the visibility of direct services in the agency.

In addition to addressing conflict of interest, stakeholders expressed hope that other direct service issues may move closer to resolution as a consequence of the higher visibility and tightened focus from the recast deputy commissioner role. These issues include short-term initiatives such as reorganizing services at the Anoka-Metro Regional Treatment Center, restructuring the program size to qualify for federal reimbursement—Minnesota has spent millions of state dollars on services that could be paid with federal dollars. The issues also include longer-term initiatives such as integrating the state's freestanding behavioral health hospitals with primary health care systems. Interviewees contended that private health systems have been interested in connecting with the behavioral health hospitals but have backed away because of the complexity of the DHS decision-making process.

Role relationships: regulatory and direct provider

Structural conflict of interest. There was little unanimity among stakeholders interviewed for this study. About 60 state agency employees, service providers, consumer advocates and informed observers provided a wide range of perspectives, opinions and recommendations, and frequently offered contradictory conclusions. The one point that came closest to a generally accepted position, however, is that housing both regulatory and direct service provider roles in DHS is awkward at best, creating a permanent potential for conflict of interest, and potentially inhibiting good management decision-making.

Possible regulatory impact. Both current and previous DHS leaders have acknowledged that, at times in its past, the agency did not regulate its own direct service provision as it would other service providers. The OLA report supported the acknowledgement, noting as an example that state-run adult foster care facilities have had more investigated and substantiated complaints per facility than non-state facilities, but have been less likely to receive license suspensions or revocations, conditional licenses or fines.[9] The report notes that, for other services, DHS has not levied fines for regulatory infractions as frequently as for non-state facilities. While that might not appear to be a significant issue—the agency, in effect, taking money out of one pockets and putting it in another—it provides a basis for private service providers to believe not all providers are held to the same standards. It also prompts consumer advocates to question if other "free passes" are being given to state-operated services. It also leads some DHS managers to ruminate whether the agency would ever shut down one if its own programs as readily as it might shut down another service provider.

While the potential for conflict of interest is generally recognized, the actuality of conflict of interest is more contentious. Data tends to be perceptions and anecdotes. Some agency staff, as well as some consumer advocates, insist DHS is more rigorous in its inspections of state-operated services than it is with other providers. A reason given for more rigor is the realization that the people served directly by the state include some of the most frail, and some of the most potentially dangerous, service consumers. DHS's decision to just a conditional license to the Minnesota Security Hospital, accompanied by a fine in December 2011, is cited as an example of the agency's ability to be tough on itself.

Possible direct care impact. Questions have also been directed to whether state direct care providers appropriately respond to regulation. Some DHS staff privately allege that while state managers might work well on high levels, state service providers on the frontline have developed a cultural mindset that they are above regulation. This is anecdotally supported by MDH regulatory staff who shared several examples where they contend DHS service providers displayed an attitude that they simply cannot be shut down.

While MDH staff referred primarily to frontline situations, they also referenced the Cambridge Regional Treatment Center. In Fall 2011, MDH regulators contacted DHS about renewing its license for the Minnesota Extended Treatment Options (METO) program at Cambridge. In January, DHS submitted an incomplete license application, and then in the next month informed MDH that METO facility had been closed and was replaced with another, unlicensed facility. MDH doesn't approve facility licenses until its licensing and engineering staff—and the state fire marshal—determine that the building was fit for occupancy. The Cambridge facility was licensed in April 2012, almost ten months after the first residents had moved in.[10]

Conflict of interest in public view. The conflict of interest issue comes into public view whenever a consumer of state-operated services carries out a violent act. Two incidents resolved this year illustrate the situation. In January, the DHS Licensing Division reported it found no evidence that the Minnesota Security Hospital violated any regulations in an incident in which a consumer, out on a day pass, attempted to stab his mother to death. In June, the division again declined to cite the hospital when a consumer stabbed two people in the face with pencils he had been allowed to have. In both cases, DHS leadership reviewed the situations and concluded the regulators came to the proper decision—a conclusion supported by some consumer advocates. In both cases, however, news media made a point of noting that the licensing investigators who cleared the hospital of wrongdoing also work for the same agency that runs the facility.

For observers, perhaps a more troubling recent example involved the Minnesota Treatment Options (METO) program, referenced above, that was operated by DHS on the campus of the former Cambridge Regional Treatment Center. A 2008 report by Ombudsman for Mental Health and Developmental Disabilities—a separate state agency—found that the DHS staff engaged in excessive and inappropriate use of restraints, such as metal handcuffs and leg hobbles. In 2009 a class action lawsuit was filed; the result was a promise by DHS to downsize and repurpose the facility by 2011; adopt new seclusion and restraints policies and a new oversight process; increase staffing and training; and compensate the consumers.

The concern of some consumer advocates is that DHS's own regulators did not identify the problems discovered by the ombudsman office. DHS has since insisted that the licensing division was correct in not finding regulation violations. One advocate response was that DHS is relying on following the letter of the law. Advocates suggested that the DHS regulators might not have been so lenient had the same situation been found in the private provider's facility.

After five years the Cambridge situation is not fully resolved and, with its connection to the developing Olmstead Plan (which deals with restraint issues), it will likely remain in the media spotlight and continue to raise conflict of interest concerns.

In recent years, DHS has taken action to address concerns surrounding its regulatory and direct service roles. The commissioner now requires immediate notification of consumer deaths, the establishment of the OIG has moved regulation to a higher level and the placement of all direct care and treatment under the deputy commissioner position also signals a higher level of responsibility. As noted earlier, role separation has been clarified with direct service under one deputy commissioner, payment and regulation under the other deputy commissioner and policy directly under the commissioner.

Role relationships: confluence of all roles

Tension has been identified between any two service-related roles, but hasn't always been considered a significant operational issue. From an administrative perspective, a more prevalent concern has been the simple fact that the roles all reside in the same agency. When these roles with all of their attendant functions are combined with the myriad of other roles and functions also housed in DHS, they contribute to what appears to be overarching issues for the agency: enormity and complexity. While many stakeholders recommended moving some roles out of the agency primarily to resolve conflict of interest concerns, many others made the same recommendation solely to address improving the agency's capacity to manage itself.

Agency enormity. DHS is the largest state agency with roughly 6,200 employees. If its regulatory role (specifically the Licensing Division) was transferred, it would affect about 100 employees and DHS would remain the largest state agency by far. If its direct service role were transferred, it would affect about 4,480 employees, well over 70 percent of the agency. If all DHS direct care and treatment staff were considered a separate agency, it would be approximate in size to the Department of Corrections and only surpassed by the Department of Transportation. To put it another way: of the 24 agencies generally viewed as comprising the governor's cabinet, an agency of the direct care and treatment programs would be larger than 14 of the other agencies *combined*.

Agency complexity. In terms of complexity, DHS arguably has the most varied and expansive scope of responsibilities of any agency. As some stakeholders observed, a governor and a legislature would not likely consider it acceptable to appoint, for example, a Corrections commissioner who did not have an experiential background in running a corrections system. Yet governors and legislatures routinely approve Human Services commissioners with no experiential background in running a specialty health care system, even though that is their responsibility. The reason, of course, is because the health care system is only one of a large number of responsibilities, many of which have higher visibility. Besides running a specialty health care system and developing policy and programs for vulnerable populations—the roles considered in this evaluation—the DHS commissioner is responsible for programs that provide health care coverage for low-income people, secure economic assistance for struggling families, provide food support, oversee child protection and child welfare services, enforce child support, and coordinate related efforts involving other state and local government units and private organizations.

Complexity is an integral part of organizational dynamics. In the private sector, if organizations determine complexity is negatively impacting their work, they can respond in a variety of ways. They can recast their mission. They can use merger, acquisition and divestiture strategies to add and shed units based upon whether their role continues to have a compatible “fit” within the larger organization. Private sector organizations also have the capacity to channel complexity by placing responsibility at different points within their structure (such as using limited liability corporations). These options are not easily applicable in the public sector, where statute and tradition demand that each agency operate with one central leadership, one budget process, one set of policies and one set of practices.

The relationship between the Minnesota Sex Offender Program (MSOP) and State-Operated Services (SOS) serves as an example of how central policies and processes can inhibit good management. Until 2008, MSOP was a component of SOS and, according to numerous staff, was struggling with difficult policy and facility problems. The commissioner at that time brought in new leadership, separated the two programs and allowed MSOP to develop its own set of policies. This led to greater transparency in staffing and business operations, allowed fiscal questions to be clarified and refined and ultimately led to physical improvements. When the two programs were operating under common standards, patients and staff in the MSOP were intermingled with their counterparts in the Minnesota Security Hospital. While the two units might seem very similar, there are crucial differences—the most basic being that one unit included a vulnerable population and the other unit’s population included people who preyed on the vulnerable. This caused problems.

In this study, indications have been that allowing different policies in the same agency, focused on specific program areas, leads to gains in efficiency and effectiveness. A key difference appears to be faster decisions. A program with such a population mix is inherently volatile and potentially dangerous, and decision making needs to happen quickly. It can be slow enough when proposals move up and down a chain of command focused on, and directly knowledgeable of, a program, but it can be exceptionally slow when the chain of command includes high-level leaders legitimately distracted by other pressing concerns.

Due to its early and innovative work with the Results-Based Accountability process, DHS is widely credited as a state leader in documenting and increasing performance improvement. Yet the OLA found very little SOS performance measurement in the past six biennial budgets and a number of priority improvement initiatives there have made little headway The experience of MSOP and SOS is seen as illustrating a source problem: an organizational structure in which direct care and treatment programs are only a small part of a very full leadership plate.

Role relationships analysis

Interviewees both inside and outside of DHS identified numerous concerns regarding the interactions of the agency’s varied roles. However, concerns are not necessarily problems. Tension between staffs in different roles was noted, but typically it was generated during the development of new approaches or practices and it could be a positive dynamic force. Other concerns are problems, but don’t necessarily rise to a level that demands intervention. For example, service providers who raised the issue of the payor requirements appearing as additional layer of regulation also noted that it was only an issue of appearance and of minimal consequence.

The one issue that did rise to a high level of concern was the appearance of conflict of interest between the DHS regulatory and direct service provider roles. Even here, it must be acknowledged that the agency has, for better or worse, maintained both of these roles for years. This might be viewed as an indication that a change is not necessarily required, but recent abuses, headlines and lawsuits haven’t helped and add to the urgency that both actual and perceived conflicts of interest be eliminated. A change may be preferable for agency leaders who find themselves forced into an awkward position of publicly exculpating themselves after self-examinations, and for consumer advocates and Minnesotans in general who are asked to trust that the self-examinations are credible.

It isn’t simply the major issues that should be of concern. The relatively minor issues, in the aggregate, also have an impact on human service delivery. All of the DHS roles, along with their attendant concerns, simply add to the enormity and complexity of the agency. Agency leaders, responsible for many other pressing issues, have provided fairly nominal direct care program information to the Legislature. Legislators, themselves responsible for so many other pressing issues, have accepted fairly nominal direct care information. Without criticizing the capabilities of any current or former agency commissioners, it can be noted that they are expected to be executives with an understanding of a vast range of social welfare issues affecting at-risk children, at-risk elderly, people with disabilities, people with health problems, and many others; a comprehension of agency programs helping those populations deal with health care, employment, transportation, financial skills, independent living, adoptions and guardianships; ; managing and regulating federal programs like Medicaid; and leading the state’s largest purchaser of health services. In addition to this and more, the commissioner is expected to lead the state’s own specialty health services system.

The 2013 OLA report concludes with an extensive list of recommended actions, many of which could—and perhaps should—have been done long before. The Cambridge METO lawsuit settlement agreement also has an extensive list of actions that DHS is committed to complete; the court monitor has reported that the agency cannot achieve compliance with the settlement on schedule. Again, without criticizing the capabilities of any former or current agency commissioners, the organizational structure of the agency might well be served by actions that either tighten the focus of agency activities or enhance decision-making by shortening the chain of command.

Issue resolution options

To address issues generated by housing the regulatory and direct services roles, as well as considering performance issues exacerbated by agency size and complexity, DHS can consider at least four options, ranging from passivity to continuing its course to reorganizations.

Option: Rely on external forces

In all of its work, DHS does not have much of a “do nothing” option. Even if the agency selected that approach, things would nonetheless change, simply because there are many circumstances, trends and change agents that will influence the organization regardless of DHS’s intentions. These include the continuing evolution of the health care field, accelerated by the Affordable Health Care Act, which may push DHS to better coordinate—and maybe integrate—its specialty health services with the primary health care system. Federal agencies including CMS have at times imposed some organizational restrictions on service and regulatory roles; they continually review and change their rules. New developments in the evolving field of vocational rehabilitation may impact the operation of MSOCS. Judicial review may require some changes with MSOP. The state Olmstead Plan, still being written, and continuing compliance work with the Cambridge METO settlement, could result in policy, programmatic and organizational changes. If more program participant problems attract enough media attention, a governor or legislature may demand immediate visible change. While DHS might not need to take any initiative, it does need to prepare proper responses to the initiative of others.

Option: Continue internal reorganization

The current DHS commissioner has received kudos for raising awareness of role conflicts and institutionalizing improvement through organizational changes, including creation of the OIG position. Last year, a barrier between the direct care services role and the regulatory role was created by assigning one to the deputy commissioner and one to the chief financial and operating officer. Last month, that barrier was heightened by changing those titles to the deputy commissioner for direct care services and the deputy commissioner for policy and operations. This is the first time DHS has had two deputy commissioners; the roles are parallel and equal in overseeing all central office functions.

In a sense, much of the value of the title change is symbolic: having a position labeled deputy commissioner instead of assistant commissioner doesn’t necessarily make much difference in terms of authority but does convey a heightened level of significance. The commissioner has bolstered recent organization changes by filling those positions with individuals who generally receive very high marks from stakeholders both in and out of the agency. As a whole, interviewees tended to see DHS slowly moving toward having the right people in the right places.

The reorganization might be characterized as a short-term gain and a long-term risk. The change process is only assured until the next commissioner arrives with a new set of priorities.

Option: Remove the regulatory role

Study 1 of this evaluation examines the regulatory roles of DHS and MDH and recommends ways to improve their interaction with each other and with stakeholders. It concludes that an immediate merger or movement of operations into one agency would have both positive and negative consequences. It proposes four escalating options: two of them keep the roles in their respective agencies, and two of them propose joining the licensing divisions at MDH. All four options are recommended to improve the regulatory role of these two agencies.

Moving some Licensing Division operations to MDH is also an option here, but for a reason outside the scope of the first study: it removes the inherent conflict of interest of having the regulatory and direct care provision roles in the same agency. It would create a stronger, clearer and more permanent barrier between the regulatory and direct service roles.

Option: Remove the direct provider of care services role

Should the regulatory role move from DHS to MDH, it would reduce the rationale for moving the direct care services role out of the agency since it would eliminate the conflict of interest between regulation and direct care provision. Other reasons would remain, including any conflict with payment and policy roles, but not necessarily anything that would require such a major undertaking as making direct care provision its own organization or agency. However, from the perspective of taking a large and complex agency and breaking it into more manageable and understandable component, the option may merit consideration. As a freestanding agency, direct care and treatment services could set policies and practices more appropriate for its role, conduct budgeting and planning focused on its mission and obligations, and operate with a shortened and more attentive chain of command.

There is always a cost associated with reorganization. Study 1 included an estimate by another agency of about $1,000 per person for physical relocation. Other costs can include IT systems, letterhead and identity change, lease changes, staff communication, etc. Should a specific reorganization proposal ever advance, a detailed cost estimate would be needed at that time. However, at its most simple level, establishing direct care and treatment services as a separate agency is more of a conceptual or nominal movement. It might be that the only essential change is eliminating a DHS deputy commissioner position and creating a new direct care agency commissioner position. On day one, the work remains the same: no one needs to move, no new support units are needed (the current ones cover the work) and the new agency is already a fully functioning entity. Based upon the earlier MSOP and SOS model experience, hopefully the change would be accompanied by some efficiency gains.

Few, of course, would presume that a new agency can be created without cost, and few would bank on the move resulting in efficiency gains. There are many unknowns—too many to determine what would need to be done and what the costs and gains might be. Before a public dialogue can commence, DHS would need to develop a transition strategy, a high level but realistic look at: what would be involved in making the move, including statutory changes; how the new agency would be able to develop more focused policies and practices; and how those practices could result in efficiency gains. Given that the transition strategy would be developed in a changing environment of federal policies and priorities, litigation settlement compliance and Olmstead Plan evolution, DHS will need dedicated time and resources just to comprehend and consider what could be done.

Conclusion

The OLA report quotation at the beginning of this study included the following:

> Organizational changes—for example, devoting a DHS deputy commissioner position

> solely to the oversight of state-run services, or even making State-Operated Services an agency separate from DHS—might simplify oversight and accountability. But such organizational changes are not a panacea; proper oversight and direction for SOS will depend on what leaders do, not on what titles they hold.

This study confirms the statement; structural change never replaces the need for good leaders. But the statement can also be turned about; having good leaders isn't necessarily a panacea either, especially when structural change can simplify oversight and accountability. While both are critical, good organizational design has sometimes shown more staying power than good leaders.

Role conflict in DHS is real. Much of the identified conflict can be manageable, even acceptable. However, conflict between the regulatory role and direct service role is troubling and poses a question as to whether or not DHS is properly looking out for the safety and well-being of the highly vulnerable participants in its own programs. It is readily acknowledged as a having been a problem in the past, and the concern is what is needed to keep in only in the past. Public confidence and transparency can be threatened when the agency is required to judge and possibly penalize its own behavior.

Multiple reasons suggest a change. Study 1 of this evaluation looked at the regulatory roles in DHS and MDH, and included recommendation options to move the role from DHS to MDH in order for the similar divisions to work together better. Study 2 indirectly looks at the same situation but from another perspective; the same move also benefits DHS by removing the regulatory and direct service role conflicts.

Together, roles exacerbate DHS enormity and complexity. There is a question whether any DHS commissioner can be expected to keep involved in the vast range of concerns in the state's largest agency. Over the years, direct care service problems with poor performance measurement, incomplete initiatives, lax management and slow decision-making have been blamed upon overly-centralized processes and little time available for the commissioner to address real but low-profile issues.

A new, focused agency makes sense. This conclusion is consistent with the OLA observation that making SOS its own agency apart from DHS might simplify oversight and accountability. Including MSOP with SOS in an agency might, in addition, reinforce role clarity, tighten the purpose of the agency (or agencies), speed decision-making and give policy, budget and priority-making flexibility to direct care and treatment programs.

A new, focused agency is not a sure thing. Practical questions abound. While restructuring costs might be minimal, they would be real and are still unknown. A transition strategy, fully developed with the premise that it may be implemented, is needed to answer the practical questions of timing and support service use. Most important, a transition strategy would address how the new agency would shape its policies and practices. Based on such a strategy, state leaders would be in a position to assess the value of making the final decision.

Recommendations

1. Move DHS Licensing Division operations to MDH

Study 1 recommended an array of options to improve regulatory issues that, directly or indirectly, involve both state agencies with service provision to frail elderly, people with disabilities and people in need of substance abuse or mental health treatment. These are service areas where DHS has both regulator and direct service provider roles. The options included placing merged regulatory units within MDH, but also included approaches without reorganization. The recommendation of this study, however, is that a move or merger of licensing operations to MDH is the preferred approach, because it has the additional benefit of removing a troubling conflict of interest environment within DHS. The agency acknowledges that at times in the past, it has been lax in regulating its own service programs, but believes the problem has been resolved by appointing good people to increasingly visible positions. Those individuals are highly regarded, but they aren't permanent; as long as licensing stays within DHS, conflict of interest concerns will reemerge with every high-level personnel change.

As noted earlier, the DHS Licensing Division regulates other services that it does not also provide. Within the scope of this study of role relationships, there is no compelling need for DHS to transfer those operations to MDH and so they are not part of this recommendation. On the other hand, if it is given that a portion of the division is moved, and if both DHS and MDH see potential value in a full transfer, then it would make sense for the agencies to pursue full transfer.

2. Continue the current DHS restructuring effort

DHS leadership is well aware of the policy and program issues that the agency faces, and both the current and previous administrations deserve credit for attempting to address them through structural, operational, personnel and role revisions for at least the past five years. During the past two years in particular, a number of changes have been made, and it makes sense to track them in order to determine how effective they are in improving agency practices. Current leadership, in its response to the OLA report recommendations, makes clear that it is committed to a continuous improvement process. That approach should be acknowledged and encouraged.

3. Develop a transition strategy for a new service agency

The DHS direct care and treatment programs could be removed from the rest of the agency and recast as a service-specific agency of its own. In the course of this evaluation, interviewees frequently suggested this notion as the simplest and clearest way to address an array of long-standing concerns. Almost as frequently, the notion was dismissed as close to frivolous because surely the state would never make such a major change.

Perhaps it won't. There are many questions that would need resolution: reorganization costs, any new ongoing expenses, reporting relationships, potential new policies and rules, and potential implications for other state agencies need to be considered. Although transferring programs to a new agency doesn't inherently impact the number of jobs or job security, assurances would be sought. Even how the issue is phrased and framed—the creation of a new large agency versus the slimming of an even larger agency—needs more thought. There are good reasons why the state might not consider such a major change at this time.

Yet the possibility deserves further consideration. The agency does have internal conflicts, potential and real, in housing its varied roles. The agency has a complexity that isn't well understood by many, and it inhibits the quality of the agency's work. The leadership's focus is forced to go in many divergent directions. Costs, though real, may be worthwhile, and the potential may be there to offset expenses with efficiencies from undistracted leadership.

It is recommended that the Legislature direct DHS to develop a transition strategy, a plan of action outlining how the direct care roles would become a separate agency, what the actual costs would be, and what steps the agency would take to promote its own policy development, budget processes and service efficiencies to improve its future effectiveness. The preparation of a transition strategy would not require the Legislature or the agency to necessarily implement the strategy, but it would enable an informed and thought-out decision to be made later. The agency should be given at least 18 months to complete a transition strategy.

Study 3: Risk Issues

Summary

This report is the third study of an evaluation completed by Minnesota Management and Budget (MMB), Management Analysis & Development (MAD). As directed by the legislature, this report focuses on “reasonable client risk assessments, planning for client risk reductions, and determining reasonable assumptions of client risks” in relation to client rights and provider liabilities and responsibilities (“risk issues”). Risk issues have taken on new significance in recent years, spurred by recent lawsuits, federal policies and other factors that require or promote person-centered planning and client choice. To examine these issues, MAD consultants reviewed selected statutes and risk assessment and planning processes at the Minnesota Departments of Health (MDH) and Human Services (DHS), completed a literature review, interviewed approximately 60 stakeholders and conducted further analysis to develop conclusions and recommendations. In this report, **“risk issues” refers not to risk, but rather to the whole package of issues surrounding client risk assessment, planning and determining “reasonable” risk levels in relation to other factors, as described in the legislative directive for this report** (i.e., health care, client health care rights, provider liabilities and provider responsibilities to provide minimum standards of care).

Findings

- The Olmstead Ruling, Jensen Settlement and the focus on home and community-based, person-centered care by the state, CMS and others are important factors driving the current interest in risk issues.

- State policies and procedures regarding risk assessment and planning are made within the context of current agency missions and statutes. The MDH mission centers on health and safety, while the DHS mission has a greater emphasis on independence and non-institutional settings. New home and community-based licensing standards explicitly mention risk, calling for a balance between risk and opportunity. MDH and DHS processes and standards are moving toward more a holistic approach to risk issues to simultaneously address safety, health, well-being, choice, rights and risk.

- Perceptions on ways to resolve risk issues show:
  - There is a great range of perspectives on how to address risk issues at the community, agency and individual level. This can hamper efforts to build consensus among stakeholders.
  - Risk issues are often framed as questions of how to balance choice against health, safety and other risks, and what makes a risk acceptable.
  - Suggestions for improving individual assessments and planning processes include properly diagnosing the source of risk conflicts, developing better risk tools and using a team approach to resolve conflict.

- Options for addressing provider liability concerns that some say are leading to restrictions in choice include traditional tort reform (such as a cap on damages) or alternatives to tort reform such as negotiated risk agreements, evidence-based practices and insurance risk pools.

Analysis and Conclusions

- The diversity of expertise and vantage points of all stakeholders, including MDH and DHS, both facilitates problem solving and creates significant challenges to building consensus. Key players need to develop a common understanding of risk issues and alternative strategies.

- Risk issues need to be viewed more holistically: imagining risk issues as a continuum or balance between autonomy and choice on one end, and safety and protection on the other end, implies a dichotomy that does not exist and sets the stage for conflict.

- At the policy level, MDH and DHS collaboration is needed so they speak with a consistent voice and use collective expertise to address risk issues. This is happening with increasing frequency at the agencies. Further collaborative efforts are needed to address the genuine frustrations providers have about what are, or are perceived to be, conflicts between agencies and divisions in how they are regulated.

- Joint MDH and DHS involvement is needed in resolving individual risk issue situations in a manner consistent with high health care standards and person-centered care and choice. To create more evidence-based practices, MDH and DHS have rich sources of data they can draw from in developing new risk tools and supports.

- There is limited and inconsistent research regarding the impact of tort reform on reducing defensive care and service provisions, and, importantly, mixed results on tort reform’s impact on client outcomes. Efforts to promote overall quality are likely to have a positive impact on all stakeholders’ ability to address risk issues at the policy and individual level, particularly if quality is broadly defined to include health, safety, autonomy and well-being.

Overview of Recommendations

Recommendation 1: To build a more evidence-based and multi-faceted understanding of risk issues across stakeholders, the state should assure there is an ongoing forum for discussing risk issues, addressing policy and practical concerns, and developing consensus.

This forum could be a new group or existing group, such as extensions of the State Quality Council or Olmstead Subcabinet with broader representation from all stakeholders. The forum should be a place to provide, discuss and receive information. The role of this group and its deliverables should be well documented and publicized, with strong project management and effective mechanisms to assure the group’s mission is accomplished (e.g., change in statute, use of interagency agreements, annual reports to the legislature).

Recommendation 2: To build MDH and DHS capacity on risk issues, the agencies should embed organizational, staff and service performance systems with risk-related expectations, standards and measures.

Specifically, MDH and DHS should embed (or continue to embed) a focus on risk issue information into: policy manuals, staff and provider training and standards, and related documents; ongoing review of MDH and DHS statutes, policies and communications to identify where a consistent state policy related to risk issues could be stated or clarified; and MDH and DHS quality initiatives (with a goal of a holistic, consistent perspective related to basic risk issues).

Recommendation 3: MDH and DHS should work together to address priority areas of concern, respond to provider questions and implement other strategies for improving cross-agency problem solving, collaboration and communication on risk issues.

Specifically, MDH and DHS should work together to plan and implement initiatives to address key areas of risk, such as assisted living. In these efforts, each agency should understand and articulate its roles and responsibilities, such as whether they are serving in an advisory or equal-partner role. It is also recommended that the agencies develop a single point of entry for providers who have licensing and risk issue questions, track provider issues and consider ways to assess and communicate to stakeholders about how changes in policy and funding affect state and provider capacity to address risk issues and related outcomes.

Recommendation 4: To help resolve risk issues at the individual level, MDH and DHS should use multidisciplinary teams to develop solutions and create a system for tracking and sharing risk issue knowledge and strategies.

Specifically, MDH and DHS should use multidisciplinary, joint teams to respond to individual situations and identify the real and priority issues in the situations. The agencies should develop systems to track and share information between MDH and DHS on patterns of provider and client risk issues and share and incorporate what has been learned from teams into quality initiatives, training and informational materials.

Recommendation 5: MDH and DHS should jointly use and/or develop practical tools to assist stakeholders in addressing and resolving risk issues at the individual level.

For example, MDH and DHS should develop or continue to develop: tools such as up-to-date, clear, user-friendly websites and manuals; checklists for how and when it is appropriate, legal and advisable to set limits; specific training on risk issues, and associated risk communications; use of risk/harm/abuse reduction and prevention plans, rather than risk management plans; and use of the assessment and service contracting process to specify what all parties agree to regarding reasonable risk, in compliance with state and federal standards.

Recommendation 6: MDH and DHS should continue to examine and implement the most promising alternatives to traditional tort reform.

It is recommended that MDH and DHS do not pursue additional, traditional tort reform, but instead continue to expand use of tort reform alternatives such as evidence-based practices. The agencies should also explore the expanded use of insurance risk pools, alternative dispute resolution and provider and client education and technical assistance. Per recommendations from the SQC and Olmstead Planning Committee, DHS and MDH should examine the relationships among the Americans with Disabilities Act, the Vulnerable Adults Act and liability and insurance laws and practices, calling on legal and other expertise to determine if there are inconsistencies in the state's approach.

Introduction

This is the third study conducted by Minnesota Management and Budget (MMB), Management Analysis & Development. Study 1 focuses on regulatory responsibilities of the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS). Study 2 addresses the multiple roles of DHS as a provider, regulator and payor for state program services. Study 3 responds to the legislative's directive to MMB to complete an examination of the following *risk issues*:

> For long-term care regulated in both departments, evaluate and make recommendations for reasonable client risk assessments, planning for client risk reductions, and determining reasonable assumptions of client risks in relation to directing health care, client health care rights, provider liabilities and provider responsibilities to provide minimum standards of care[11]

Significance of risk issues

Risk assessment and planning has historically been conducted to eliminate or reduce threats to person's risks to health and safety. Tensions arise when an individual's personal choices and autonomy are restricted (or potentially restricted) when an agency, provider or others limit choices due to safety, liability or other concerns. Risk issues have taken on new significance in recent years, spurred by recent lawsuits, federal policies and other factors that require or promote person-centered planning and client choice. Risk assessment and planning is no longer centered on reducing risks to health and safety; it also includes reducing risks to independence and autonomy. Many questions arise, with potentially significant implications for service choice, quality, health, well-being, access and costs. For example, what risks are acceptable, and who gets to decide, especially if someone has cognitive difficulties or their ability to make decisions changes over time? What is the relationship between client choice, risk, health and provider liabilities and responsibilities? What are "reasonable" client risks and assumptions? To what degree is it necessary to *balance* client independence and safety, and to what degree can these goals be *simultaneously* achieved?

Several groups have recently considered risk issues: the State Quality Council (SQC), the Olmstead Planning Committee (OPC) and the Olmstead Subcabinet, creating bullet lists or brief reports focused on risk-related concerns. This report uses information from these reports and builds upon it to provide a broader look at the issues and offer additional recommendations to the Minnesota Departments of Health (MDH) and Human Services (DHS).

Study scope

One person interviewed for this study remarked that risk issues were the elephant in the room—everyone can see it but no one knows how to take the first bite. As noted by Paula Span and Rosalie Kane in 2010, "[the root of] this question is a philosophical one: how to balance safety with the things that make life worth living," such as security, meaningful activity, relationships, dignity, autonomy and privacy12. If the net is widely cast, as it is in the legislative directive for this report, risk issues can be relevant to nearly all aspects of chronic care planning, assessment, service delivery and evaluation, financing and policy.

This report therefore limits its review and analysis as follows:

- Per legislative directive, the report focuses on long-term care regulated by MDH and DHS. However, the report uses the concept and term of "chronic care" rather than long-term care. "Chronic care" implies that care and services are provided for a relatively long term of time, compared to acute care; it does not imply whether a condition is life-long. Chronic care is used because of the limitations of other terms (e.g., LTC often refers to elder care; "continuing care" often refers to the services administered through DHS's Continuing Care division, "long term services and supports" refers to specific Medical Assistance (MA) services, etc.). "Chronic care" is defined under "terminology" in the next section.
- The use of restraints is not within the scope of this study. This important issue is a subject of the Jensen agreement[13] and the state will address it through the Jensen settlement process.
- Sources of findings are primarily limited to the following sources:
    - Brief review of selected literature.
    - MDH and DHS statutes and initiatives affecting risk issues.
    - MDH and DHS risk assessment, risk planning and risk reduction processes
    - Examinations of risk issues by other groups (State Quality Council, Olmstead Planning Committee and Olmstead Subcabinet).
    - Interviews with about 60 in-state representatives of state agency leadership and staff, service providers, consumer advocates, informed observers and about 10 representatives of other states.

Terminology

This report repeated uses several terms as shorthand for key concepts associated with risk issues (see Appendix A for list of acronyms and other sources for defining terms):

- **Client risk** generally refers to risks to physical health, mental health, independence, choice and general well-being.
- **Chronic care** generally refers to long-term care (LTC) and other non-acute services provided in institutional, residential and community-based settings, including services to people with disabilities, people with mental health issues and people 65 years of age or older.
- **Federal policy** usually refers to policies of the Centers for Medicare and Medicaid

Services (CMS).

- **Home and Community Based Services** refers to services provided in non-institutional settings or services provided through Medicaid HCBS waivers.[14]
- **Person-centered or person-directed care**: These terms are used in a wide variety of ways in literature, policy and procedures. In this report, the term is used generally to refer to assessing, planning or providing services with the goal of a person making her/his own choices about care, services and how to live, to the extent that this is possible.
- **Risk Issues** refers to issues surrounding client risk assessment, planning and determining "reasonable" risk levels in relation to other factors, as described in the legislative directive for this report (i.e., health care, client health care rights, provider liabilities and provider responsibilities to provide minimum standards of care).

Background

Section overview

- The Olmstead Ruling, Jensen Settlement and the focus on home and community-based, person-centered care by the state, CMS and others are important factors driving the current interest in risk issues.

- The State Quality Council briefly considered risk issues in 2013 and delayed further reporting until 2014. A subgroup of the Olmstead Planning Committee in 2012 developed a short report on empowerment and choice. The Governor's Olmstead subcabinet makes reference to risk issues its draft plan. Recommendation made by these groups include conduct a further review of current laws and liability issues and provider training for all involved parties.

Current focus on risk issues and person-centered care

Assessing risk, developing care plans and other risk-related issues have long been a central focus of many state and lead agency activities. The state's current focus on risk issues is spurred by two lawsuits (the Olmstead Ruling and Jensen Settlement), CMS's focus on person-centered care and home and community based services, and a concomitant shift away from institutional care in Minnesota.

Olmstead Ruling and Jensen Settlement

In Olmstead v. L.C. (527 U.S 581, US Supreme Court 1999), the court ruled that two plaintiffs had the right to receive care in the most integrated setting appropriate, and that their unnecessary institutionalization was discriminatory and violated the Americans with Disabilities Act (ADA).[15] The Supreme Court held that "public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity."[16] The court advised states to create formal Olmstead plans to demonstrate compliance with the ADA and Olmstead ruling. CMS issued Olmstead plan guidance to states in 2001. Minnesota began drafting its Olmstead plan in 2013.

In 2009, in another court case, three residents of the Minnesota Extended Treatment Options program (METO) sued the State of Minnesota and DHS regarding treatment they received at METO.[17] The settlement agreement required the state to close METO and required DHS to establish an Olmstead Planning Committee (OPC). The OPC was created in 2012 and included individuals with disabilities, family members, providers, advocates and senior DHS decision-makers.[18] See more information on the Olmstead ruling and Jensen settlement in Appendix B.[19]

Focus on Community-based and Person-Centered Care

MDH and DHS efforts to promote individualized care are aligned with changes in federal policy and the private sector. The concept of person-centered care has existed for decades.[20] In 1987, for instance, Congress passed reforms to require nursing homes to provide individualized, person-centered care. Figure 1 shows one depiction of the concept. Although focused on elders, this figure shows the type of continuum behind many risk issue discussions—the goal of person centered or person directed care is that people make their own choices about services and how to live, as possible.

Figure 1: Pioneer Network's Continuum of Person-Directedness

Provider Directed	Staff Centered	Person Centered	Person Directed
Management makes most of the decisions with little conscious consideration of the impact on elders or staff.	Staff consult elders or put themselves in elders' place while making the decisions.	Elder preferences or past patterns form basis of decision making about some routines.	Elders make decisions every day about their individual routines. When not capable of articulating needs, staff honor observed preferences and lifelong habits
Elders accommodate staff preferences; are expected to follow existing routines	Elders accommodate staff much of the time—but have some choices within existing routines and options	Staff begin to organize routines in order to accommodate elder preferences—articulated or observed	Staff organize their hours, patterns and assignments to meet elder preferences.

Low Continuum of Person-Directedness High

Developed by Mary Tess Crotty, Genesis HealthCare Corp,
based on the model by Susan Misiorski and Joanne Rader, distributed at the Pioneer Institutes, 2005.

CMS has highlighted person-centered planning and is promoting its use through HCBS waivers. CMS's definition emphasizes that a person-centered planning process is directed by the family or the individual with LTC needs (rather than professionals) and includes the identification of "personally-defined outcomes and training supports, therapies, treatments and or other services the individual is to receive" to achieve personally-defined outcomes in the most inclusive community setting.[21]

CMS and Minnesota's Medicaid program (Medical Assistance (MA)) also have a "self-directed services" option under the MA State Plan and MA waivers. In this context, self-direction includes person-centered planning process and means that participants (or their representatives, if applicable) "have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports." This is an alternative to the agency delivery model.[22]

Beyond chronic care, the National Association for Regulatory Administration's (NARA)[23] also notes the need for a holistic view of human service regulation that includes person-centered care. Specifically, NARA states that human service regulations should protect against health and safety risk while focusing on quality and individualized care; allow for coordination with relevant agencies' laws, regulations, services and funding; and be interpreted in up-to-date manuals or guidance documents.

Shift to more community-based care

For decades, the state and federal policies have helped shift long-term services and supports from institutional settings to HCBS. In Minnesota, as of 2010, a large majority of Medicaid-eligible people with disabilities (94 percent) and seniors (61 percent) who need LTC were living in their communities rather than in an institutional setting.[24] Minnesota received the best score in the nation on a State Long-Term Services and Supports Scorecard published by AARP, in large part because Minnesota provides Medicaid and state-funded HCBS that balance the majority of spending toward HCBS.[25] As discussed later in this report, some people think this shift toward community-based care requires are more vigilant focus on certain risk issues.

Recent efforts to examine risk issues

Three groups have recently addressed risk issues in Minnesota, at least in part: The State Quality Council, a subgroup of the Olmstead Planning Committee (OPC) in 2012 and the Governor's Olmstead Subcabinet. The OPC completed the most comprehensive look at this issue, devoting several pages to the topic and recommendations. Brief information on these efforts is below; see Appendix C for more detailed information.

State Quality Council

The SQC is charged with helping the state improve HCBS, including an examination of risk issues. Its charge includes:

- Identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

- Recommend to the legislature, by January 15, 2013, statutory and rule changes related to promote individualized service and housing choices balanced with appropriate individualized protection.[26]

The SQC has taken a cursory look at risk issues and proposed that new HCBS licensing standards include “risk” as a factor to be considered in a participant’s service plan and expressed concerns over case manager workloads. The group plans to report to the legislature in 2014 after it has looked more closely the relationship between the Americans with Disabilities Act, the Vulnerable Adults Act, liability laws and practices.

Olmstead Planning Committee

The OPC created a short summary of risk issues and recommendations in 2012. Recommendations related to using case-by-case evaluations to determine ways to enable to person to safely perform desired activities, addressing liability issues on a systemic and individual basis, and involving people will disabilities, their families and advocates in the state’s new risk assessment and planning process (MnCHOICES).[27] The OPC also recommended that the state enforce consumer choice, provide related training to involved parties, review relevant laws to assure they do not reduce individual choice, address risk management policies and standards in a consistent manner, support a network of Peer Integration Specialists and ensure that when balancing choice and risk, choice is given more weight than risk. A full report of the OPC’s recommendations on empowerment and choice is provided in Appendix D.[28]

Olmstead Subcabinet

Minnesota’s draft plan for integrating people with disabilities into community settings, the Olmstead Plan,[29] does not focus on risk, per se, but its vision statement emphasizes choice, self-determination and a client’s need for information to weigh the risks and benefits of service options. In describing how they will implement Olmstead-related activities, DHS mentions the need to use risk management plans to reduce and prevent crises, “empower individuals to make choices and manage risk” (e.g., through peer support and linkage lines) and assure person-centered planning and personal choice. MDH notes that there is “ongoing tension between a person’s choice/self-determination and provider liability/licensure.” The department describes the need for more access to information and resources on health risks, and more funding and staff to collect and interpret data to identify and address areas of concern.

Selected Statutes and Initiatives Affecting Risk Issues

Section overview

- Neither DHS nor MDH mission statements explicitly mention risk, choice or safety. The MDH mission centers on health, while the DHS mission focuses on helping people meet basic needs. Similarly, MDH statutes focus on the health and safety, while DHS statutes have a greater emphasis on independence and non-institutional settings.

- New HCBS licensing standards accentuate choice and person-centered care. They explicitly mention risk, calling for a balance between risk and opportunity, with supports to allow a person to “engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety or rights.”

- New licensing standards for home care and HCBS waiver services indicate that MDH and DHS, working together on these legislative proposals, are moving toward more holistic requirements for assuring multiple goals of safety, health, well-being, choice, rights and risk.

Agency missions and related statutes

Mission and statutes

State policies and procedures regarding risk assessment and planning are made within the context of current agency missions and statutes. MDH and DHS missions do not conflict, but there is an obvious and predictable difference in emphasis that provides important context for discussions of risk issues. MDH’s vision statement is to keep “ALL Minnesotans Healthy.”[30] DHS’s values include a focus on people, providing safety nets and being accountable. The statutory descriptions of agencies’ missions are nearly identical. Statute directs both agencies complete such duties as prevent waste and unnecessary spending, operate efficiently and coordinate activities with other governmental agencies where appropriate.[31] Agency missions stated on websites are:

- **DHS:** The Minnesota DHS, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.[32]

- **MDH:** Protecting, maintaining and improving the health of all Minnesotans.[33]

A review of excerpts from Minnesota Statutes Chapter 144 (Department of Health) and Chapter 245 (Department of Human Services) illustrate the diversity of goals in chronic-care (See Appendix E for more detail). Statutes do not appear to contradict each other. In fact, they have overlapping themes related to assuring health, quality and individualized care or services.

- **Chapter 144** (MDH), for example, requires that home care rules to include provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services.[34] Nursing facilities must meet the minimum “health, sanitation, safety and comfort standards.”[35] Rights in the Health Care Bill of Rights[36] include the right to be treated with courtesy and respect, receive appropriate medical and personal care based on individual needs, and actively participate in care planning. It also describes the right of “competent patients and residents” to refuse care if informed of the likely results.[37]

- **Chapter 245** (DHS), like Chapter 144, specifies health and safety goals for many services and programs (e.g., Personal Care Assistance services must be designed to ensure participants’ safety, health and welfare).[38] A strong theme in Chapter 245, however, related to integrated settings, independence and choice, service availability and

> cost-effectiveness. For example, mental health residential treatment services must be designed to "help clients achieve the highest level of independent living."[39] In some cases, risk and independence are discussed simultaneously. For example, in statues related to services for developmental disabilities, the definition of "least restrictive setting" includes an environment where services "do not subject the consumer or others to unnecessary risks to health or safety; and maximize the consumer's level of independence, productivity and inclusion in the community."[40]

Another relevant statute is the Vulnerable Adults Act.[41] It emphasizes protection and safety: "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe [environments]…"

New law re: home care and HCBS licensing

Starting in 2013, MDH and DHS are implementing new licensing systems for home care and home and community based services (HCBS).[42] (See more detail on the 2013 session law in Appendix F and more information on affected HCBS services in Appendix G). The HCBS licensing standards are part of DHS reforms to expand community-based care, promote person-centered care. They also explicitly mention risk: [43]

> The integrated/inclusive delivery [of HCBS] must support, promote, and allow the following: **A balance between risk and opportunity**, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing **that may otherwise present a risk to the person's health, safety, or rights**.[44]

New home care and licensing standards are moving toward requirements for assuring the multiple goals of safety, health, well-being, choice, rights and risk[45]. For example, a major characteristic of the HCBS licensing ("245D") is a strong emphasis on individual rights, client-centered care and client choice. In some cases, risk issues are specifically identified (Table 1). Also, amendments to Minnesota Statute 2012 Chapter 144 also add references to choice, inserting the phrase "while respecting a client's autonomy and choice" to the requirement that home care regulations assure, to the extent possible, the health, safety, well-being and appropriate treatment of service recipients.[46] MDH and DHS also are directed to jointly develop an integrated licensing system that "shall promote quality services that recognize a person's individual needs and protect the person's health, safety, rights and well-being.[47] Even with the new provisions, however, home care and HCBS standards indicate how the agencies have ongoing differences emphasis in some areas, reflecting differences in federal directives to both promote self-direction and assure safety. For instance, the HCBS statute (245D) emphasizes person-centered planning and self-determination, but these terms are not mentioned in the home care statute (144A).[48]

Table 1: Examples of risk-related language HCBS licensing

Topic	Specifications (**emphasis added**)
Person-centered planning and delivery	Services must be provided "in a manner that supports the person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes"[49] Service recipients rights include **the right to "refuse** or terminate services and be informed of the consequences of refusing or terminating services."[50]
Self-determination	**Self-determination** is operationalized as supporting and providing "opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and the affirmation and protection of each person's civil and legal rights."[51]
Balance of risk and opportunity	The integrated/inclusive delivery must support, promote and allow the following: **A balance between risk and opportunity**, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing **that may otherwise present a risk to the person's health, safety, or rights.**[52]
Restriction of rights	• Rights may be restricted under certain subdivisions "only if determined necessary to ensure the **health, safety, and well-being** of the person. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and **provide support to reduce or eliminate the need for the restriction"** in the most integrated setting/inclusive manner. • Any restriction must be documented in the person's coordinated service and support plan.[53] The schedule for reviewing the need for the restriction must be occur semiannually, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager.

Selected DHS, MDH and related initiatives

A brief look at some of the MDH and DHS initiatives mirrors a look at agency mission and statutes: on the one hand, there are examples of differences in perspectives and focus, and on the other hand, agency (and joint agency) initiatives are broadly focusing on improving and addressing risks related to the safety, health, choice and personalized care. Overall differences in emphasis include: a *population* focus versus a *service recipient (public financing)* focus; an emphasis on "patient-centered care" versus "person-centered care;" and *health care* provision versus *rebalancing* services toward community care. Appendix H contains an overview of selected chronic care initiatives.

Risk Assessments, Plans, Service Agreements and Supports

Section overview

- MDH and DHS use or administer the use of a wide variety of tools for assessing service needs, risks and preferences. Assessments are used to determine need for services, ascertain client preferences, assist people with planning and, in some case, determine eligibility for public programs (primarily MA).
- The state is changing the ways assessment and planning is conducted, as MDH, DHS, and lead agencies work to implement MnCHOICES. The draft MnCHOICES assessment reflects a holistic view of a person, covering cognitive function, life quality, health, safety, choice, rights, self-direction and other domains.[54]
- New state law requires Abuse Prevention Plans, rather than Risk Management Plans, in certain situations. APPs are shorter and limit their focus to the population, physical plant and environment in control of the license holder and location; RMPs are more expansive.[55]
- Service agreements and contracts specify the types of services the provider will provide. Many other organizations and tools assist people in understanding their options, weighing risks and addressing problems such as neglect and abuse (e.g., Ombudsman programs, linkage lines, Office of Facility Complaints (OFC), advocacy groups).

Current Assessments

Generally, public health nurse, social workers or registered nurses complete assessments for people who need or think they need chronic care services. These professionals may be employed by county human services, county public health departments or managed care organizations. In developing wellness plans, some people are also assisted by certified peer specialists. Some assessment processes are only available to people who are seeking publicly-funded care (e.g., MA PCA assessments) while others are more generally available (e.g., long-term care consultation) (see Table 2).

Table 2: Examples of Current MDH and DHS Chronic Care Assessments

Name	**Description**
Long-term care consultation (LTCC)	Anyone can request a LTCC from their county, regardless of public program eligibility. The LTCC assists people in making care decisions and selecting support and service options. LTCC uses the MnCHOICES tool and process, as discussed in the next few pages.[56]
Rule 25 assessments	Alcohol and drug counselors complete Rule 25 chemical use assessments for anyone who requests one, or for whom an assessment is requested.[57]
HCBS waiver	People must obtain an assessment to receive HCBS waiver services

Name	Description
assessments	(e.g., to verify categorical and level of care eligibility criteria).
Adult Mental Health	Adult mental health targeted case management services assist people with ongoing assessment and planning needs, as do other forms of case management.[58]
Home Health Aide Services	For MA-funded care, a registered nurse from a home health agency completes an assessment to determine need for service.[59]
MA PCA services	An assessor visits the person in their home and reviews their daily needs and health, and completes the PCA Assessment and Service Plan.[60]

Current Care Plans

Care plans are required for all people receiving chronic care services. In some cases, this is a Coordinated Services and Support Plan (CSSP) and in other cases it is a Community Support Plan (CSP). For instance, people with a developmental disability (DD) who are receiving HCBS have a Coordinated Service and Support Plan that is developed and signed by the participant working with a case manager.[61] The plan includes elements of related to choice and safety. For example, the plan must:

- Include the person’s need for service;
- Reasonably ensure the health and safety of the recipient;
- Identify the person’s preferences for services;
- Provide for an informed choice (Table 4); and
- Identify goals and services to be provided.

Table 3: Definitions of Informed choice and informed consent for DD waiver services

Topic	Per Minnesota Statute 2012 § 256B.77
Informed choice	A voluntary decision made by the enrollee or the enrollee's legal representative, after becoming familiar with the alternatives, and having been provided sufficient relevant written and oral information at an appropriate comprehension level and in a manner consistent with the enrollee's or the enrollee's legal representative's primary mode of communication.
Informed consent	The written agreement or an agreement as documented in the record, by a competent enrollee, or an enrollee's legal representative, who: (1) has the capacity to make reasoned decisions based on relevant information; (2) is making decisions voluntarily and without coercion; and (3) has knowledge to make informed choice.

Community Support Plans developed for waiver participants using consumer directed support services also includes elements of health, safety and consumer choice. As DHS’s policy manual explains:[62]

- The process of developing the CSP must be person-centered. In person-centered planning, the person is the focus of the planning and directs the development of the plan with support from the people who know him or her.

- Some of the aspects of care the CSP must identify include: emergency needs of the person and how they will be met; goods and services that will be provided to meet the person's assessed needs; overall outcomes; and "safeguards that are required to reasonably maintain the person's health and safety."

New MnCHOICES process

The state is fundamentally changing how assessments are conducted. MnCHOICES is an assessment and planning tool, a web application and a process. It is currently being used for LTCCs and will be used more broadly in the future in other contexts. Specifically, DHS staff describe that MnCHOICES will:

- Use a person-centered approach to tailor services to individual's strengths, goals, preferences and assessed needs.
- Replace four assessments DD Screening, LTCC, PCA and, in the future, Private Duty Nursing (PDN).
- Combine assessment with service planning process.
- Determine eligibility for programs and services.
- Be used for all ages and disability types.
- Be completed by a certified assessor using web-based application (only a certified assessor can complete an assessment/reassessment and develop a support plan).
- Be used to advance quality improvements.
- Be initially released in the summary of 2013, with future releases to-be-determined.[63]

The MnCHOICES process separates assessor and case management functions.[64] The assessor's Community Support Plan (CSP) that must include options and choices to meet identified needs and identify "health and safety risks and how those risks will be addressed, including personal risk management strategies." The case manager-monitored Coordinated Services and Support Plan (CSSP) must "reasonably ensure the health and safety of the recipient," reflect the person's informed choice between institutional and community-based services; choice of services, supports, and providers; and meet other goals.

The draft MnCHOICES assessment includes questions in many domains such as cognitive function, life quality, health, safety, choice, rights and self-direction.[65] Risk issues are addressed throughout the assessment. For example, assessors indicate their conclusions regarding the person's capacity for independent vs. supported self-direction and whether the person or their representative agrees with their conclusions. *Safety/Self-Preservation* section questions include: "Does the individual have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation? Are there any limits that have been placed on your decision-making (e.g. for financial, health, or safety reasons?" In a section on *Service Related Rights and Choices*, assessors ask, "do you feel that you have enough say in what is included on your plan? Who decides what you do each day, like when you get up, when you eat, or when you go to sleep? Do you feel safe?" (See more information on MnCHOICES in Appendix H).

Selected risk management and abuse prevention plans

Risk Management Plans: An example of one way DHS currently addresses safety risks is the requirement that DD service providers create risk management plans for each person they serve. License holders may provide services such as residential-based habilitation, day training and habilitation, supported employment, Intermediate Care Facility for Developmental Disability (ICF-DD) and respite care. The risk management plan (RMP) must "identify areas in which the consumer is vulnerable, based on an assessment" for many areas, such as susceptibility to physical, emotional, sexual and financial abuse.[66] It also requires an assessment safety needs, community survival skills, water survival skills, ability to seek assistance or provider medical care and access to toxic substances or dangerous items. The RMP must identify action a staff person will take to protect the consumer and minimize risks. (See more on RMPs and abuse prevention plans in Appendix I)

Abuse Prevention Plans: Current statute[67] requires all license holders serving vulnerable adults to establish and enforce ongoing written program abuse prevention plans (APP) and individual abuse prevention plans according to requirements in Minnesota Statute 2012 § 626.557, Subd. 14. New law[68] stipulates that some providers, such as providers of intensive support services, create APPs instead of the most expansive risk management plan.[69] The APPs are "limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided."[70] The assessment includes an evaluation of these factors:

> "age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.[71]"

CMS-required assurances for HCBS: The replacement of risk management plans with abuse prevention plans is aligned with CMS-required assurances for HCBS. CMS refers to "abuse, neglect and exploitation" when specifying what is required of states in regulating HCBS. The Health and Welfare Assurance includes: "Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen. This assurance emphasizes the role of HCBS waivers in reporting, investigating and resolving serious incidents which include, at a minimum, cases of abuse, neglect and exploitation."[72] See CMS assurance in Appendix J for more information.

Service agreements

Chronic care providers and service agreements must adhere to state and federal law, rules and standards. They also are affected by industry best practices, the provider's own quality review and improvement systems, and guidance from trade associations. All Minnesota Health Care Plan (MHCP) providers must meet professional, certification or licensure requirements according to state and federal laws and regulations, and be enrolled as an MHCP provider with the state.

Service agreements and contracts specify the types of services the provider will provide. This includes, in some cases, references to preferences, self-determination and rights. For example, the HCBS agreement defines "purchased services" as:

> Outcome-based services authorized on an MMIS Service Agreement or authorized by a Managed Care Organization that are provided in response to the eligible person's identified needs as specified in their individual plan, based upon the needs and preferences of the person and the person's personal goals, and which are consistent with the principles of most inclusive environment, self-determination, and other rights of the person.[73]

As another example, when someone moves into a building that offers assisted living services, they sign an agreement or lease related to housing with services contract, and then sign a service agreement for home care services provided by a licensed home care agency.[74] Residents receive assessment and care planning services per home care licensure requirements; for example, a nurse assesses physical and cognitive needs and proposes a services plan.[75] The agency providing health care services must follow the nurse's plan in implementing services.

MDH also provides a "uniform consumer information guide" to help people choose an assisted living setting. The guide mentions informed choice and independence, noting that: "While establishments[76] vary in size, services and costs, they share a common philosophy that each individual makes informed choices about where they live and what kind of help they need and that each individual lives with their maximum independence, dignity, respect and privacy."[77]

Other services and supports

Many other organizations and tools affect risk issue discussions and outcomes, and assist people in understanding their options and weighing risks. These organizations also work to assure that state services and regulations address both choice and safety goals. There is a clear trend toward more client choice in several CMS and state initiatives and recent headlines have also brought the issue of safety to the forefront of state regulation and policy.[78] Other services and supports include:

- **Advocacy groups and related groups**, such as the Minnesota Council on Disabilities, councils and groups for specific disabilities, conditions or populations, and the Minnesota Disability Law Center.

- **Ombudsman offices:** Minnesota has ombudsman for long-term care, mental health and developmental disabilities (DD) and managed care.
    - The Ombudsman for Mental Health and DD responded to 16,772 reports of problems in the FY08 to FY09 biennium.[79] Across all issues, including health and chronic care but also areas such as child custody, issues comprising more than ten percent of all reports were serious injury (18%), abuse/neglect (13%) and staff/professional issues (13%).
    - The Ombudsman for LTC[80] handled about 2,500 complaints in 2010. A large majority of complaints (93%) related to residential facilities such as nursing homes (72%) and board and care homes/housing with services/assisted living

(21%). The Ombudsman notes that "Over the last several years, the number of complaints received has been higher in categories related to resident rights rather than resident care."

- **MDH's Office of Health Facility Complaints (OHFC):** The OHFC reported 2,094 complaints in SFY 2011, 40 percent related to nursing homes, 35 percent to home health, 14 percent to hospitals and ten percent to other licensed entities[81]. OHFC also received 10,168 facility reported incidents. Of these, a large majority (85%) related to nursing homes. Overall, "neglect" was by far the most common category of complaints/incidents in nursing homes and home care. State websites and related assistance: This assistance includes the Disability Linkage Line, Senior Linkage Line and websites and publications from many state agencies, especially MDH and DHS.

- **Provider assistance**: Many providers use websites, consultation and other assistance to help people understand their choices and risks in difference services options.

Perceptions on Resolving Risk Issues

Section overview

This section discusses options for resolving risk issues and options, based on literature, interviewee data (see more detail on interviewee results in Appendix K). MAD's conclusions and recommendations regarding best options follow in the last two sections of this report.

Major issues and options considered in literature and interviewee sources include:

- There is a great range of perspectives on how to address risk issues at the community, agency and individual level. This can hamper efforts to build consensus among stakeholders.

- Risk issues are often framed as questions of how to balance choice against health, safety and other risks, and what makes a risk acceptable.

- Suggestions for improving individual assessments and planning processes include properly diagnosing the source of risk conflicts, developing better risk tools and using a team approach to resolve conflict.

- Options for addressing provider liability concerns that some say are leading to restrictions in choice include traditional tort reform (such as a cap on damages) or alternatives to tort reform such as negotiated risk agreements, evidence-based practices and insurance risk pools.

Diversity of viewpoints

The results of this study highlight the multi-faceted nature of risk issues, and the range of perspectives that can affect how a person or organization proposes to address them.

At the individual level, each person has her or his perspective based on a variety of factors, such as needs, experience, culture, preferences, personality, etc. There is no one "client voice," as one interviewee noted.

When looking across agencies, several interviewees felt that MDH has a greater focus on health, while DHS focuses more on person-centered care. Such generalities are difficult to prove one way or the other. However, the statutory mission of the agencies and their major initiatives do focus on these areas. A health versus social service perspective revealed itself in other comments, where some interviewees said that a medical perspective on risk favor the use of health care workers or professionals to conduct activities such as home care and medication administration, while a social service perspective was more supportive of accepting of risk and the use of "non-medicalized" services (e.g., general support care workers and self-administration of medication).

Underlying principles can also vary by the type of service provided. For example, as a gross generalization, people who are elderly and frail, people with a developmental disability and people with mental health or substance abuse issues—along with their families and other involved parties—can have different expectations about acceptable types of risks. For example, some programs work to reduce or eliminate risk. Substance abuse programs, in contrast, often use the strategy of harm reduction. Rather than working to eliminate a risky behavior (i.e. drug use), harm reduction accepts that the behavior is inevitable—the objective is to reduce adverse consequences. It emphasizes the measurement of health, social and economic outcomes, as opposed to the measure of drug consumption.[82]

Given varied levels of understanding and viewpoints among risk issue stakeholders, several interviewees emphasized the importance of building consensus by creating advisory groups or forums through agency efforts or outside groups such as the citizen's league. Several people suggested building on the work and structure of state Olmstead groups. Some states have worked with a broad-based Olmstead council to address risk issues. When trying to build connections and common ground between agencies, other states mentioned that they hold monthly meetings between major regulatory agencies and conduct calls between involved agencies to resolve differences. National survey data suggest the difficulty of spanning across various interests to build consensus on chronic care regulatory issues. A 2010 survey of over a thousand LTC advocates, providers, policymakers and others concluded "there is little consensus on any aspect of LTC, which, according to policy scholars, is yet another barrier to solving the problems that the field faces—'If experts cannot agree on a solution, then policy makers are loathe to try to adopt one.'"[83]

Risk paradigms

Autonomy focus

Many years ago, Rosalie Kane discussed the challenges states face in complying with Olmstead requirements, saying "the focus of institutional care is one safety, patient protection and risk avoidance. Many are concerned this bias will have spillover effects on the provision of long-term services in the community."[84] She suggested a paradigm shift. "The current approach among care providers seeks to achieve the best quality of life consistent with health and safety outcomes. The reverse formulation—seeking the best safety and health outcomes consistent with resident's autonomy and quality of life—would establish an entirely different priority system." In a similar vein, the Olmstead Planning Committee also recommended that "the State should ensure that all laws and rules address the balance of choice versus risk and insure that *choice is given more weight* than risk is given."[85]

Revisiting these issues in 2010,[86] Kane echoed many of the same themes about promoting choice. She also acknowledge that "things grow much more complicated" when talking about people who have lost some cognitive ability or when their decisions affect the safety of others. Moreover, restricting choice due to concerns about the safety of others must be considered in relation to liability concerns and ADA protections.

Safety focus

While there is a drive toward client choice in many state programs, there are also concerns among some that the expansion of community-based settings poses a special risk to people, because it is assumed that regulators or professionals have less control over non-institutional settings. It is beyond the scope of this study to compare quality of care in different settings. However, recent research comparing the risk of poor outcomes from institutional care versus community-based care is inclusive, due to "limited evidence and the methodological limitations of studies reviewed."[87] Other research and qualitative information show mixed results on this issue. For example, a survey of LTC experts found that there is more concern about the quality of nursing homes than community care[88] and the most frequent source of complaints to the Office of Facility Complaints relates to nursing home care, despite the increase in community-based care. Interviewees who cited the inappropriate use of restraints and other major quality problems in institutional settings would no doubt point out that abuse and neglect can occur in any setting. On the other hand, home care services delivered through personal care assistants has been the subject of numerous investigations and complaints.

Acceptance of risks

In interviews with leaders in Minnesota and other states, a common theme was that providers or a state cannot always ensure safety—risk is part of life. Some interviews said that state agencies are stuck between a rock and a hard place: people have high expectations of government and if something bad happens or choice is restricted, the response is the same: "how dare you?"

According the US Department of Homeland Security, risk control does not mean eliminating risk. Rather, similar to the harm reduction approach used in some substance abuse programs, risk control is "deliberate action taken to reduce the potential for harm or maintain it at an acceptable level."[89] The USDHS defines risk, acceptable and residual risk and risk tolerance as follows:[90]

- **Risk:** potential for an unwanted outcome resulting from an incident, event or occurrence, as determined by its likelihood and the associated consequences
- **Acceptable risk:** level of risk at which, given costs and benefits associated with risk reduction measures, no action is deemed to be warranted at a given point in time
- **Residual risk:** risk that remains after risk management measures have been implemented

- **Risk tolerance:** degree to which an entity, asset, system, network or geographic area is willing to accept risk

Addressing individual situations

Determining the source of the problem

Interview and literature review data indicate that a barrier to effectively addressing risk issues is incorrect diagnosis of a source of a problem, such as incorrectly assuming that it is a state or federal policy that is forcing an entity to restrict someone's choice. As Eric Carlson summarized regarding Assisted Living settings, "regulations are often blamed unfairly for autonomy incursions that are not regulatorily mandated."[91] He opined that providers may have a "general risk aversion and 'law-related anxieties' that often are not well founded":

> If it is taken as a given that most residents should not go outside unaccompanied, be in a bathtub in privacy, have a glass of wine without a doctor's prescription, or stay awake in a chair watching a late movie, it is not because specific regulations prohibit these events. Rather, it is because providers fear that untoward consequences will be judged as neglectful or substandard care. They may also believe that only an unaffordable level of staff supervision and attention would make individualization of schedules possible on a widespread basis and that residents should not be left alone on any account.

Risk plans and service contracts

Study interviewees suggested that risk plans and service contracts have the following characteristics—they are:

- flexible and client-centered (e.g., flex with life changes)
- have agreed-upon client/provider responsibilities, assuring that the client fully understands what they are agreeing to and is engaged in planning, and the provider is released from preventing the risk
- deal with the different needs of different populations
- clearly specify what is mandated and what the funder will pay for
- are assessed by whether peoples' lives are better off

Tools and supports for stakeholders

General experience as well as regulatory best practices indicates that decision making can be enhanced by focusing on what is important, updating out-of-date processes and providing adequate training.[92] Practical tools and supports that could be created to assist stakeholders (including MDH and DHS) in prioritizing and addressing risk issues include:

- **Develop and use best practices and tools** to resolve common points of contention between a client and others when choices are or may be limited due to safety concerns. For example, the Wisconsin Department of Human Services has developed educational and training materials for assessing and addressing risk in community-based LTC, covering frail elders, adults with disabilities, recovery-based community mental health and evidence-based practices for alcohol and drug abuse. The curriculum provides guidance to interdisciplinary team members in assessing risk, assessing choice, reducing risk and supporting better choices, and notes where provider responsibilities increase in regard to risk reduction activities (e.g., when the person has marginal decisional capacity). There is also a limit-setting checklist intended for agency use with people without cognitive impairments. It lists considerations in setting limits and negotiating them. Excerpts from the limit-setting checklist and curriculum are show on in Table 4; more detail is in Appendix L.

- **Compile data and give providers related tools and education to prevent risk** (e.g., Track corrective actions to identify problem areas, such as "falls" and then provide that information and related guidance).

- **Provide enhanced "risk communication"** to exchange information on risk issues and improve the ability to people or groups to act appropriately in response to risk issues. At the community or policy level, communication vehicles could include forums, websites, manuals, phone calls and training (e.g., training to staff, providers, clients and MnCHOICES assessors regarding risk issues). At the individual level, risk communication includes assuring that clients have access to the information they need to make informed choices and understand risks, and using joint MDH and DHS teams assess and address complex situations.

A team approach to problem-solving

In other states, agencies reported using project managers and interdisciplinary teams to address complex situations (e.g., transitions between settings and assessing risk in LTC settings). Minnesota stakeholder interviews likewise supported this approach.

Table 4: Examples of items from Wisconsin' LTC Curriculum and Limit-Setting Checklist[93]

LTC Curriculum	Limit-Setting
Steps in Assessing and Addressing Risk 1. **Assess the risk(s):** notice risk factors (case managers may avoid noticing risks if they fear conflict or feel incompetent to address them, so use harm reduction and motivational methods, evidence-based methods, etc.). 2. **Assess the choice(s):** for example, does the person have decisional capacity? 3. **Reduce the risk** (a.k.a. "harm reduction"): for instance, balance team member responsibility with responsibilities of person (and family). 4. **Support better choice(s):** for example, discover what motivates them.	**Steps for Limit Setting** 1. Do *Brief Intervention*, *Motivational Interventions* and *Harm Reduction* with the member and/or family. 2. Express your concerns and ask about member's (or family's) perspective. 3. Attempt joint problem solving and/or try to negotiate a compromise. 4. Only after the above steps have been done, consider [if] any specific limits need to be set. 5. Go through the Limit-Setting Checklist listed below. 6. When possible, inform the family member of limits in advance, so that they can make

LTC Curriculum	Limit-Setting
	informed choices.
Provider responsibilities include: • A provider is more responsible for avoiding harm and risk if the person is legally defined as a "vulnerable adult" (DD, frail elder, disabled) or lacks or has marginal decisional capacity. • A provider's responsibility is to fully inform the person, with greater responsibilities if the person needs extra accommodations to fully understand, or cannot understand. • A provider's responsibilities to reduce risk are greater when a person's abilities are less; the provider must do whatever covered services work to reduce harm, as needed.	**Limit-Setting Checklist includes:** • If this involves AODA [alcohol or drug addiction]: Do we set similar limits for members with other chronic conditions such as diabetes or high blood pressure? If not, is there punishment or bias here? • How can you propose and present these limits in a way that is not putting you in a parental or authoritarian role? Whenever possible, limits should be negotiated, rather than unilaterally decided by the agency (This is not always possible). • Limits should be set in a step-wise order with a gradual, rather than sudden, restriction in liberties. This can include suggesting more restrictive living situation if other harm reduction options have failed to ensure minimal health and safety.

Tort and related reforms

A common theme across all sources of data is that a fear of lawsuits (and state citations) can lead providers to overemphasize client safety and thereby restrict client choice. The Congressional Budget Office reported in 2009 that "many analysts surmise that the current medical liability system encourages providers to increase the volume or intensity of health care services to protect themselves against possible lawsuits."[94] Thus, some people see traditional tort reform as a way to lessen provider lawsuit fears and facilitate choice (e.g., cap jury awards). Other people cite problems with this approach and embrace alternatives to traditional tort reform, as discussed below. Against the backdrop of the debate, studies find that the number of medical malpractice suits is dropping due to tort reform, growth in risk management responses to adverse events, difficulty in obtaining legal representation for smaller claims and a variety of other legal, social and economic factors. [95]

Types of Reform

Traditional reforms that have been "widely implemented at the state level" include joint-and-several liability reform, collateral sources rule reform, limiting of noneconomic damages and limiting punitive damages.[96] Minnesota has implemented reforms in many of these areas (see more information in Appendix M). For example:

- In 2003, joint and several liability statutes were amended to raise "the threshold for the imposition of joint and several liabilities from 15 percent to greater than 50 percent. Parties less than 50 percent responsible are to be held responsible only for their percentage of fault."

- In 1986, “Noneconomic Damages Reform” limited the award of damages for loss of consortium, emotional distress or embarrassment to $400,000.
- In 1990, “Punitive Damages Reform: Clear and Convincing Requirement” required a plaintiff to prove punitive damages by clear and convincing evidence.[97]

Alternatives to traditional reform being considered or used across the country (Table 5) include:

- providing a safe harbor to providers who use evidence-based guidelines or nationally accepted guidelines;
- establishing special pre-trial screening and special health care courts;
- establishing compensation and insurance pools;
- creating (or requiring) use of alternative dispute resolution program;
- preventing lawsuits through a “disclosure, apology and offer” model; and
- negotiated risk agreements (discussed in more detail later in this section).

Table 5: Other Reform Types[98]

Reform Type	**Description of Reform**
Special screening and courts	**Pre-trial screening** (e.g., a state requires malpractice cases to be screened): “by a medical review panel, mediation office or some other panel or official before the cases go to court. Pre-trial review is intended to identify cases that lack merit (although the lawsuits generally are not precluded from moving forward by such a finding) and to encourage the parties to settle the case without litigation.”[99] **Establishment of health courts** (e.g., similar to bankruptcy courts or patent courts): A 2012 national poll found that nearly two-thirds of voters favor the idea of creating special health courts to settle medical claims.[100]
Evidence based guidelines	**Safe harbor via evidence-based guidelines:** This reform protects providers (physicians) from suit if they follow evidence-based clinical practice guidelines.[101]
Alternative Dispute resolution	**Alternative Dispute Resolution:** For example, a chronic care provider could include a “pre-dispute medication and arbitration clause in LTC admission agreements and contracts, providers and residents agree to route future disputes into efficient, fair, effective forms—mediation and arbitration—rather than the lawsuit system.”[102]
Compensation and Insurance Pools	**Patient Compensation funds:** Some states “have established Patient Compensation Funds or state-operated malpractice insurance pools,” as a variation on capping award amounts. In this model, the physician’s liability is capped at a certain amount, while the state is able to make additional payments from the compensation fund.[103] **Removal of certain injuries from the court system:** In this case, certain injuries could be moved to an alternative process in which the state assigns

Reform Type	Description of Reform
	compensation on a no-fault basis (e.g., like birth injury funds operated in Florida and Virginia).[104] **Set compensation:** This reform mandates payment of sums for specific injuries, similar to workers compensation.
Disclosure model; more patient participation	**The Disclosure, Apology and Offer model:** This model, also known as the Michigan Model, reaches beyond a provider simply saying, "I'm sorry." The model's principles include compensating patients when unreasonable medical care caused injury, supporting caregivers and the organization if care was reasonable or did not harm clinical outcome, and reducing injuries and claims by learning through patient experiences (Gavin, 2012). Of the later, one physician said, "integrating patients and families into a hospital's quality and safety culture needs to become one of the important elements of patient-centered care." (Welch, 2013)
"Fair share" Acts	**Assigning Responsibility:** In contrast to "joint and several liability," many states have "fair share" acts generally requiring that awards be based on a defendant's level of responsibility for an injury.
Negotiated Risk Agreements	**NRAs:** Used in assisted living, these agreements a signed agreement between a resident and the provider that outlines resident preferences re: a negotiated resolution; and the resident's acknowledgement and acceptance of consequences.

Impact of Tort Reform

For most traditional and newer tort reforms, there is a wide range of opinion regarding whether the reform is a positive or negative development. In debates on Pennsylvania's Fair Share Act proposal, for example, some people positively referred to it as "lawsuit abuse reform" that "brings fairness," while others referred to it as a "wrong-doers protection act" and evidence that the state is "more interested in appeasing big business than protecting innocent victims.[105] However, research generally suggests that tort reforms have had little or no effect on outcome variables such as costs and supply of services.[106] An exception is caps on noneconomic damages, "which have well-documented effects on several of the outcomes" (e.g., increase in defense costs of litigation and some evidence of lower rates of service use). Importantly, a 2009 CBO [107] analysis found that relatively little research has been conducted on the impact of tort reform on health outcomes. Some research finds that reform may harm outcomes, but other studies conclude otherwise.[108] The evidence base for evaluating innovative tort reforms[109] is also small and inconclusive—many have not been tested in the U.S. or been systematically evaluated.

The National Consumer Voice for Quality Long Term Care (LTC) lists many reasons it thinks (traditional) tort reform would harm consumers. For example, they say it would make LTC facilities less accountable for harmful actions, limit consumer access to the civil justice system and limit compensation for LTC consumers.[110]

Negotiated Risk Agreements

Negotiated risk agreements have been specifically developed for chronic care settings. They are sometimes considered as an alternative to tort reform (in that some people suggest their use to prevent lawsuits), but they are not generally included in formal analyses of traditional or alternative forms to tort reform. For that reason, NRAs are considered separately here.

NRAs are used almost exclusively for Assisted Living settings. NRAs are a signed agreement between a resident and the provider regarding the risk issue or concern, resident desires and preferences, possible consequences of this desire or preference, alternative approaches to minimize risk, a negotiated resolution and the resident's acknowledgement and acceptance of the potential negative consequences of action (see sample NRA in Appendix N).[111] The US Department of Health and Human Services described NRAs as one approach proposed to achieve a balance between autonomy and safety and operationalize resident autonomy.[112] NRAs are also viewed by proponents as a way to identify risk, communicate, support residents' rights to make choices that entail risk, assign responsibility and limit provider liability.[113] Some people posit that this is especially true when there is conflict among parties, the consumer's preference poses risk to others and the preference poses a risk to the consumer.[114]

However, others tend "to view NRAs as having a sole purpose—an attempt to avoid liability for negative outcomes resulting from negligence." They opine that NRAs could be used to force residents to accept substandard care.[115] Interviewees from other state said generally said NRAs were not a viable tool preventing lawsuits. One cited problem is that NRAs cannot be used to waive government requirements or facility liability.[116] Eric Carlson suggests abandoning the term "negotiated risk" because the term refers to two different types of situations: a facility is unable to provide needed care, and a resident refuses care that a facility is willing and able to provide. He also notes that "allowing residents to make decisions that conflict with professional recommendations can be accomplished without negotiated risk through established care planning procedures."[117] Also, while NRAs might be a reasonable communication or tool for a person with full decision making capacity, what if the client lacks capacity to enter into a contractual agreement?[118] An additional factor to consider is that even when the behavior might pose a risk to the person or others, the state and providers must abide by ADA law regarding whether these factors constitute a reason to constrict choice.

Analysis and Conclusions

Section overview

- The diversity of expertise and vantage points of all stakeholders, including MDH and DHS, both facilitates problem solving and creates significant challenges to building consensus. Key players need to develop a common understanding of risk issues and alternative strategies.

- Risk issues need to be viewed more holistically: imagining risk issues as a continuum or balance between autonomy and choice on one end, and safety and protection on the other end, implies a dichotomy that does not exist and sets the stage for conflict.

- At the policy level, MDH and DHS collaboration is needed so they speak with a consistent voice and use collective expertise to address risk issues. This is happening with increasing frequency at the agencies, but further efforts would continue to build capacity. Collaborative efforts are needed to address the genuine frustrations providers have about what are, or are perceived to be, conflicts between agencies and divisions in how they are regulated.

- Joint MDH and DHS involvement is needed in resolving individual risk issue situations in a manner consistent with high health care standards and person-centered care and choice. To create more evidence-based practices, MDH and DHS have rich sources of data they can draw from in developing new risk tools and supports.

- There is limited and inconsistent research regarding the impact of tort reform on reducing defensive care and service provisions, and, importantly, mixed results on tort reform's impact on client outcomes. A better approach to change is to implement the most promising alternatives to tort reform such as evidence-based practices and other quality initiatives and tools. Efforts to promote overall quality initiatives are likely to have a positive impact on all stakeholders' ability to address risk issue at the policy and individual level, particularly if quality is broadly defined to include health, safety, autonomy and well-being

- *In turning to the conclusions and recommendations of this report, it is important to restate that* **"risk issues" refers not to risk, but rather to the whole package of issues surrounding client risk assessment, planning and determining "reasonable" risk levels in relation to other factors,** *as described in the legislative directive for this report (i.e., health care, client health care rights, provider liabilities and provider responsibilities to provide minimum standards of care).*

Building consensus among risk issue stakeholders

The diversity of expertise and vantage points on risk issues is both requisite and a challenge to risk issue resolution. Varied perspectives are inevitable and necessary to have the composite knowledge, expertise, expertise and flexibility needed to resolve complex and sensitive risk issues. Previous efforts to examine risk issues may have been too narrow in focus and even more diversity is needed—it is critical, for example, that the voice of people seeking or receiving services be clearly heard on the range of risk issues, coming from a many points of view (e.g., people with difference in needs, cultures, ethnicities, age and levels of cognitive ability).

Although a multiplicity of viewpoints is expected and needed, it is nearly impossible to move forward with workable plans if there is not some level of common understanding and agreement on basic issues. Several factors can complicate consensus-building efforts. All parties are dealing with the rapid pace of change in health and chronic care laws and programs, including barriers and opportunities afforded by new delivery systems and initiatives. Stakeholders are responding to recent lawsuits and changes in demographics and state and federal resources. Also, risk issues are only one of many considerations in how people provide, fund, receive or regulate care. Other concerns include efficient operations, legal compliance, quality of care, costs, reputation, workforce issues and service access. Third, when conflict arises at the community, agency or individual level, involved parties assume they know the source of a problem—but if this assumption is wrong, time and resources are wasted, and client choice may be restricted, until the real source of the problem is discovered. Interviewees and others cited cases where "state policy" was the assumed problem, but further analysis showed it was actually an insurance or fear-of-lawsuit issue.

- **To continue progress in addressing risk issues, a more targeted and ongoing focus and discussion is needed, with clear follow-up plans.** Key players need to build a common understanding of risk issues and alternative strategies for conflict resolution, to help assure that a diversity of opinion among service recipients, state agencies, providers and others facilitates rather than prevents problem resolution.

- **Risk issues need to be viewed more holistically**
    - Many people refer to the continuum or balance between risk and choice, and call for an emphasis on one or the other. This conception implies that one goal comes at the expense of the other and sets the groundwork for conflict. It also seems imprudent to generalize that one aspect of risk will trump another, given the many issues that can be involved in an individual situation or policy. Imagining risk issues as a continuum or balance between autonomy/choice on one end, and safety/protection on the other end, implies a dichotomy that does not exist. Risk issues involve a host of complex interrelated factors rather than two end points. A person with many choices can be safe, and a person with few choices can be harmed.
    - Also, thinking of risk in terms of acceptable and residual risk may be helpful in future discussions, as a reminder that as long as we are alive, some level of risk is present. As noted earlier, the USDSH defines *acceptable risk* as the level of risk at which, given costs and benefits associated with risk reduction measures, no action is deemed to be warranted at a given point in time. *Residual risk* is risk that remains after risk management measures have been implemented. It is important that this definition references both benefits and costs. While people generally acknowledge that risks cannot be totally eliminated, for many reasons, it is also important to acknowledge that choice expectations often cannot be met in full because of host of issues beyond state and provider control.

Building capacity and collaboration at MDH and DHS

At both the system and individual level, resolution of complex risk issues at requires the combined expertise and perspectives of MDH and DHS. This expertise is needed in the area of risk planning, assessment, person-centered care, person-directed care, health and safety, to name a few. In addition, MDH and DHS are both involved in large initiatives that have the power to inform and improve risk decisions and chronic care in Minnesota, such as Reform 2020 focus on reduce reliance on institutional care, mental health reforms and large-scale efforts to eliminate health disparities. Risk issues are fundamental to both MDH and DHS and cross many of the loose boundaries sometimes used to determine whether an entity is regulated by MDH or DHS (e.g., “facilities” vs. “programs” or “medical” vs. “social service” or “Medicaid” vs. “public health”).

MDH and DHS activities show an increasing tendency to adopt a more holistic view of the person when considering risk issues. For example, DHS and MDH are working together to make MnCHOICES assessments and planning available statewide for many people who are seeking services, have disabilities, are elderly or want to learn more about their chronic care options. The future MDH and DHS integrated licensing system is intended to promote "quality services that recognize a person's individual needs and protect the person's health, safety, rights and well-being.[119] Other elements of new HCBS licensing standards and home care legislation also explicitly mention health, safety, risk and personal choice.

- **In working with all involved, MDH and DHS need to speak with a consistent voice and pool their collective expertise to address risk issues.** Interview data, as well as common sense, suggest that when the two agencies present conflicting views or directives (or don't know each other's position). This confuses and alarms providers and service recipients. A common voice is also important in the state's response to the legislature, federal agencies (e.g., CMS), the Olmstead ruling and the Jensen settlement.

- **Collaborative efforts are needed to address the genuine frustrations providers have** about what are—or are perceived to be—conflicts between agencies and divisions in how they are regulated and address risk issues. MDH and DHS are working to improve a common website for providing chronic care licensing information, as described in Study 1 of this evaluation. In other areas of policy, the state has developed a common point of entry for people to report or receive information about policy (e.g., such as the new statewide system for reporting suspected maltreatment of vulnerable adults).

MDH and DHS have rich sources of data they can develop and use to improve risk issues at the systemic and individual level. At present, it appears that some differences in risk perspectives result from a lack of data to identify priority risk issues and separate fact from fiction (or anecdote from patterns). Sources of data include MnCHOICES, Ombudsman offices, linkage lines, waiver reviews, the Disability Waiver Rate System and other major initiatives such as MDH's health disparities initiative. This information (such as the LTC Ombudsman's finding that, recently, most complaints are related to rights) could help all stakeholders understand key issues and develop data-based strategies for improving risk assessment, risk planning and risk reduction strategies.

- **More data on risk issues, compiled across a variety of programs, would assist the state in better understanding, documenting and addressing the root causes of risk conflicts and how to resolve them.**

Resolving risk issues at the individual level

Assessment and service planning includes directives for care plans to person-centered, reasonably ensure the health and safety of the recipient or include safeguards that are required to reasonably maintain the person's health and safety. When these goals appear to be in conflict at the individual level (e.g., a particular conflict situation), combined MDH and DHS expertise can help determine the degree to which the problem's real or assumed source is a state policy, county policy, provider policy, client preference, consumer preference, insurance regulation, fear of lawsuit or other factor. Joint MDH and DHS involvement, and taking a broad-based look at risk issues, increases the likelihood that safety, health and choice are all promoted. Interviewees provided examples of situations where the problem was first viewed as a struggle between assuring safety and allowing choice. Upon discussion, however, the team analyzed the multiple factors involved and worked with all parties to resolve the issue in a new way that allowed the person to be safe while participating in the activity the person desired.

- **At the individual level, in complex situations, joint MDH and DHS involvement is needed to help identify the source of the problem and develop solutions within the guidance of the person or their family or guardians.**

Strong overall quality initiatives are a potent tool in assuring reasonable client risk assessments, planning for client risk reductions and determining reasonable assumptions of client risks. There is a natural tension between assuring safety/protection and allowing a client to engage in behavior that is (or is perceived to be) risky. An underlying question is what quality measures and practices promote both safety and choice? Risk issues may be increasingly be rolled up into broader quality discussions, particularly as measurement and payment systems become more sophisticated. MDH and DHS are expanding their use of evidence-based practices through the development of new initiatives, tools and delivery systems, such as health homes and behavioral health homes. In the area of assessment and planning, for instance, MnCHOICES has been refined over many years. However, there continues to be a need for specific tools to assist all parties understand and resolve issues at the individual level.

- **Additional education and tools that focus on risk issue dilemmas could strengthen agency, provider and client approaches to risk issues.**
- **Efforts to promote overall quality initiatives are likely to have a positive impact on all stakeholders' ability to address risk issues, particularly if quality is broadly defined. It would be helpful to align risk issue tools and approaches with quality approaches, so that each effort informs the other.**

Tort reform, including negotiated risk agreements

Many people express concern that fear of lawsuits can lead providers to deliver more care and more safety measures than needed and therefore reduce client choice. Tort reform is an oft-cited way to address this problem.

As has always been and will be the case, sometimes people are over-protected from potential risks, sometimes they are under-protected. On one hand, limited federal research and interview findings indicate that chronic care providers sometimes do practice defensive medicine and defensive safety. These defensive safety measures have the potential to limit personal choice. In other situations, there is evidence of the need for more service and protection; recent headlines, for example, make clear the level of harm (including death) that can occur where there is neglect, abuse, poor quality, inappropriate care or other problems. The context for fear of lawsuits includes the fact that medical malpractice lawsuits generally affect very few providers and their prevalence is decreasing.

There is limited and inconsistent research regarding the impact of tort reform. The CBO, for instance, found mixed evidence of the impact of traditional tort reform on service use or care outcomes.[120] It is not prudent to move further down the path of tort reform when its impact on health outcomes is not known, especially for people with disabilities and who are elderly and frail. In addition, Minnesota has already implemented tort reform in the area, which seems to have the greatest impact on reducing preventive medicine (cap on non-economic costs). Negotiated risk agreements appear to be of little practical use as a way to prevent lawsuits because they are unlikely to hold up in court.

- **Compared to traditional tort reform, efforts to promote overall quality are more likely to have a positive impact on all stakeholders' ability to address risk issues at the policy and individual level, particularly if quality is broadly defined to include health, safety, autonomy and well-being.**

Future efforts to examine risk issues

Risk issues can affect all people who use or might need services, not just people who need chronic care services at some point in their lives. For example, a four-hour emergency room visit or an overnight stay in a hospital can have myriad risk issues associated with it. Risk issues also involve many stakeholders beyond MDH and DHS, including, of course, the client, families, providers and advocates. Other involved parties include health licensing boards, professional organizations, public prosecutors and the legal profession at large, legislators, the federal government and the general public, to name a few. However, per legislative directive, the current study focuses on MDH, DHS and non-acute care. The report provides high-level analysis of risk issues and options for improvement. Future efforts that include the whole host of stakeholders are important in expanding 1) the scope of the study, to include populations beyond people in need of chronic care and 2) the depth of the study, to develop practical and more specific ways to address key risk issues such as differences between individuals and subpopulations (including when to apply risk issue policies consistently regardless of condition or population, and if and when to adjust for differences); client's right to refuse services; complex legal, administrative and policy issues affecting liability and the impact of funding changes on risk issues, provider liabilities and client's right to refuse care (e.g., what happens if MA funding is reduced and a client refuses preventative health care services that save money for the state?).[121] The next section provides recommendations regarding future efforts to examine risk issues.

Recommendations

Some of the recommendations below are already in progress in some way, or reflect recommendations made in previous reports by the SQC and Olmstead groups.

Build understanding and consensus among risk issue stakeholders

Recommendation 1: To build a more evidence-based and multi-faceted understanding of risk issues across stakeholders, the state should assure there is an ongoing forum for discussing risk issues, addressing policy and practical concerns, and developing consensus.

There needs to be more agreement or at least more understanding of the complex nature, many values, and multiple variables associated with risk decisions among stakeholders. An ongoing group is needed to help assure progress toward better strategies for addressing important and sensitive risk issues.

- Options for this forum include a new group or existing groups. For example:
    - The State Quality Council could continue to focus on risk issues. It is currently charged with this task and has started work in this area. However, this group is focused on home and community-based waivers, and risk issues are much broader than this. If the SQC focuses on risk issues, it could be the start of an effort that goes beyond HCBS.
    - A new Olmstead group (or subgroup of a future Olmstead group) could work on this issue. At the time of this report, the Olmstead planning committee had ended, and it was not clear whether the Olmstead subcabinet would continue beyond the release of the Olmstead plan. If an Olmstead group continues in some form, this group (or subgroup) could address risk issues IF the group included representation from MDH, DHS, people with disabilities (including frail elders), families or guardians, providers, advocates, legal experts and other stakeholders. This group would be a regrouping of many of the interests represented in the earlier Olmstead planning committee and current Olmstead subcabinet.

- **The forum should be a place to provide, discuss and receive information.** Discussions led jointly by MHD/DHS could clarify situations when state policy is or is not the source of an apparent risk issue conflict. The group should review and incorporate, as appropriate, previous work of others (e.g., this study, the State Quality Council and Olmstead groups). The group could explore ways to engage the broader community (e.g., Citizens League).

- **The role of this group and its deliverables** should be well documented and publicized, with strong project management that helps assure clear and useful goals, timelines, deliverables and communications. The group should display up-to-date reports of its progress on a state website. Effective mechanisms should assure this group completes its duties (e.g., change in statute, use of interagency agreements, annual reports to the legislature).

- **Questions for the group to consider include:** What real dilemmas and patterns exist based on data collected via the ombudsman and other sources? What is the best way to prioritize risk issues and strategies, and help assure a coherent approach at the statewide level? How does new information from MDH and DHS initiatives (e.g., data from MnCHOICES and the Disability Waiver Rate Setting System) inform the risk discussion?

- **All parties should acknowledge** that individuals, MDH, DHS, providers, advocates and receiving services value both choice and safety. Certain groups of individuals, professionals, divisions and staff may be more focused on one aspect than the other, but this is a generality only—and all perspectives are needed. To the degree that that differences in perspectives are proven to cause any real negative consequences for consumers or the state, they should be dealt with in practical ways (e.g., as previously mentioned, training). It is also recommended that the group:
    - avoid referring to a risk and choice "balance" or "continuum" and instead acknowledge the myriad of issues involved in risk assessments, planning and decision-making; and

  - review and refine what is meant by “acceptable” or “reasonable” risks, perhaps starting with definitions used by the US Department of Homeland Security.

Build MDH and DHS capacity on risk issues

Recommendation 2: To build MDH and DHS capacity on risk issues, the agencies should embed organizational, staff and service performance systems with risk-related expectations, standards and measures.

MDH and DHS should continue to bolster staff and agency capacity by incorporating risk issues into current systems for training and developing staff, and assessing individual and agency performance. These types of changes could also help change the culture toward a more holistic view of risk situations and concerns. Some of these efforts are already underway and could be expanded. Specifically, MAD recommends that MDH and DHS incorporate a focus on risk issues into:

- **Staff and provider training and standards, and related documents,** such as training for staff, PCAs, MnCHOICES assessors and case managers. Experiential training (e.g., using hypothetical situations based on real scenarios) would be helpful. Position descriptions and staff development plans could also be modified to assure/build knowledge, skills and abilities to address risk issues.

- **Policy manuals posted on MDH AND DHS websites that are up-to-date.** These are important sources of information for lead agencies and others in administering and providing risk assessments and plans (e.g., MnCHOICES, HCBS waivers). The state needs to assure that MDH and DHS have the resources to keep these tools up to date.

- **Ongoing review of MDH and DHS statutes, licensing/certification/registration policies and communications** (e.g., website) to identify where a consistent state policy related to risk issues could be stated, especially if needed to clarify any conflicting information or policy.

- **MDH and DHS quality initiatives,** with a goal of a holistic, consistent perspective related to basic risk issue, where “quality” includes at least these factors: autonomy, freedom of choice, person-centered care, physical health, safety and general well-being.

Foster MDH and DHS collaboration on priority risk issues

Recommendation 3: MDH and DHS should work together to address priority areas of concern (e.g., assisted living), respond to provider questions and implement other strategies for improving cross-agency problem solving, collaboration and communication.

In the last few years, MDH and DHS have worked together on major initiatives, revealing some of the benefits and challenges of collaborating on policy and operational issues. To maintain and accelerate joint progress on risk issues, it is recommended that MDH and DHS:

- **Work together to plan and implement initiatives to address key areas of risk,** such as assisted living, with each agency understanding it roles and responsibilities in the joint effort.
    - On collaborative efforts, clearly discuss and document each agency's role, responsibilities and expectations. For example, are the agencies working as equal partners, does one agency have the lead or is one of the agencies serving in an advisory role? Agencies could develop and share plans to clearly operationalize these and other aspects of collaboration.
    - Assisted living is a reasonable place to start in assuring that MDH and DHS have a coherent policy regarding risk issues, including related statutes, policies, programs, training, licensing, registration and certification requirements. Everyone seems to agree consensus and clarity in this area is needed. Home care policy is another area where there is confusion or the potential for conflict regarding the roles of various involved parties in addressing different types of risk.

- **Address provider questions and facilitate cross-agency problem-solving by:**
    - Providing a single point of entry for providers to receive information about chronic care licensing issues.
    - Developing a joint MDH AND DHS tracking system to identify and analyze patterns in provider questions and concerns and use them to continually improve statewide responses.
    - Sharing and incorporating what is learned into other MDH and DHS activities and communications, such as quality initiatives and training.

- **Consider whether there is a transparent way to assess and communicate to providers and others about how changes in chronic care policy and funding affect state and provider capacity to address issues,** including the impact on client choice, safety, quality and provider liability. The history of regulation is focused on the interplay between assuring quality and access and managing costs. At this point of time, with budget cuts, health care reforms and changing demographics, the issue of cost cannot be ignored in the risk discussion.

- **Implement the suggestions for improving MDH and DHS regulatory communication and administration in Study 1** of this evaluation (e.g., improve interagency communication, report annually to the legislature). While no one expects either agency to go along with the other if it is not aligned with the agency's goals, everyone should expect a generally coherent state policy. A change in organizational structure (e.g., regulatory functions within one agency) could facilitate discussion and policy development across programs, settings, services and funding sources. *However, "moving boxes" often does not solve underlying issues.*

Use MDH AND DHS teams to resolve risk issues at the individual level

Recommendation 3: To help resolve risk issues at the individual level, MDH and DHS

should use multidisciplinary, joint teams to develop solutions and create a system for tracking and sharing risk issue knowledge and strategies.

For many involved parties, risk issues affect very practical issues such as whether, when and how a person with cognitive difficulties or other challenges can safely leave a facility or take a bath alone. The outcomes of these decisions also have important implications for a person's independence, health and well-being; affect the family or other caregivers and can raise liability concerns for the state and providers. It is important that multidisciplinary teams address these situations and are supported with information and best practices.

- **Use multidisciplinary, joint MDH and DHS teams** to respond to individual situations and identify the real and priority issues in the situations. The team should be united in its dual focus on promoting client independence and health/safety, and addressing the real issues with involved parties. MDH and DHS already use joint teams to respond to some situations; MAD suggests it be used more broadly as needed. The state could also consider the use of virtual teams where appropriate.
- **Develop systems to track and share information** between MDH and DHS on patterns of provider and client risk issues emerging in Ombudsman offices and helplines, MnCHOICES and disability waiver rate setting data, and other information from MDH and DHS initiatives and divisions, so that joint strategies can be developed to address them. It is also important to use information from other major initiatives. For example, MnCHOICES is beginning to collect extensive information on client assessments, plans and outcomes. In addition, the new disability waiver rate setting system will collect information regarding HCBS recipients with complex service needs.
- **Share and incorporate what has been learned** from teams and the tracking system into other MDH and DHS activities (e.g., quality initiatives, staff/provider/client training and informational materials).

Develop practical tools to assist all stakeholders

Recommendation 4: MDH and DHS should jointly use or develop practical tools to assist stakeholders in addressing and resolving risk issues at the individual level.

There has been ongoing discussion of risk issues among all stakeholders and the development of related tools (MnCHOICES), but there is a need for more practical tools to help all stakeholders address complicated risk issues. Specifically, it is recommended that MDH and DHS develop or continue to develop the following for staff, providers and current and potential service recipients:

- **On-line and other tools** such as up-to-date, clear, user-friendly websites and manuals, and checklists for how and when it is appropriate, legal and advisable to set limits. These materials should highlight person-centered care, include a holistic viewpoint on risk issues, and provide some guidance on the roles of various stakeholders, and if and how roles change given a person's cognitive abilities. Other tools include continued technical assistance and related materials to help providers identify and address patterns of complaints/issues (e.g., address risk, safety and autonomy issues related to falls, assisted living and nursing home “elopement”).

- **Specific training on risk issues, with associated risk communications.** This could include webinars, on-site training and dissemination of best practices related to provider, client and agency roles in assessing and addressing risk issues, perhaps using Wisconsin’s LTC risk curriculum training as a place to start.
- **Use of risk/harm/abuse reduction and prevention plans, rather than risk management plans.** Generally speaking, risk management plans unreasonably expect a provider to address all risks, whether related to the provider’s scope of services. Abuse prevention plans, in contrast, are more directly related to provider-influenced risks and therefore less likely to unnecessarily limit choice.
- **Use the assessment and service contracting process to specify** what all parties agree to regarding reasonable risk, in compliance with state and federal standards. While documents such as negotiated risk agreements may not be able to prevent lawsuits, it benefits all parties if risks and client/provider responsibilities are clearly articulated in early in the assessment process and in service contracts.

Implement alternatives to tort reform

Recommendation 5: MDH and DHS should continue to examine and implement the most promising alternatives to traditional tort reform.

Many people assume that liability concerns limit choice if providers emphasize safety over choice to avoid the potential for lawsuits. However, as the Olmstead ruling and Jensen settlement illustrate, lawsuits can also happen in regards to limiting choice. Moreover, federal policies are requiring a person-centered care planning process that is directed by the family or the individual with LTC needs (rather than professionals). To address liability concerns, it is therefore recommended that MDH and DHS:

- **Continue to expand the use of evidence-based practices.** Evidence-based care can help support an understanding, expectation and standard for what is a reasonable level of care in a community and state, as well as the roles of those involved. The state continues to promote evidence-based care and services. An ongoing Olmstead group, as well as agencies, should continue to keep pace with current advancements in addressing risk and quality issues, where “quality” includes elements related to physical health, mental health and self-determination.
- **Do not pursue additional traditional tort reform or Negotiated Risk Agreements** unless further research and advisory groups clearly identify the value and feasibility of these mechanisms in improving care quality or supporting reasonable risk assessments/solutions.

- **Explore the expanded use of insurance risk pools, alternative dispute resolution and provider/client education and technical assistance,** to proactively address fears and quality concerns before they become problems.
- **Per recommendations from the SQC and Olmstead Planning Committee,** examine the relationships among the ADA, Vulnerable Adults Act and liability and insurance laws and practices, calling on legal and other expertise to determine if there are inconsistencies in the state's approach.

Appendix A: List of Terms and Acronyms

Acronyms

ADA: American with Disabilities Act
APP: Abuse Prevention Plan
ARRM: This is not an acronym—this is the name of an organization that promotes community-based services (the organization was formerly known as Association of Residential Resources in Minnesota).
CFFS: Community First Services and Supports
CHIP: Children's Health Insurance Program
CM: Compliance Monitoring Division, MDH
CMS: Federal Centers for Medicare and Medicaid Services
DD: Developmental Disability (or Disabilities)
DHS: Minnesota Department of Human Services
HCBS: Home and Community Based Services
ICF/DD: Intermediate Care Facility for Persons with Developmental Disabilities
LTC: Long Term Care
MA: Medical Assistance (Minnesota's Medicaid program)
MCO: Managed Care Organization
MDH: Minnesota Department of Health
METO: Minnesota Extended Treatment Options program
MMB: Minnesota Management & Budget
MnCHOICES: "an automated, comprehensive and person-centered assessment and support planning application"
MSOP: Minnesota Sex Offender Program
NRA: Negotiated Risk Agreement
OHFC: Office of Health Facilities Complaints, MDH
OIG: Minnesota Office of the Inspector General, DHS
OLA: Office of the Legislative Auditor
OPC: Olmstead Planning Committee
PCA: Personal Care Assistant
RMP: Risk Management Plan
SOS: State-Operated Services, DHS
SQC: State Quality Council

Appendix B: Information on Olmstead ruling and Jensen settlement

Olmstead Ruling[cxxii]

Olmstead refers to a 1999 Supreme Court judgment in the case Olmstead v. L.C. (US Supreme Court 1999).[cxxiii] In Georgia, two women with developmental disabilities (known as L.C. and E.W.) who were diagnosed with mental illness were voluntarily admitted to Georgia Regional Hospital for treatment in a psychiatric unit (Atlanta Legal Aid Society 2004). After some time, they and associated professionals determined they were ready to move to a community setting, with supports. However, they were not successfully discharged and, in 1995, the Atlanta Legal Aid Society brought this lawsuit. It was eventually heard by the Supreme Court. The Supreme Court ruled that under Title II of the Americans with Disabilities Act the women had the right to receive care in the most integrated setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA.

In *Olmstead v. L.C.*, the Supreme Court held that "public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity."[cxxiv]

The Olmstead ruling suggested that states produce formal plans (Olmstead Plans) to demonstrate ADA compliance, and CMS issued guidance in 2001.

Jensen Settlement

In the summer of 2009, three former residents sued the State of Minnesota and DHS regarding treatment received at the Minnesota Extended Treatment Options program (METO).[cxxv] This class action lawsuit centered on METO's use of restrains and seclusion at METO for residents with developmental disabilities. Two years later, the plaintiffs and the state reached a settlement agreement, which the court approved in December 2011. As a result, METO closed and any successor program must comply with the ruling in *Olmstead v. L.C.* and use person-centered planning principles and positive behavior supports. The settlement agreement also requires DHS to establish an Olmstead Planning Committee.

Minnesota's Olmstead Planning Committee was formed in 2012 to create recommendations for an Olmstead State Plan. The group's members included individuals with disabilities, family members, providers, advocates and senior DHS decision-makers. Members were appointed as part of the Jensen Settlement Agreement or by mutual agreement between DHS and the Plaintiffs, from a diverse pool of interested persons from around the state, through a public application process.[cxxvi] The Olmstead Planning Committee made public recommendations regarding a state Olmstead plan in October 2012.

In early 2013, Governor Mark Dayton issued an executive order that established the a subcabinet to “develop and implement a comprehensive Minnesota Olmstead Plan: (i) that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the most integrated setting, and (ii) that is consistent and in accord with the U.S. Supreme Court’s decision in Olmstead v. L. C., 527 U.S. 581 (1999).” [cxxvii]

Text from Joint Press Release[cxxviii]:

FEDERAL DISTRICT COURT APPROVES CLASS ACTION SETTLEMENT AGREEMENT TO RESOLVE LAWSUIT INVOLVING RESIDENTS WITH DEVELOPMENTAL DISABILITIES AT STATE FACILITY

SAINT PAUL – June 23, 2011 – Federal District Court Judge Donovan Frank has signed an Order this morning approving a comprehensive $3 Million class action settlement agreement negotiated in a lawsuit brought by three families against the State of Minnesota and other defendants for restraining and secluding residents with developmental disabilities, prior to September, 2008, at Minnesota Extended Treatment Options (METO), a state operated facility. The settlement agreement was reached after several months of negotiations following a two-day mediation of the case in September.

Today’s preliminary approval of the settlement agreement appoints Shamus O’Meara, counsel for the families and partner with the law firm of Johnson & Condon, P.A., as Class counsel, who will be mailing notices to all persons who ever resided at METO, including class members (defined as all individuals who were subjected to the use of any aversive or deprivation procedures, including restraints or seclusion while a resident of METO from July 1, 1997 through May 1, 2011), of the settlement and their rights and obligations under it. The settlement agreement provides that the Court will apportion the settlement proceeds to the Class members and may take into account the documented number of times they were restrained or secluded under a schedule provided in the agreement. The settlement protocol also allows Class members the opportunity to submit additional information to the Court for consideration as a part of the apportionment of the settlement proceeds.

The Settlement Agreement contains numerous provisions that will improve conditions for people with developmental disabilities placed in METO or its successor facility, including immediately and permanently discontinuing the use of mechanical restraints (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, posey cuffs, and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities. The agreement also includes a revised DHS policy providing that in the event of an emergency which poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety, certain manual and Velcro strap mechanical restraint may only be used on residents of METO and its successor facilities. In order to help assure that the limitations on the use of restraints are observed, the settlement mandates that a third party expert will be consulted in connection with each use of restraint, an employee of the State Health Department will serve as an external reviewer, and the Court will receive quarterly reports from the external reviewer as to whether the facility is in substantial compliance with the Settlement Agreement.

The State has also agreed to increase staffing and training requirements for the care of people with developmental disabilities, and has agreed that people with developmental disabilities will not be transferred to Minnesota Security Hospital and Anoka Metro Regional Treatment Center solely for reasons of their disability. Moreover, the State and the families jointly agreed to develop effective policies and practices for the treatment and care of people with developmental disabilities, including those who are sent to state operated facilities. The agreement provides that the State will form key committees to include stakeholders within the developmental disabilities community to study, review and modernize the DHS rule (Rule 40), which governs and protects people with developmental disabilities, to reflect current best practices, including the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the “most integrated setting” and “person centered planning, and development of an “Olmstead Plan” consistent with the 1999 U.S. Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999).

Shamus O’Meara, commenting on the settlement, stated:

> “This settlement agreement is the result of near constant negotiation by the parties over the past several months. It establishes lasting, positive change for the families who have been through so very much in this difficult, emotional situation. We are very proud of the efforts of all parties, their consultants, counsel, and the Federal Court in working together to develop lasting and meaningful changes that will improve the lives of people with developmental disabilities and their families. This settlement is truly a defining moment for the families of people with developmental disabilities in Minnesota.”

The three Plaintiff families named in the lawsuit, who will serve as class representatives, include Jim Brinker/Daren Allen, Elizabeth Jacobs, and Jim and Lorie Jensen, on behalf of their sons, Thomas, Jason, and Bradley, who were METO residents.

Commissioner Lucinda Jesson of the Minnesota Department of Human Services, which oversees the METO program, said the department is pleased to reach a settlement and noted the practices described in the lawsuit had ended.

> “This settlement provides for more protections for the vulnerable clients we serve,” Jesson said. “It also commits DHS to treat our clients closer to their homes and communities. These are steps we need to take.”

The lawsuit, originally filed in July 2009, contended METO staff routinely restrained residents in a prone face down position and placed them in metal handcuffs and leg hobbles, placed residents in seclusion and isolation rooms for extended time periods, and deprived them of visits from family members, among other claims. The lawsuit sought damages for violations of the federal civil and constitutional rights of residents with developmental disabilities, and asked the Court to enter an injunction against the State to prohibit its restraint and seclusion practices, and to declare them unconstitutional.

In the settlement, the defendants have denied liability for all of the claims.

For more information, please contact:

For Plaintiffs/Class:
Shamus P. O'Meara
Johnson & Condon, P.A.
7401 Metro Boulevard, Suite 600
Minneapolis, MN 55439-3034
952.806.0438
SPO@Johnson-Condon.com

For State/DHS:
Terry Gunderson
DHS Communications Director
(651) 431-2912
Terry.gunderson@state.mn.us

Appendix C: Recent efforts to examine risk issues

State Quality Council

SQC Purpose: The SQC was originally established by the legislature in 2011 as a result of recommendations from the 2007 Minnesota Quality Assurance Panel. The council is directly involved in HBCS licensing efforts and the identification of risk and choice issues. The purpose of the council is to improve the quality of services provided to Minnesotans with disabilities and meet CMS requirements.[cxxix] In partnership with DHS, the SQC deals with issues concerning HCBS waiver quality assurance, quality improvement and licensing.[cxxx] In 2011 the legislature asked the SQC to address risk issues. Specifically:

- Identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and
- Recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2013, statutory and rule changes related to the findings under Clause 3 that promote individualized service and housing choices balanced with appropriate individualized protection.[cxxxi]

The council's risk discussions included briefings from Chris Bell, co-chair of the Olmstead Committee,[cxxxii] and Barbara Turner of ARRM. Turner described the relationship between the state's reform efforts and risk, noting that new models of service include less direct supervision, and "if those making decisions do not support choices and associated risk; people are stuck."[cxxxiii] ARRM's Plan of Action is to develop a risk task force and legislative recommendations.[cxxxiv] She advocated for research which would allow people to "embrace some risks, while protecting local, state and private agencies from the threat of lawsuits." Elements of the suggested research included: barriers that restrict freedom and rights, experience of other states with expanded risk, risk pools and tort reform, commonly accepted definitions of "reasonable and prudent" as applied to persons with various disabilities, CMS risk-related standards and requirements and "federal impediments" to addressing individual risk and state laws.

SQC conclusions: The SQC presented four conclusions to the legislature regarding risk issues (Table 1). The council noted that inclusion of "risk" as a factor in HCBS waiver standards will allow for discussions about risk, and expressed concerns about case managers' role in addressing these issues, given high caseloads. Beyond that, the council reported that it needs more time to examine these issues, and will report back in January 2014.

Table 2: SQC 2013 Conclusions on Risk Issues

Topic	SQC Conclusion

Topic	SQC Conclusion
245D	Proposed 245D standards include “risk” as a factor to be considered in the participant’s service plan. That provision will allow for discussions among appropriate parties to address the ability of participants to make risky choices.
Case Managers	Case managers will play an increasingly important role in this process. The State Quality Council is concerned about caseloads increasing concurrently with case managers having increased responsibilities.
More Research Needed	The SQC needs more time to examine the relationship among the ADA, the Vulnerable Adults Act, and liability laws and insurance laws and practices.
2014 Report to Legislature	The SQC will take up this issue again when it reconvenes, calling on legal expertise from county attorneys and trial lawyers, among others. The SQC will report its findings and recommendations to the legislature in January 2014.

Olmstead groups

Olmstead Planning Committee (OPC) Examination of Risk and Choice: OPC’s Vision and Principles Statement[cxxxv] includes references to risk issues. For example, one principle states that people should be empowered to make choices for themselves, and that “quality of life is enhanced when individuals with disabilities gain more control in their lives including deciding whether to take a risk.” Another principle calls for individually-controlled decision-making, where possible, and emphasizes the importance of accurate assessments in facilitating choice.

The Committee’s *Risk & Choice*[cxxxvi] subcommittee was established “to develop new options for responding to the issues that inhibit choices” for people with disabilities. The subcommittee wrote that: “unfortunately, empowering individuals to live their own lives in the community of their choosing, as mandated by Olmstead, raises complex issues around the issue of risk of harm and potential liability. Many concerns about potential harm from community integration arise from myths, fears and stereotypes about disability and disease.” The subcommittee also concluded that:

- “Risk to self is not a permitted statutory basis for exclusion of a person WITH A DISABILITY under the ADA.[cxxxvii]

- Perceived or actual fear about the health and safety of persons with disabilities and others in the community can and will torpedo efforts at integration unless they are effectively dealt with.

- People with disabilities should not be subjected to risk management policies which are not applied to non-disabled adults in similar circumstances.

- A valid risk management policy must be applied on a case-by-case basis to evaluate whether some form of accommodation, service, or support, which, if provided, would enable an individual to safely perform an activity or achieve a personal goal.
- … an effective risk management policy must be able to respond to systemic barriers created by fears of risk of harm to self or others. Fear about the possibility of litigation, bad publicity, or individual liability must be adequately addressed on a systemic as well as an individual basis."

The committee's recommendations included:

- involve persons with disabilities, their families and advocates in MnCHOICES[cxxxviii] implementation and evaluation;
- assure enforcement of consumer choice by all providers;
- provide training (related to empowerment, risk management and self-advocacy);
- review relevant laws (e.g., Vulnerable Adults Act), to assure they do not reduce individual choice;
- address risk management policies and standards in a consistent manner (e.g., so they do not conflict with the ADA);
- develop/support network of Peer Integration Specialists; and
- ensure that all laws and rules address the balance of choice versus risk and ensure that choice is given more weight than risk is given.[cxxxix]

Olmstead Subcabinet

In early 2013, Governor Mark Dayton issued an executive order that established the subcabinet to "develop and implement a comprehensive Minnesota Olmstead Plan: (i) that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the most integrated setting, and (ii) that is consistent and in accord with the U.S. Supreme Court's decision in Olmstead v. L. C., 527 U.S. 581 (1999)."[cxl]

The order highlights independence and choice, including:

> **Whereas,** the State of Minnesota recognizes that such services advance the best interests of all Minnesotans by fostering independence, freedom of choice, productivity, and participation in community life of Minnesotans with disabilities.

The subcabinet consists of the following eight agencies: DHS, MDH, Minnesota Housing Finance Agency and departments of Employment and Economic Development, Transportation, Human Rights, Corrections and Education. The Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Governor's Council on Developmental Disabilities are *ex officio* members. The Subcabinet is required to have a draft

Olmstead Plan in place by November 1, 2013.

The Olmstead Subcabinet published a “very preliminary draft” of Minnesota’s Olmstead Plan for stakeholder comment in June 2013.[cxli]

- Overall, the plan’s vision statement emphasizes choice, self-determination and readily available information about “rights, options, and risks and benefits of these options, and the ability to revisit choices over time.”
- DHS’s measures include percent of people who direct their own services and who report they are given “informed choice” at their (MnCHOICES) assessment. Another measure is the percent of all individuals’ plans that include a plan to address risk management to reduce/prevent crises.
- DHS strategies include “empower individuals to make choices and manage risk” (e.g., through peer support and linkage lines) and assure person-centered planning that allows people to “be leaders in decision-making regarding their own care.”
- MDH notes that it is “cognizant of the ongoing tension between a person’s choice/self-determination and provider liability/licensure.” The department describes the need for more access to information and resources on health risks, and more funding and staff to collect and interpret data to identify and address areas of concern.
- MDH strategies also raise the issue of informed choice: “all licensing programs and standards under the authority of MDH will review and revise as needed regulatory language to ensure that persons with disabilities are able to make informed decisions about health-related issues. This is expected to include, for example, the licensing of nursing homes, hospitals, clinics, pubic and institutional swimming pools.”

Appendix D: OPC Draft Recommendations for Empowering Choice

Below is a copy of the Final Draft—October 15, 2012 version of the Olmstead Planning Committee's recommendation for " Changing the Service System to Empower Individuals with Disabilities"[cxlii]

Since the 1970's society's views of people with disabilities has been evolving to recognize the uniqueness of an individual's abilities and limitations. Despite forty years of improvement, lack of employment and resulting poverty frequently cause individuals with disabilities to enter into the social services system. While the requirement for an individualized assessment and response is a cornerstone of disability policy this is not always reflected in the service system. Although person centered planning is considered a "best practice" often times individuals feel like their choices are not honored. Authorization for services and supports comes from a "case manager."

There are certain prerequisites if individuals with disabilities are to be empowered:

- Every individual should be presumed competent, unless declared otherwise by a court, to direct the planning process, make choices, achieve his or her goals and outcomes, and build a meaningful life in the community.
- Every individual has strengths, can express preferences, and can make choices.
- Every individual with a disability should have his or her choices and preferences accurately assessed and understood using a formal assessment process which is regularly updated. Currently, DHS is implementing MnCHOICES as its assessment tool.
- Every individual with a disability should be provided a budget for housing and services which he or she can use to make choices, with, as appropriate, the assistance of family and significant others.
- Every individual should be able to have the timely assistance of an advocate such as a certified peer specialist, peer integration specialist or self-advocate.
- Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.
- Through the individualized planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.
- An individual's cultural background is recognized and valued in the individualized planning process.

Empowering Choice While Managing Risk

Unfortunately, empowering individuals to live their own lives in the community of their choosing, as mandated by Olmstead, raises complex issues around the issue of risk of harm and potential liability. Few endeavors in life, if any, can be accomplished without some risk of harm. Moreover, taking a risk can have positive as well as potential negative consequences. However, the ability to make choices enhances the quality of life of persons with disabilities. Most people weigh the potential benefits and the potential negatives when considering a course of action, whether or not this is done consciously or unconsciously.

When it comes to disability, however, risk taking is often viewed as having only potential negative consequences. Perceived or actual risk to the health and safety of people with disabilities or others in the community can undercut efforts at individual empowerment and community integration.

Continuing efforts to provide persons with disabilities real control over decisions affecting how they participate in all aspects of community life raises concerns in a variety of contexts. State and county official's[cxliii] providers of disability services, family members[cxliv] and people in the community sometimes believe there is a potential for harm to people with disabilities and others resulting from unrestricted community integration of people with disabilities.

Many of these concerns arise from myths, fears and stereotypes about disability and disease. For this reason, disability rights advocates crafted the Americans with Disabilities Act (ADA) to permit public and private disability programs to exclude only those persons whose disabilities posed a significant risk of substantial harm to others which could not be mitigated by some form of mandated accommodation which would not impose an undue burden or alter the nature of the program in question.[cxlv] Risk to self is not a permitted statutory basis for exclusion of a person WITH A DISABILITY under the ADA.

However, perceived or actual fear about the health and safety of persons with disabilities and others in the community can and will torpedo efforts at integration unless they are effectively dealt with. There are many policy complexities to the appropriate management of risk in the context of community integration. Many persons with disabilities are perfectly able to accurately assess risks and rewards without assistance and without someone second-guessing there decisions. People with disabilities should not be subjected to risk management policies which are not applied to non-disabled adults in similar circumstances.

Moreover, every human being, including a person with a disability, has abilities and limitations. A valid risk management policy must be applied on a case-by-case basis to evaluate whether some form of accommodation, service, or support, which, if provided, would enable an individual to safely perform an activity or achieve a personal goal.

Finally, an effective risk management policy must be able to respond to systemic barriers created by fears of risk of harm to self or others. Fear about the possibility of litigation, bad publicity, or individual liability must be adequately addressed on a systemic as well as an individual basis.

Recognizing that different disability populations have developed unique strategies regarding peer supports it is important to support multiple strategies to assist individuals with disabilities. For example, while self- advocates serving persons developmental disabilities and certified peer specialists serving people experiencing mental illness are closely related in terms of outcomes achieved they employ different successful practices. The OPC supports throughout its recommendations the expansion of peer supports for all disabilities. Thus, one of the recommendations below is to develop a new peer support called a Peer Integration Specialist. A certified peer specialist or a self-advocate could also be a Peer integration specialist. The key idea is to make peer support a critical component of the new service system.

Recommendations

- The State should involve persons with disabilities, their families and advocates in the implementation and evaluation of MnCHOICES to ensure it accurately identifies the abilities and desires of all people with disabilities.

- The State should develop a process to ensure that there is enforcement of consumer choice by all providers including but not limited to case managers as well as service providers.

- The State should provide regular training on empowerment of individuals with disabilities, their right to live in a community of their choice, as appropriate and the options for housing, services and supports which are generally available. Such training should be offered frequently to all stakeholders including people with disabilities and their families.

- The State should review laws and rules including the Vulnerable Adult and Nurse Practices statutes to ensure they do not reduce individual choice.

- The State should address risk management policies and standards in a consistent manner. Currently, the State Quality Council and several private entities are considering policies and standards for risk management. Best efforts should be made to ensure that existing and proposed risk management policies and standards are reviewed and do not conflict with applicable law including the ADA.

- The State should ensure that all laws and rules address the balance of choice versus risk and insure that choice is given more weight than risk is given.

- The State should provide ongoing training to stakeholders on applicable risk management policies and standards to ensure that concerns about empowering individuals with disabilities to be fully integrated into the community is not derailed by unwarranted health and safety concerns.

- The State should support the development of a position called a Peer Integration Specialists that helps train and support individuals with disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a network around the state, and payment to assist other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting peer integration specialists to meaningfully participate in workgroups and task forces that effect services and the evaluation of quality.

- The State should support a self-advocacy network in Minnesota that helps train and support individuals with developmental disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a self-advocacy network around the state, and payment to self-advocate assisting other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting self-advocates to meaningfully participate in workgroups and task forces that effect services and the evaluation of quality.

Goals

- The State should, over the next 5 years, hire and train 1,000 Certified Peer Specialists to assist individuals in understanding, making and implementing their choices.
- The State should, over the next 5 years develop a network of 500 paid Peer Integration Specialists to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.
- The State should, over the next 5 years, develop a network of 500 paid or volunteer self-advocates to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.

Appendix E: Examples of Statutory References to Health, Choice, and Other Goals

Note: This table intentionally does not include changes resulting from the 2013 HHS Omnibus bill (see Appendix F). Also, most of the services listed require an MDH or DHS license or registration. **Emphasis added**.

	Statute Excerpt	**Source**
General Duties: MDH and DHS	**MDH**: The state commissioner of health shall have general authority "…. development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the **health** of the citizens." **DHS**: General duties not stated in statute	MS 144.05 Subd. 1 MS 245.03
Mal-treatment of Vulnerable Adults	"The legislature declares that the public policy of this state is to **protect** adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing **safe** environments for vulnerable adults; and to provide **safe** [environments]"	MS 626.557 Sub. 1
Professional nursing	Professional nursing means providing "a nursing assessment of the actual or potential **health needs** … " and care that is "**supportive to or restorative** of life."	MS 148.171 Sub. 15
Nursing Board*	Mission statement excerpt: " … protect the public's health and safety … "	NA
Health Care Bill of Rights	Rights include the right to be treated with courtesy and respect, the right to appropriate medical and personal care based on individual needs, and the right to participate in planning of their health care.	MS 144.651 Sub. 5, 6 10
HCBS for PWD	"The commissioner shall apply for the HCB waivers in order to: (i) promote the support of PWD in the most **integrated settings**; (ii) expand the **availability** of services for persons who are eligible for MA; (iii) promote **cost-effective** options to institutional care; and (iv) obtain **federal financial participation**."	MS 256B.40
Elderly Waiver	The commissioner is authorized to apply for a HCBS waiver for the elderly, authorized "… in order to obtain **federal financial participation** to expand the **availability** of services for persons who are eligible for medical assistance."	MS 256B.0915 Subd. 1a
Home care services	[Home care rules shall] include the following: "(1) provisions to assure, to the extent possible, the **health, safety and well-being,**	144A.45 Sub. 1 (1)

	Statute Excerpt	**Source**
	and appropriate treatment of persons who receive home care services …”	
Home care bill of rights	Bill of rights includes discussion of suitable and up-to-date plan, “and subject to accepted medical or nursing standards, to **take an active part** in creating and changing the plan and evaluating services.”	144A.44 Subd. 1 144A.44(2)
Extended PCA	“… provided to ensure participants’ **safety, health, and welfare** …”	256.0659
Nursing homes	Subd. 3. Standards. (a) The facility must meet the minimum **health, sanitation, safety and comfort** standards …	144A.04 Subd. 3(a)
NH admission contracts	Subd. 2. Waivers of liability prohibited. An admission contract must not include a waiver of facility liability for the **health and safety** or personal property of a resident while the resident is under the facility's supervision.	MS 144.6501 Subd 2.
DD Quality —Least Restrictive Environment	Subd. 14. “Least restrictive environment” means an environment where services: [first element listed, then] … (2) do not subject the consumer or others to **unnecessary risks to health or safety**; and (3) maximize the consumer's level of **independence, productivity,** and **inclusion** in the community.	MS 245B.02 Sub. 14
MH Residential Treatment	“[Services] must be designed to: (1) **prevent placement** in settings that are more intensive, costly, or **restrictive** than necessary and appropriate to meet client needs; (2) help clients achieve the highest level of **independent** living; [etc.].”	MS 245.472 Subd. 1(1)-(4)

*Not a statutory reference, but included here because of its relevance to nurse licensing statutes.

Appendix F: New Licensing Standards

Source: New licensing standards for home care and HCBS waiver services, in Law of Minnesota 2013, Chapter 108.

NOTE: The bill will become official 2013 law in the summer of 2013.

Component	**Examples of statutory references to health, safety, and choice (**emphasis added**)**	
Integrated Licensing	a) The Department of Health Compliance Monitoring Division and the Department of Human Services Licensing Division shall jointly develop an integrated licensing system for providers of both home care services subject to licensure under Minnesota Statutes, Chapter 144A, and for home and community-based services subject to licensure under Minnesota Statutes, chapter 245D. The integrated licensing system shall: … (2) **promote quality services that recognize a person's individual needs and protect the person's health, safety, rights, and well-being;**	Article 8, Sec 60 (a)(2)
Waiver Provider standards (WPS): person-centered planning	[**Person-centered planning and service delivery**:]. (b) Services must be provided in a manner that supports the person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes, consistent with the principles of: (1) person-centered service planning and delivery that: (i) identifies and supports what is important to the person as well as what is important for the person, including preferences for when, how, and by whom direct support service is provided; (ii) uses that information to identify outcomes the person desires; and (iii) respects each person's history, dignity, and cultural background; (2) **self-determination that supports and provides: (i) opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication;** and (ii) the affirmation and protection of each person's civil and legal rights; and (3) providing the most integrated setting and inclusive service delivery that supports, promotes, and allows: (i) inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member; (ii) opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports; and	Article 8, Sec. 29, [245D.07] sub. 1a(b)

Component	**Examples of statutory references to health, safety, and choice (**emphasis added**)**	
	(iii) **a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights**	
WPS: definitions	Subd. 29a. **Self-determination.** "Self-determination" means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act	Article 8, Sect 22, [245D.02], Subd. 29a.
Waiver provider standards basic support	Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person.	Article 8, Sect. 23, Subd. 1(b)
Home care services (basic and comprehensive)	**Quality management.** The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order **to ensure safe and competent services** to clients. The ~~rules~~ regulations shall include the following:(1) provisions to assure, to the extent possible, the **health, safety and, well-being, and appropriate treatment** of persons who receive home care services **while respecting a client's autonomy and choice;**	Article 11 Sect. 18, Sub. 1 Article Sect. 9 [144A.45] Subd. A(1)
Home care bill of rights	**Rights include …** Subdivision 1. **Statement of rights.** A person who receives home care services has these rights: (1) the right to receive written information about rights ~~in advance of~~ before receiving ~~care or during the initial evaluation visit before the initiation of treatment~~ services, including what to do if rights are violated;(2) **the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care,** medical or nursing standards, to take an active part	Article 11, Sect. 8, Subd 1, (1)-(22) - excerpts

Component	**Examples of statutory references to health, safety, and choice (**emphasis added**)**	
	in ~~creating and changing the plan~~ developing, modifying, and evaluating ~~care~~ the planned services;(3) the right to be told ~~in advance of~~ before receiving ~~care about the~~ services ~~that will be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and ~~the consequences of these choices including~~ **the potential consequences of refusing these services;(4) the right to be told in advance of any change recommended changes by the provider in the service plan of care and to take an active part in any change decisions about changes to the service plan;** (14) the right to be free from physical and verbal **abuse, neglect, financial exploitation, and all forms of maltreatment** covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;……………… (17) the right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:(i) the ~~recipient of services~~ client engages in conduct that significantly alters the ~~conditions of employment as specified in the employment contract between~~ terms of the service plan with the home care provider ~~and the individual providing home care services, or creates~~;(ii) the client, person who lives with the client, or others create an **abusive or unsafe work environment** for the ~~individual~~ person providing home care services;…	
Community First Services and Supports to replace PCAs	[For CFSS] (r) "**Person-centered planning process**" means a process that is directed by the participant to plan for services and supports. The person-centered planning process must: (1) include people chosen by the participant; (2) provide necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions; (3) be timely and occur at time and locations of convenience to the participant; (4) reflect cultural considerations of the participant; (5) include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning; (6) provide the participant choices of the services and supports they receive and the staff providing those services and supports; (7) include a method for the participant to request updates to the plan; and (8) record the	Article 7 (Continuing Care) Sect. 49 [256B.85] Sub 2(r)

Component	**Examples of statutory references to health, safety, and choice (**emphasis added**)**	
	alternative home and community-based settings that were considered by the participant (b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.	Article 7 Sect. 49 [256B.85) Sub 1(b),

Appendix G: Services Subject to 245D Licensure

(This is information copied from a DHS internal document from the Fall/Winter 2012-2013)

Chapter 245D will govern the provision of home and community-based services. Most of the services are covered by one of Minnesota’s Medicaid waiver plans: the community alternative care (CAC) waiver, the community alternatives for disabled individuals (CADI) waiver, the developmental disability (DD) waiver, or the elderly waiver (EW). Phase one passed in 2012 and included currently unlicensed services. Implementation was delayed at the direction of legislature to develop a license fee structure with stakeholder input. Phase 2 will be introduced in 2013 and transitions other currently licensed services.

A single 245D-HCBS program license will be issued to each license holder for the provision of services statewide. A license holder may also hold individual facility licenses for each community residential setting and day services facility where the 245D services are provided. DHS Licensing will monitor the 245D-HCBS program license and the day service facility satellite licenses. County licensing agencies will continue to monitor the corporate adult foster care homes that convert to a 245D-Community Residential Setting satellite license.

Basic Support Services: Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, habilitation, or rehabilitation of the person. All of these services are currently unlicensed. Basic support services include:

1. 24-hour emergency assistance, immediate response only; excluding on-call counseling, and equipment, installation, monitoring, and testing.
2. Companion services, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program.
3. Homemaker services, excluding providers licensed by the MDH under chapter 144A and those providers providing cleaning services only.
4. Night supervision.
5. Personal support.
6. Respite care services, including in-home respite provided in a person’s own home or out-of-home respite provided in a setting licensed by DHS.

Intensive Support Services: In addition to the basic support service level of assistance, supervision, and care, intensive support services provide services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

1. Behavioral programming.

2. Specialist services.
3. Crisis respite,[cxlvi] including in-home crisis respite provided in a person’s own home or out-of-home crisis respite provided in a setting licensed by DHS.
4. Independent living skills training provided in a person’s own home.
5. Semi-independent living skills (SILS) provided in a person’s own home.
6. Residential-based habilitation, including:
    a. in-home family support provided in a person’s family or own home
    b. supported living services provided in a:
    c. person’s family or own home;
    d. setting licensed by DHS; or
    e. supervised living facility (SLF) licensed by MDH
7. Foster care services provided in a setting licensed by DHS.
8. Residential services provided in a SLF licensed by MDH and certified as an ICF/DD.
9. Day training and habilitation (DTH).
10. Pre-vocational
11. Structured day
12. Supported employment services.

Appendix H: Selected Chronic Care Initiatives

Initiative	Focus	MDH/DHS involvement
Accountable Care Demonstration	The ACD, through a CMS State Innovation Model Initiative, implements a model that is "team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services" and use payment reform models.[cxlvii]	MDH DHS
Health Care Homes[cxlviii]	HCHs are an approach to primary care to improve individual and population health and contain costs. Design principles "focus broadly on the continuum of 'health' and incorporate expectations for engagement of the patient, family and community." The model includes behavioral health homes.[cxlix]	MDH DHS
Reform 2020[cl]	Reform 2020 refers DHS efforts to reform Medical Assistance (MA) to increase people's independence and health, reduce reliance on institutional care and meet other goals. It includes: • *Community First Services and Supports* (CFSS), to replace the PCA benefit with expanded self-directed options. • *Anoka Metro RTC Demonstration*, to facilitate transition between community and inpatient settings. • *Money Follows the Person* (continued) to individualize care and/or reduce institutional care. • *Centralized Vulnerable Adult Reporting*, to replace 84 county-based "common entry points" with a statewide 24/7 response.	DHS
The Adult Mental Health Reform 2020[cli]	Recommendations from this committee to DHS included calls for DHS to establish a risk and safety management committee to identify and evaluate high risk situations, and explore development of teams to assist with transitions to community treatment, and increase use of peer specialists.	DHS
The MN Health Care Reform Task Force	This group was created to provide the state with advice on federal and state health reform implementation, the task force recommended new pay-for-value financial models, and care models based on patient-centered care and evidence-based programs.[clii]	MDH DHS
Eliminating Health Disparities Initiative	EHDI works "to eliminate disparities by partnering with populations of color and American Indians to create their own healthy futures." MDH's work includes a focus on helping adults prevent and manage chronic conditions (e.g., diabetes and	MDH

Initiative	Focus	MDH/DHS involvement
(EHDI):	cancer).[cliii]	
DHS Waiver Review Initiative	The waiver review is designed to assure compliance by lead agencies in the administration of HCBS programs. DHS and contractors review selected administrative issues that address person-centered service planning and delivery (e.g., “choice questions answered in care plan”) and “participant safeguards” (e.g., “health and safety issues are outlined in the plan).[cliv] DHS is also changing its system for setting HCBS provider rates.	DHS
Minnesota Disability Project	In 2007 MDH worked with an advisory group to create a plan for *Promoting Better Health for Minnesotans with Disabilities*. The plan called for a system that ensures individual’s safety and security needs, (including abuse prevention), empowers the consumer’s voice, promotes choice and addresses disparity and cultural issues. MDH did not receive funds beyond a planning grant, but the effort led to changes, such as more data collection on the needs of people with disabilities.[clv]	MDH

Appendix I: MnCHOICES

Topic	**MnCHOICES**
What is MnCHOICES?	• Supports longstanding core county function—conducting assessments • Combines assessment with service planning process • Determines eligibility for programs and services • Used for all ages and disability types • Completed by a certified assessor using web-based application • Functions offline—without an internet connection • Replaces four assessments: o Developmental Disability Screening (DD) o Long-Term Care Consultation (LTCC) o Personal Care Assistance (PCA) o Private Duty Nursing (PDN) (in the future) • Uses person-centered approach to tailor services to individual’s strengths, goals, preferences and assessed needs • Changes who conducts assessments • Only certified assessors • County of location responsible for conducting all assessments
Why is it needed?	• Minnesota’s system for long-term services and supports will: • Support people in having a meaningful life at all stages of life • Keep Minnesotans in their community; prevent more costly institutionalization • Be flexible, responsive and accessible • Ensure the system’s sustainability in order to be available to those who need it in the future • Changing demographics and economic pressures put Minnesota’s current system for long-term services and supports at risk of not being sustainable • Opportunities to support innovation and reform • Compliance with federal requirements • Strong county-state partnership
State Role	• Provide administrative framework that supports person-centered services • Establish a framework for setting clear & consistent expectations • Provide a functional assessment application • Assure fair and timely MnCHOICES payment to counties • Provide innovative and meaningful training • Collect and analyze data for quality improvement
County Role	• Provide and direct service in local communities • Act as state’s administrative arm • Ensure staffing and technology resources to support MnCHOICES

Topic	**MnCHOICES**
	• Generate and use data to promote shared policy goals • Advance continuous quality improvement
Certified assessors	• DHS will provider Certified Assessor Training (includes requirements to pass course tests) • Only a certified assessor can complete an assessment/reassessment & develop a support plan • Must meet qualifications and experience: o A minimum of a bachelor’s degree in social work, nursing with a public health certificate or other closely-related field and at least one year of home- and community-based experience, or o A two-year registered nursing degree with at least two years of home- and community-based experience.
Assessment Teams	• Team of social workers, public health nurses and other professionals • Experience and expertise with all populations—all ages and disabilities • Support in understanding programs and developing support plans

Appendix J: Elements of Risk Management Plans and Abuse Prevention Plans

Risk Management Plans: Statute excerpt from 245B (DD Services) 245B.06, Subd. 2, d-f.

> (d) License holders jointly providing services to a consumer shall coordinate and use the resulting assessment of risk areas for the development of each license holder's risk management or the shared risk management plan. The license holder's plan must include the specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability areas. The specific actions must include the proactive measures being taken, training being provided, or a detailed description of actions a staff person will take when intervention is needed.
>
> (e) Prior to or upon initiating services, a license holder must develop an initial risk management plan that is, at a minimum, verbally approved by the consumer or consumer's legal representative and case manager. The license holder must document the date the license holder receives the consumer's legal representatives and case manager's verbal approval of the initial plan.

Abuse Prevention Plans: Statute excerpt from 245A.65 (Maltreatment of VASubd. 2

Subd. 2. Abuse prevention plans.

All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

> (a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).
>
> (b) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients

Abuse Prevention Plans 626.557 (Reporting of Maltreatment of Vulnerable Adults) Subd. 14(a-c)

Subd. 14. Abuse prevention plans.

(a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

Appendix K: CMS HCBS Assurance-Health and Welfare

	Stipulation (Assurance 4)
General statement	**Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen.** This assurance emphasizes the role of HCBS waivers in reporting, investigating, and resolving serious incidents which include, at a minimum, cases of abuse, neglect and exploitation.
Reporting & Investigation	A state must have a system for reporting and investigating critical events including, at a minimum, cases of abuse, neglect, and exploitation.
System elements	The system must describe elements such as, the definition of critical events, identification of individuals/entities that must report incidents, reporting timeframes and reporting methods, who and when and how investigations mare conducted, process and timeframes for informing participant (and/or others) of investigation results, etc.
How states comply	Many states comply with this assurance through the establishment of a critical incident reporting system. Often these systems define critical incidents more broadly than abuse, neglect and exploitation.
Risk assessment requirement	Among other things, a state must assess the risk for abuse or other serious incidents during the service planning process. States usually provide guidance on how to identify a participant's potential areas of vulnerability and the proactive steps that should be taken in the service plan to mitigate their occurrence. Track, investigate and resolves reports of abuse, neglect and exploitation as well as other critical incidents.
States must also….	Assure that participants (and involved family or other unpaid caregivers, as appropriate) are informed about their rights and protections, including how they can safely report an event and receive the necessary intervention or support. Assure that HCBS waiver agencies, vendors and workers (including case managers) are well informed of their responsibilities to identify and report all critical incidents. Provider responsibilities are typically described in licensure requirements, contracts or service agreements, job descriptions and agency policies. Responsibilities are also reinforced through periodic state training. Evaluate the nature, frequency and circumstances of reported cases and determine how the HCBS waiver can prevent or reduce similar occurrences in the future.

Source: CMS, *Assurance 4-Health and Welfare.* Accessed June 7, 2013, http://www.hcbsassurances.org/healthwelfare/health1.html.

Appendix L: Interview Results

Interviews with agency leadership and stakeholders

This study included interviews with approximately 60 interviews with high level MDH and DHS staff, several legislators and representatives of many advocacy and provider organizations. **This section reports on the *comments and opinions* of interviewees. *It does not evaluate claims*.** Also:

- Interviewees were selected for their level of decision-making, experience and expertise.
- Perceptions are often extremely important in policy-making discussion and decisions.
- This summary focuses on themes that are aggregated across multiple responses.

Issues

General comments

Several[clvi] respondents mentioned the status of issues surrounding client, state and provider issues related to choice, safety, risk assessment and risk liability. Respondents noted the shift to community-based care and person-centered care in highlighting the importance of risk issues. Comments among this group included the following types of topics:

- It's an important and ongoing question regarding how risk, safety, choice, liability and regulation interact and should be balanced. Even on the client level, there is not one voice. Over-emphasizing safety can restrict choice and add to costs.
- Is it more difficult to manage risk in community-based services? Responses varied: On the one hand, said one, it is easier to see lines of responsibility in 24-hour facilities; others said risk issues cross settings and people are not always safe in institutions.
- The state is working on risk issues in various ways, such as the Olmstead efforts and interagency cooperation.
- Respondents gave many examples of risk dilemmas. For example, if someone refuses medication in the community, does the state have consistent standards for dealing with this? What if a client falls down and doesn't want to go to the ER? When services are reduced because of budget cuts, and people are at higher risk of harm, are providers still liable if someone is harmed because of this?
- Some perceived state policy barriers to "choice" are actually other kinds of barriers (e.g., insurance requirements).

Varied or conflicting policies and perspectives

Many people discussed the issue of how different parties in the system have conflicting policies, practices or approaches to dealing with risk/choice/safety issues. As seen in paraphrased comments below, interviewees cited conflicts in many parts of the system:

- **Between MDH and DHS, and between settings:** A few people said DHS is likely to emphasize promoting choice (even if it involves some risk), while MDH is likely to emphasize safety and limiting harm; this can result in two different reactions to the same situation or conflicting guidelines to providers. A few people mentioned different perspectives by division (e.g., aging versus disability services), while also noting these differences are decreasing.

- **By service, across the system:** When looking across services, some parties point to the ambiguity in defining medical versus social services. For example, is memory care a medical service? Does medication administration need to be managed by a health care professional? What’s the real difference between home health aides and PCAs? This has implications for who regulates and how services are regulated, including level of professional staff required for monitoring and service provision. The issues appear to be particularly unclear related to home care and assisted living. One question in that area is, if a provider registered as “housing with services” registered as a facility only (in which case client independence and choice are maximized) or does the provider have other responsibilities related to overall health/supportive care?

Risk Assessment and Treatment plans

- A few people mentioned that risk management plans and program management plans can take dozens of hours to complete because care managers/providers need to plan for every risk. It was hoped that this was addressed in the new waiver licensing standards, where risk management plans are replaced by abuse prevention plans.

- A few people thought current efforts to align assessment and waiver standards across population groups were misguided because they did not take into account different competency and risk issues that affect different subgroups.

- As an example of different perspectives, some mental health providers may focus on harm reduction (which accepts a continuing level of risky behavior while working to reduce adverse consequences) while other providers focus on risk management or abuse prevention.

Liability: Tort reform and Negotiated Risk Agreements

- Several people said that a provider may be driven to protect or over-protect a client due to fear of lawsuits, MDH citations, negative headlines or associated increases in insurance costs.

- Several people mentioned that service needs and expectations of safety and standards are rising, but payment rates are going down. This led to questions concerning the adequacy of payment in meeting rising needs for risk assessment, planning and management and how adequacy in payment might affect provider liability (e.g. are they still liable if they don’t have the resources to provide it?). Another question related to how the state’s promotion of choice (and certain kinds of choices) relates to whether these choices are costing or saving the state money.

- Assisted living is problematic, said some people, for this reason: the provider, licensed as housing with services, might promote independent living and provide minimal nursing services, per a resident's request; but in terms of liability, is the provider responsible for the resident's overall health and safety?

Interviewee Recommendations

Areas of emphasis

A few people said that the state generally had a good balance in addressing independence, risk and safety issues and no changes were needed.

Several people discussed the need to shift the overall emphasis of service assessment and provision toward client choice and independence. For example, the state should talk about a continuum of freedom or independence rather than continuum of risk or safety and acknowledge that people with and without disabilities all have some acceptable risks in life. A few people a said a focus on safety can lead to a neglect of other values, such as a person's happiness.

Several people cited issues at the now-closed Minnesota Extended Treatment Center and St. Peter State Security Hospital (e.g., regarding use of restraints, quality problems) and said there is a need to assure those types of problems do not occur.

Decision making at the policy level

At the overall state policy level, several interviewees suggested ways to build consensus around risk issues. These included:

- There needs to be one group to deal with this, such as Olmstead or State Quality Council, new task force or new community engagement (e.g., Citizen's League).

- Continued leadership and better communication between MDH and DHS is needed, to come to consensus and develop a consistent approach

- Teams of both MDH and DHS could come up with solutions when risk issues are encountered at the individual level (e.g., e.g., identify real issue(s), create solutions for promoting both safety and choice).

Risk assessments and care plans and service contracts

Many people emphasized the use of plans and agreements for documenting client needs, preferences and agreed-upon client/provider responsibilities. Suggested characteristics of these plans and contracts included:

- flexible and client-centered (e.g., flex with life changes)

- have agreed-upon client/provider responsibilities, assuring that the client fully understands what they are agreeing to and is engaged in planning, and the provider is released from preventing the risk
- deal with the different needs of different populations
- clearly specify what is mandated and what the funder will pay for
- are assessed by whether peoples' lives are better off

Other recommendations

Several people made other suggestions for addressing risk issues, such as: use fiscal notes to show the impact of budget cuts on safety and quality risks, implement legal reforms or use insurance risk pools[clvii] to address liability concerns, address workforce issues[clviii] to improve quality/address risk issues and continue to explore use of technology (e.g., cameras) to address risk.

Appendix M: Excerpts from Wisconsin's Risk Guidelines[clix]

Introduction

- This curriculum is a combination of guidelines and trainings from three different areas—LTC for frail elders and adults with disabilities, recovery-based community mental health services, and evidence-based best practices for alcohol and drug abuse. Community-based managed long term care program practitioners must be able to negotiate all of these issues while balancing member choice with health and safety.

- For many people, consumer empowerment raises immediate questions about the limits of consumer choice and about practitioners' liability for "bad" choices. In fact, only a very small minority of choices really do involve serious risk. The vast majority of consumer choices involve no risk, or no risks beyond what's part of "normal life" for adults. Exaggerating the assumption that "consumer choice equals more risk" only fosters excessive paternalism.

- Consumer empowerment asks us to shift from "How do we prevent people from making bad choices?" and "How do we protect people--and ourselves from liability?" to the following questions:

    - How can we help disempowered people gain skills and opportunities in choice-making?

    - How can we support people in learning and practicing the life skills of choice-making?

    - How can we facilitate success, including learning lessons from set-backs?

    - When should we try to prevent bad things from happening?

    - When should we try to stop a person from making a particular choice?

List of Paradigm Shifts

- From paternalism … To Self-Determination

- From professionals know best … To consumer empowerment

- From medical model/deficits-based … To Normalization/Strengths-based

- From power over … To power under: supporting their life & goals

- From services … To quality of life—human flourishing

- From health & safety as primary … To quality of life—human flourishing

- From segregation … To building community relationships, inclusion
- From agency (institutional) ends … To consumers' ends
- From purchasing services … To supporting consumer outcomes

Regulation lags behind

- Fear of liability & regulatory sanctions causes providers' self-interest to override consumers' autonomy and (not uncommonly) civil rights.
- Excessive fear & attempts to control—e.g., home health nurses can feel overly responsible …
- Overall: balance of RISK and RIGHTS—Liberties, Autonomy/Self-Determination.
- i.e., balance of SAFETY and AUTONOMY.
- Tricky with vulnerable populations, marginal competence/decisionality

4 COMPONENTS – ALL ON-GOING, CONCURRENT, OVERLAPPING

A. ASSESS THE RISK(S)

1. Do notice risk factors
2. See assessment forms for details of what not to miss
3. Assess immediacy, level, & cause of risk

Respond immediately if emergency/crisis

If MCO/providers' responsibility: Not "member choice!" You're responsible.
MCO/PROVIDERS' responsibility is to assess for and recognize risk factors.
MCO/PROVIDERS are responsible for preventing harm to others, especially "Vulnerable persons."
MCO/PROVIDER is more responsible for avoiding harm & risk if
A. Person is legally defined "vulnerable adult" (DD, frail elder, disabled)
B. Person lacks or has marginal decisional capacity
MCO/PROVIDERS' responsibility is to fully inform person.
MCO/PROVIDERS' responsibilities are greater if person needs extra accommodations to fully understand, or cannot understand.
MCO/PROVIDERS' responsibilities are:
• Recognize & address (assess & intervene/help with) psychological/emotional issues
• Get out of power struggles
• Advocate for member with other parties
MCO/PROVIDERS' responsibilities are greater when member's abilities are less.
MCO/PROVIDERS must do whatever covered service works to reduce harm PRN.

B. ASSESS THE CHOICE(S)

1. Does person have decisional capacity?
2. Is this a fully informed choice?
3. Are there psychological/emotional dynamics at play?

C. REDUCE THE RISK

1. Balancing your responsibility with theirs (and family’s)
2. Breaking problems into small parts and solving each

D. SUPPORT BETTER CHOICE(S)

1. “Short-cut”: Discover what motivates them
2. Assess “Stage of Change”
3. Do Motivational Interventions—Using “Brief Interventions” with “FRAMES” method
4. Support skills development in choice-making—including lessons learned
5. Support likelihood of success

Appendix N: Tort Reform and Related Reforms

Minnesota Tort Reform and Related Reforms

Other problems with the tort system. In addition to concerns with over-service/defensive medicine, experts cite many additional problems with the tort system. Most information relates to acute care and includes:[clx]

- The current system can impede, rather than improve, patient safety initiatives. For example, a physician may withhold information, not admit mistakes, and be discouraged from participating in adverse event reporting and other patient initiatives, if they feel that admitting mistakes will provide incriminating information in a lawsuit.
- There "is no real evidence that the medical liability system deters negligent care."
- The tort system largely ignores health care provider systems issues, thus missing a major reason why errors might occur in the first place.
- Also: the system "does a poor job compensating patients injured by medical malpractice," it has high administrative and litigation costs, and there are basic fairness and equity issues (e.g., "meritorious claims" may receive nothing, and injury severity is often not well-related to awards).

Four common types of reform:[clxi] Four types of tort reform frequently enacted by states are to modify joint-and-several liability, modify the collateral sources rule, limit noneconomic damages and limit punitive damages. These types are described below, with more detail in Table I1.

- Modify joint-and-several liability ("States have based the amount for which a defendant can be held liable on the proportion of fault attributed, but the formulas differ substantially from state to state. In addition, most of the reforms apply to specific types of torts or have other restrictions.").
- Modify the Collateral source rule[clxii] ("Typical reforms either permit evidence of collateral-source payments to be admitted at trial, allow awards to plaintiffs to be offset by other payments, or both.").
- Limit non-economic damages (as of 2005, caps ranged from $250,000 to $750,000. More than half of the forms applied to torts involving medical malpractice).
- Limit punitive damages ("various types of limits include outright bans; fixed dollar caps ranging from $250,000 to $10 million; and caps equal to a multiple of compensatory awards.").

Table I1: Minnesota Tort Reform[clxiii]

Reform Type	**Description of Reform and Minnesota Action**
Modify Joint and Several Liability	**Joint and Several Liability Reform: HF 1493 (1988):** Minn. Stat. Ann. § 604.02 Subd. 1. Provides that defendants found to be 15% or less at fault shall pay no more than four times their share of damages. **Joint and Several Liability Reform: HF 872 (2003);** Amended Minn. Stat. § 604.02. Raises the threshold for the imposition of joint and several liabilities from 15 percent to greater than 50 percent. Parties less than 50 percent responsible are to be held responsible only for their percentage of fault.
Modify Collateral Source Rule	**Collateral Source Rule Reform: SB 2078 (1986): Minn. Stat. § 548.36.** Permits the admissibility of evidence of collateral source payments only for the court's review. Provides for awards to be offset by collateral source payments, unless the source of reimbursement has a subrogation right. *The statutory provision allowing a court to offset collateral source payments was not unconstitutionally vague and did not violate the due process, equal protection, or right to remedy provisions of the State Constitution. Johnson v. Farmers Union Central Exchange, Inc., 414 N.W.2d 425 (Minn. App. 1987).* **Medical Liability Reform: Contingent Fee Reform: Minn. Stat. § 548.36.** Requires that contingent fees in medical liability cases be based on the award adjusted for collateral source benefits.
Limit Non-economic damages	**Noneconomic Damages Reform: SB 2078 (1986).** Limits the award of damages for loss of consortium, emotional distress, or embarrassment to $400,000. The $400,000 limit on damages for embarrassment, emotional distress, and loss of consortium did not violate "certain remedy" clause of the State Constitution. Schweich v. Ziegler, Inc., 463 N.W.2d 722 (Minn. 1990).
Limit punitive damages	**Punitive Damages Reform: (1990). Minn. Stat. § 549.20.** Requires a plaintiff to show that a defendant acted with "deliberate disregard" for the award of punitive damages. (The former standard required only a showing of "willful indifference.") Requires the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant. Grants trial and appellate judges the power to review all punitive damages awards. **Punitive Damages Reform: Clear and Convincing Requirement: Minn. Stat. § 549.20.** Requires a plaintiff to prove punitive damages by clear and convincing evidence. **Punitive Damages Reform: SB 2078 (1986).** Prohibits plaintiffs from pleading punitive damages in an original complaint. Requires a plaintiff to make a *prima facie* showing of liability before an amendment of pleadings is permitted by the court.

Appendix O: Sample NRA

U.S. Department of Health and Human Services-Study of Negotiated Risk Agreements in Assisted Living: Final Report

From National Provider-Negotiated Risk Agreement and Release

Note: This agreement should be noted on the Service Plan.

This Negotiated Risk Agreement and Release is entered into ____________ and _________________ (the "Resident"). The Resident is a resident of _______ and a specific issue regarding the Resident's care has arisen. This issue is described in detail below under "Issue(s)/Concern." The Resident understands that how this issue is addressed may have significant consequences upon the Resident's health and quality of life including but not limited to those listed under "Possible consequences of desire or preference." The Resident further acknowledges that he/she has had these consequences fully explained to him/her and having considered these consequences wishes to have his/her care delivered as outlined in this Negotiated Risk Agreement and Release despite the fact that the Resident may experience a decline in health and/or may experience other significant negative outcomes including injury or death. The Resident and Provider have agreed to address the issue as outlined below under "Agreed Course of Action."

Resident's Name: ____
Issue(s)/Concern(s): ____
____
____
Resident/Family desire or preference: _______________________________________
____
____
Possible consequence of desire or preference: _________________________________
____
____

Alternative approaches to minimize risk: _____________________________________
____
____

Agreed course of action: ____
____
____

Either party may terminate this Agreement by giving the other party written notice. The release contained in this Negotiated Risk Agreement and Release shall survive any termination.

The Resident, being of lawful age, in consideration of Provider's agreement to allow the Resident to receive care as outlined in the "Agreed Course of Actions," in this Negotiated Risk Agreement and Release, for himself/herself, his/her heirs, executors, administrators, and assigns, hereby release and forever discharge Provider, its directors, owners, management, agents, employees from any and every claim, demand, action or right of action, of whatever kind or nature, either in law or in equity arising from or by reason of any bodily injury or personal injuries known or unknown, death or property damage resulting or to result from the care and/or oversight provided by ______, whether by negligence or not.

Resident further states that he/she has carefully read the Negotiated Risk Agreement and Release and knows the contents thereof and signs this Negotiated Risk Agreement and Release as his/her own free act.

In witness whereof, resident has executed this release at _______ on ______, ______.

SIGNATURES:

Resident: ______________________________Date: ___________________

Provider: ____________ Representative: ________________________________

Date:____

Family Member(s): _______________________Date: ___________________

Witness: ________________________________Date: ___________________

Appendix P: Executive Summary of 2012 Minnesota Department of Health Report

Evaluation of Health and Human Services Regulatory Responsibilities

Report to the Minnesota Legislature 2012

Minnesota Department of Health

Executive Summary

A. Background

- MDH Compliance Monitoring Division regulates 30 types of entities and the DHS Licensing Division regulates 21 types of entities. There is no overlap in the scope of the licenses, registrations, or certifications issued by the MDH CM Division and the DHS Licensing Division. However, some providers may have an MDH license and a DHS license. For example, chemical health services provided in a residential setting require a DHS license related to the services provided and an MDH license as a supervised living facility.

- There are many similarities between MDH CM Division and DHS Licensing Division in *how* the divisions conduct their respective regulatory activities. Each reviews applications from providers, issues credentials, provides information to both consumers and providers, conducts onsite inspections, has a complaint intake line and investigates complaints, and takes enforcement actions against providers, when appropriate.

- Both agencies also conduct other activities that are not directly regulatory, but are related to their regulatory functions or expertise. For example, MDH CM Division Mortuary Science Section, which licenses and regulates funeral homes, funeral directors and morticians, also manages the state's mobile morgue, which would be used during a mass fatality incident. DHS Licensing Division conducts all the state's background studies for direct care providers in health facilities. Both MDGH CM Division and DHS Licensing respond to emergencies (i.e. floods, fires) affecting the entities they regulate and ensure that residents are safe.

- MDH CM Division and DHS Licensing Division are licensors and regulators. Another division in DHS operates facilities and services and is a licensee of MDH CH Division and DHS Licensing Division. These facilities are operated through the State Operated Services (SOS) and the Minnesota Sex Offender Program (MSOP) within DHS. DHS is also the state Medicaid agency and payor of some services, while MDH is the federal Centers for Medicare and Medicaid Services (CMS) state survey agency for Medicare.

B. Recommendations

- **Blend Regulatory Activities** for Facilities Licensed by MDH and DHS Licensed Programs in the Facilities.

- **Clearly Inform Providers** and the Public About MDH and DHS Regulatory Responsibilities.

- **Cross Train Staff** in MDH CM Division and DHS Licensing Division.

- **Establish Linkages** Between MDH CM Division and DHS Office of Inspector General (OIG).

- **Conduct a Broader Regulatory Evaluation** Of All the Regulatory Activities in MDH and DHS; Continue the Work Started.

Appendix Q: Summary of Office of Legislative Auditor Report

State-Operated Human Services

A summary of State-Operated Human Services, an evaluation report of the Office of the Legislative Auditor, February 2013.

Key Facts and Findings

- The Minnesota Department of Human Services (DHS) operates more than 130 residential facilities for individuals with mental illness, developmental disabilities, and chemical dependency.
- State-run human services facilities today house fewer than 1,300 residents, compared with more than 16,000 in 1960.
- The mission of DHS's state-run services is not clear in state law.
- DHS's governance structure for state-run services has been confusing, and its oversight of these services has, at times, been insufficient.
- DHS has provided little useful information to the Legislature and public for evaluating the performance of its state-run services.
- Many behavioral health patients have stayed in state-run hospitals longer than necessary, partly due to inadequate placement options following discharge.
- Inappropriate restraint and seclusion of patients contributed to the closure of one state-run facility and serious sanctions against another. State-run facilities have experienced problems with workplace safety, and reports of physical assaults increased sharply in 2012.
- DHS has struggled to address various challenges at the Minnesota Security Hospital, including inadequate psychiatric staffing, increasing staff injuries, and frequent leadership changes.
- Many individuals enter state-run facilities following civil commitment by courts. But state law has overlapping provisions for some types of commitments and does not ensure periodic court review of all commitments.

The Department of Human Services should continue to provide some direct services to clients, but with a clearer mission and more effective resolution of ongoing problems.

Key Recommendations

- The Legislature should clarify in law that the mission of state-run facilities is to serve individuals who would not be adequately served by other providers.
- The Department of Human Services should ensure the availability of placement options for individuals ready to leave state-run facilities.
- DHS should add security to some state-run hospitals, enabling them to serve challenging patients that other facilities cannot.
- DHS should develop a plan for reducing the number of state-run group homes for individuals with developmental disabilities, and it should prepare a plan addressing the future of the Anoka-Metro Regional Treatment Center.
- The Legislature should amend state law to ensure periodic court review of civil commitments.
- The Minnesota Security Hospital should develop clear standards regarding psychiatric contacts with patients and the amount of treatment provided.

Report Summary

The Minnesota Department of Human Services (DHS) directly provides many services to individuals with mental illness, developmental disabilities, and chemical dependency. The department's State-Operated Services (SOS) Division employs more than 3,000 staff to provide inpatient and outpatient services. Expenditures for state-run services totaled about $293 million in fiscal year 2012.

State-run residential facilities range in size from group homes that serve a few individuals to the Minnesota Security Hospital's licensed capacity of 408 patients. All SOS facilities are licensed by DHS, the Department of Health, or both.

***Some state-run facilities serve unique functions, while others provide services similar to nonstate providers*.**

The state's role as a direct provider of human services should be clarified.

State law provides limited guidance on what services DHS should directly provide. Many services provided by state-run facilities are also offered by nonstate providers. Overall, state-run facilities accounted for about 3 percent of the beds in all Minnesota facilities with similar types of state licenses in 2012. The Legislature should clarify in law the role of state-run facilities to serve clients who cannot adequately be served by other providers.

Some state-run facilities serve a unique function and should continue. For example, the Minnesota Security Hospital is the only secure facility licensed to provide residential treatment to adults with mental illness. This enables it to serve dangerous individuals who cannot be housed elsewhere. Also, discharge of Security Hospital residents is determined, according to law, by the DHS commissioner based on recommendations from an independent board, and it is doubtful that nonstate facilities would serve patients for whom they had no direct control over discharge.

In contrast, there are viable alternatives to state-run group homes for certain individuals with developmental disabilities. In 2012, 384 beds were in state-run adult foster homes, a fraction of the 17,000 beds in licensed foster homes statewide. State-run homes should be continued for clients whose needs would not likely be met by other providers, but DHS officials and client advocates believe that reasonable alternatives exist for many individuals in state-run homes.

The department operates seven small community behavioral health hospitals for adults, all of which have opened since 2006. Because these hospitals have no security staff, they sometimes do not admit patients with histories of violence or aggressive behaviors. Such patients often remain in nonstate hospitals, which have struggled to provide appropriate services. To better serve as the provider of last resort, SOS should experiment with adding security staff to some of its hospitals.

Oversight and accountability of state-run services have been weak.

State law authorizes the Commissioner of Human Services to govern state-operated services. But in 2000, the commissioner created a “governing board” for these services, resulting in confusing lines of authority and some violations of state law. In 2012, DHS changed the board’s composition so that its membership now consists entirely of SOS administrators. However, the need for a governing board remains unclear.

At times, DHS leaders have not given sufficient attention to the internal oversight of state-run services. While it is encouraging that DHS’s deputy commissioner provided active oversight of SOS activities in 2012, state-run services will need sustained, effective leadership to succeed.

DHS has provided the Legislature and general public with little information on the performance of state-run services. In biennial budgets covering a 12-year period, DHS provided data on only two performance measures. Also, DHS’s public and internal Web sites have provided limited data for evaluating the performance of state-run services. Department management should ensure greater accountability and transparency for SOS activities.

There has been instability in some high-level SOS positions, partly reflecting personnel decisions within the department. For example, two key positions (chief administrator of the Minnesota Security Hospital and SOS chief operating officer) were filled in 2011 and 2012, respectively, but the hired individuals were replaced months later.

Management has not adequately addressed some persistent service delivery problems.

State-run hospitals—especially the Anoka-Metro Regional Treatment Center—have had a history of keeping many patients hospitalized longer than necessary. This has partly reflected limited post-hospital placement options. The 2009 Legislature required DHS to develop a plan for the Anoka facility, but DHS’s response offered few specifics, and DHS eventually postponed its proposed action indefinitely. As of September 2012, nearly 40 percent of Anoka’s beds were occupied by patients who no longer needed hospital care.

Many patients have remained at state-run facilities longer than necessary.

A 1999 U.S. Supreme Court ruling said that undue institutionalization of individuals with mental disabilities is discriminatory. DHS did not begin developing a comprehensive plan for complying with the court's ruling until it was required to do so by a 2011 agreement reached in response to a lawsuit. The department's plan is scheduled to be completed in mid-2013.

The department's start-up of small behavioral health hospitals for adults in recent years facilitated the closure of larger institutions. But some have had problems attracting and retaining psychiatric staff. One repeatedly failed to meet the standards required to bill for federal health care payments, costing the state several million dollars in reimbursements. These small hospitals have the potential to serve an important role, but perhaps they should collaborate more closely with nonstate hospitals. Such collaboration may require financial incentives; DHS's previous effort to establish partnerships was unsuccessful.

State-Operated Services has struggled to contain workplace safety problems at state-run facilities. In 2012, the reported number of physical assaults within SOS grew sharply. Also, many state-run facilities have high workplace injury rates. State-Operated Services recently implemented an improved system for documenting and tracking workplace incidents, but SOS policies on incident reporting and follow-up remained in need of clarification.

Inappropriate use of patient restraint and seclusion led to the closure of one facility (Minnesota Extended Treatment Options) and a conditional license for another (Minnesota Security Hospital). Since the Security Hospital restricted the use of these practices in 2011, line staff have felt ill-prepared to deal with difficult patients.

The Minnesota Security Hospital has had ongoing management problems for years. For example, there have been unresolved questions about the balance between security and treatment, and staff reporting relationships have sometimes been unclear. The facility's current managers are trying to address many problems, but it remains too soon to determine their success. The Security Hospital has had too few psychiatrists for the past year, and the amount of structured mental health treatment it provides for patients is modest.

Addressing workplace safety, providing appropriate treatment, and ensuring an adequate continuum of services remain ongoing challenges.

Many patients have stayed at the Security Hospital for years, partly reflecting a lack of placement options. DHS should, working with the Legislature if necessary, ensure that services exist for individuals ready to leave the Security Hospital and other state-run facilities—whether these options are run by DHS or other providers.

State law should require periodic court review of civil commitments, and DHS should receive court data on commitments to DHS.

Many individuals enter state-run facilities following an involuntary civil commitment by a district court. During a recent 18-month period, the courts committed nearly 4,000 individuals as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous.

Statewide, courts vary in the extent to which they have civilly committed individuals. Annual commitments per 10,000 population have ranged from less than 6 in some judicial districts to about 16 in another.

The statutory definitions of “mentally ill” and “mentally ill and dangerous” used for purposes of commitment overlap with each other. As a result, different judges may make different commitment decisions when faced with similar individuals who pose public safety risks.

Unlike most states, Minnesota allows some commitments to be indeterminate in length, without prescribing time periods for judicial review of the commitment. The Legislature should require the courts to periodically review the commitments of individuals as mentally ill and dangerous or as developmentally disabled.

DHS should be aware of all individuals for which a court has assigned responsibility to DHS. State courts do not currently provide complete information to DHS on such commitments, but they should. To help DHS conduct background checks of applicants for firearms, current law requires courts to inform DHS about individuals committed to non-DHS facilities; often, however, the courts have not done so. DHS uses multiple information sources to conduct firearms-related background checks, but the process does not appear to be entirely reliable.

Summary of Agency Response

In a letter dated February 8, 2013, Minnesota Department of Human Services Commissioner Lucinda Jesson said the report “clearly and accurately identifies the issues facing the department as we work to provide a safe and caring environment for our clients and employees.” She said the department supports the report’s key recommendations, “which are largely consistent with our own assessments and ongoing efforts to address areas needing improvement.” For example, she said the department will work on developing better placement opportunities for clients ready for discharge from its facilities and bring plans to the Legislature regarding the role of certain facilities.

More Information

The Program Evaluation Division was directed to conduct this study by the Legislative Audit Commission in March 2012. For a copy of the full report, entitled "State-Operated Human Services," 157 pp., published in February 2013, please call 651/296-4708, e-mail Legislative.Auditor@state.mn.us, write to Office of the Legislative Auditor, Room 140, 658 Cedar St., St. Paul, MN 55155, or go to the Web page featuring the report. Staff who worked on this project were: Joel Alter (project manager), David Kirchner, Jo Vos, and Maura Shramko, with assistance from Emi Bennett.

Appendix R: Endnotes

---

[1] Minnesota Department of Health, “Evaluation of Health and Human Services Regulatory Responsibilities.” February 2012. Accessed June 20, 2013, http://archive.leg.state.mn.us/docs/2012/mandated/120263.pdf.

[2] Office of Ombudsman for Long-Term Care and Minnesota Board on Aging. “Housing with Services Assisted Living Medical Assistance Study” March 2013. Accessed September 4, 2013, http://www.leg.state.mn.us/docs/2013/mandated/130469.pdf.

[3] Ibid.

[4] Laws of Minnesota 2012, chapter 247, article 2, section 9

[5] Office of the Legislative Auditor, “State-Operated Human Services.” February 2013. 115. The full report is available online at http://www.auditor.leg.state.mn.us/ped/pedrep/sos.pdf.

[6] Minnesota Statute 2013, 246.014 (a) and (b)

[7] Ibid. 31-32.

[8] Ibid. 23.

[9] Ibid. 128.

[10] This was noted in the OLA report and given further coverage in David Ferleger’s “Status Report on Compliance,” June 11, 2013, (the independent consultant and monitor report to the federal district court regarding the settlement resolving litigation around the Cambridge METO program closing).

[11] Minnesota Session Laws 2012, Chapter 257, Article 2, Section 9

[12] Span, Paula, “The Safety Dance.” *The New York Times*, June 16, 2010. Accessed June 7, 2013, http://newoldage.blogs.nytimes.com/2010/06/16/the-safety-dance/.

[13] See discussion of Jensen agreement in see section on *Recent Examinations of Risk Issues* and in Appendix B.

[14] Medicaid or Medical Assistance Waivers: States can obtain waivers of standard Medicaid to test ways of delivering and paying for health care services. There are four primary types of waivers and demonstration projects. In this report, “waivers” generally refers to HCBS waivers. These are waivers for providing LTC services in home and community settings rather than institutional settings.

[15] Ng, Terence, Alice Wong and Charlene Harrington, “Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans,” last modified May 2013. Accessed June 20, 2013, http://www.pascenter.org/olmstead/.

[16] Office for Civil Rights at the US Department of Justice, “Statement of the Department of Justice on Enforcement of the Integration mandate of Title II of the Americans with Disabilities Act and Olmsted v. L.C.” Accessed June 5, 2013, http://www.ada.gov/olmstead/q&a_olmstead.htm

[17] *Jensen et al v. Minnesota Department of Human Services, et al.* Court File No. 09-cv-1775, Document 103. Filed 06/23/11. The full settlement can be found on the Office of the Ombudsman for Mental Health and Developmental Disabilities website at http://mn.gov/omhdd/images/METO-Full-Settlement-Agreement.pdf.

[18] State of Minnesota Olmstead Planning Committee, “About the Olmstead Plan.” Accessed June 20, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_about

[19] See also related documents under “data” at the Olmstead Planning Committee website archive. Minnesota Department of Human Services, “Minnesota’s Olmstead Plan: Archives” Accessed June 5, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_archive.

[20] “Person-centered” and “person-directed” are used generally and sometimes interchangeably in this report to refer to this goal. Figure 1: Pioneer Network, “Continuum of Person-Directed Culture.” Accessed June 9, 2013, http://www.pioneernetwork.net/Providers/Continuum/.

[21] Centers for Medicare and Medicaid Services, “Definition of Person-Centered Planning.” Accessed July 18, 2013, http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf.

[22] Centers for Medicare and Medicaid Services, “Self Directed Services.” Accessed June 13, 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html.

---

[23] NARA's mission is to bring the "highest quality of comprehensive, evidence-based professional development services" to human care regulatory agencies and professionals." National Association for Regulatory Administration "The NARA Vision Series Part I: Recommended Best Practices for Human Care Regulatory Agencies, First Edition." Accessed June 12, 2013, http://www.naralicensing.drivehq.com/publications/NARA_Best_Practices.pdf.

[24] Department of Human Services, "Biennial Report on Long-Term Services and Supports for People with Disabilities." January 2013. Accessed on July 18, 2013, http://www.leg.state.mn.us/docs/2013/mandated/130288.pdf.

[25] Mollica, Robert and Leslie Hendrickson, "State Long-Term Services and Supports Scorecard: What Distinguishes High- from Low-Ranking States? Case Study: Minnesota." American Association of Retired Persons, May 2012. Accessed July 20, 2013, http://www.longtermscorecard.org/~/media/Files/Scorecard%20site/Report/Case%20Studies/AARP758_Minnesota_May8_FINAL.pdf.

[26] Minnesota Statutes 2012 § 256B.097, Subd. 3d (3, 4)

[27] MnCHOICES is a new state tool and process for assessment, and is discussed in later in this report (see section on *Assessment and Plans*).

[28] See the OPC's risk recommendations in Appendix D and the full report is at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158264

[29] State of Minnesota Olmstead Subcabinet. "Putting Olmstead's Promise into Practice: Minnesota's Olmstead Plan. Draft-June 2013." Accessed June 19, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177099.

[30] Minnesota Department of Health. "MDH Mission, Vision, Values and Goals." Accessed June 9, 2013, http://www.health.state.mn.us/about/mission.html. Also, MDH's Goals Framework includes 18 goal statements, such as "Health care in Minnesota is safe, family and patient-centered, effective and coordinated"; "Minnesota's infrastructure for health is strong, people-centered and continues to improve" and "Minnesota's health systems are transparent, accountable and engage many diverse partners." Minnesota Department of Health. "Minnesota Department of Health Vision, Mission, and Goals: A Framework for Public Health." Accessed June 6, 2013, http://www.health.state.mn.us/about/goals.pdf.

[31] Minnesota Statutes 2012 § 245.03, Subd. 2; Minnesota Statutes 2012 § 144.05, Subd. 1.

[32] Minnesota Department of Human Services. "Mission and values." Accessed June 20, 2013, http://mn.gov/dhs/about-dhs/mission-and-values.jsp.

[33] Minnesota Statutes 2012 § 144.05

[34] Minnesota Statutes 2012 § 144A.45, Subd. 1 (1).

[35] Minnesota Statutes 2012 § 144A.04, Subd. 3 (a).

[36] Minnesota Statutes 2012 § 144.651, Subd. 5, 6, 9 and 10. The Bill of Rights applies to people receiving chronic care, including residents of health care facilities (e.g., nursing homes) and certain residential and community based programs for people with chronic physical or mental health issues. Minnesota Statutes 2012§ 144.651, Subd 2.

[37] Minnesota Statutes 2012 § 144.651, Subd. 12 .

[38] Minnesota Statutes 2012 § 256B.0659.

[39] Minnesota Statutes 2012 § 245.472, Subd. 1 (1-4). Also, Minnesota Statutes 2012 §256B.40 describes the purpose of HCBS as: (i) "promote the support of people with disabilities in the most integrated settings; (ii) expand the availability of services for persons who are eligible for [MA]; (iii) promote cost-effective options to institutional care; and (iv) obtain federal financial participation

[40] Minnesota Statutes 2012 § 245B.02, Subd. 14.

[41] Minnesota Statutes 2012 § 625.557, Subd. 1.

[42] The licensing standards (245D.01 to 245D.10) will replace the county contracts that lead agencies have with HCBS providers in January 1, 2014.

[43] See Appendix E for more information on excerpts from statutes. This section contains just a few examples. (Laws of Minnesota 2013, Chapter 108, Article 8).

[44] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 29, Subd. 1a (b(3)(iii)); amends 245D.07.

[45] For example, HCBS provider license holders must ensure the service site is safe and hazard-free, document assessment of the physical plant, and if doors are locked from the inside, identify risk factors requiring use of locked

---

door and statement of specific measures to be taken to minimize the safety risk to person receiving services at the service site.

[46] Laws of Minnesota 2013, Chapter 108, Article 11, Sec. 9, Subd. 1(1); amends 144A.45)

[47] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 60, Subd. a(2))

[48] The service plan must be revised, based on client review.The statute's description of service planning focuses on services to be provided, fees, identification of staff who will provide the services, staff supervision, and contingency plans. Laws of Minnesota 2013, Chapter 108, Article 11, Sec. 19 Subd. 8(f) In another example of differences in supervision, HCBS waivers include self-directed service options which allow people to supervise certain services and tasks, while the home care statute specifies the need for comprehensive service providers to delegate home care tasks and supervise unlicensed personnel. Laws of Minnesota 2013, Chapter 108, Article 11, Sec. 19 Subd. 2.

[49] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 29, Subd. 1 (b); amends 245D.07.

[50] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 24, Subd. 2 (2); amends 245D.04.

[51] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 22, Subd. 29 (a); amends 245D.02.

[52] Laws of Minnesota 2013, Chapter 108, Article 8, Sec. 29, Subd. 1a (b(3)(iii)); amends 245D.07.

[53] Service plans are discussed in the next section.

[54] Minnesota Department of Human Services. "MnCHOICES Assessment Content." Accessed June 13, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158687.

[55] Minnesota Statutes 2012 § 245B, Subd. 2 (b)

[56] More than 70 percent of the people who receive these services are age 65 or older, but services are available to people of all ages with long-term or chronic care needs. The LTCC teams, accessed through counties, make recommendations for community services or nursing facility admission when community-based services are not feasible; the person makes the final decision about services. Individuals seeking to reside in a Housing With Services establishments (for assisted living) are required, with some exceptions, to require to receive LTCC prior to signing a lease or contract. LTCC consultations are required to coordinate with the Senior and Disability Linkage Lines. Minnesota Department of Human Services. "Aging: Long-Term Care Consultation Services help people make decisions about LTC." Accessed June 6, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006098.

[57] Minnesota Department of Human Services. "Rule 25." Accessed June 7, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=135230.

[58] Minnesota Department of Human Services. "Case Management Services – Adult Mental Health Targeted Case Management (AMH-TCM)." Accessed June 7, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=132311.

[59] Minnesota Department of Human Services. "Home Health Aide." Accessed June 7, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000823.

[60] Minnesota Department of Human Services. "PCA Consumer Information: Assessment and service plan." Accessed June 7, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161204#.

[61] Minnesota Statutes 2012 § 256B.092, Subd. 1b.

[62] Minnesota Department of Human Services. "CDCS-Process and Procedures." Accessed June 7, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_048204#serviceplanning.

[63] Minnesota Department of Human Services. "MnCHOICES: What is the Context for Change?" January 25, 2013 presentation to the Minnesota Association of Counties. Accessed June 7, 2013, http://www.mncounties.org/Meetings/webinar_archive.html. See more information about MnCHOICESS in Appendix J.

[64] Minnesota Department of Human Services. "MnCHOICES FAQs: Role of Certified Assessors and Case Managers." Accessed June 7, 2013, http://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=118013#P50_9906.

---

[65] Minnesota Department of Human Services. "MnCHOICES Assessment Content." Accessed June 13, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158687.
[66] Minnesota Statutes 2012 § 245B, Subd. 2 (b)
[67] Minnesota Statutes 2012 § 245A.65 Subd. 3.
[68] Laws of Minnesota 2013, Chapter 108, Article 8
[69] Laws of Minnesota 2013, Chapter 108, Article 8, Sect. 30(Subd.2; amends 245D.071, requiring APPs per Minn. Stat. 245A.65, subd. 2.
[70] Minnesota Statutes 2012 § 245A.65 Subd. 2.
[71] Ibid.
[72] Centers for Medicare & Medicaid Services. "Assurance 4 - Health and Welfare." Accessed June 7, 2013, http://www.hcbsassurances.org/healthwelfare/health1.html.
[73] Minnesota Department of Human Services. "Home and Community-based Waiver Services Contract." Accessed June 6, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_136716.
[74] The home care services may be provided by the AL facility (which has a home care license), through the AL facility (which contracts with a licensed home care agency) or a resident could receive services from another licensed home care agency. Aves, Lynn, Randall Chun, Emily Cleveland and Danyell Punelli. "Regulation of Health and Human Services Facilities." House Research Department, June 2012. Accessed June 20, 2013, http://www.house.leg.state.mn.us/hrd/pubs/hhsfacl.pdf.
[75] Minnesota Statutes 2012 § 144G, Subd. 4.
[76] An entity registered with MDH as a "housing with services" establishment (i.e., Assisted Living).
[77] Minnesota Department of Health. "Uniform Consumer Information Guide." Accessed June 7, 2013 http://www.health.state.mn.us/divs/fpc/profinfo/lic/UCIguide.html.
[78] For example, the Star Tribune has reported on a "sharp increase"—and backlog—in serious allegations of maltreatment of vulnerable adults and children (April 4, 2013), the death of a person with a disability in a group home who was left alone while bathing (January 12, 1012), a nursing home worker who was found to have neglected a resident who fell and broke two bones (May 2, 2013) and a rise in assaults at state-operated facilities (February 28, 2012).
[79] Ombudsman for Mental Health and Developmental Disabilities. "2008/2009 Biennium Report to the Governor." Accessed June 21, 2013, http://mn.gov/omhdd/images/0809bienniumreport.pdf.
[80] This study did not look at information from the managed care ombudsman related to chronic care services. This information is less readily available, and much of chronic care is delivered through fee-for-service (e.g., the Elderly Waiver is the only waiver for which health plans are contractually obligated to provide services).
[81] Minnesota Department of Health. "Complaint Investigations of Minnesota Health Care Facilities." Accessed June 12, 2013, http://www.health.state.mn.us/divs/fpc/dec2012ohfcrpt.pdf.

[82] Leslie, Karen Mary,"Harm Reduction: An Approach to Reducing Risk Health Behaviours in Adolescents." *Paediatrics & Child Health*, 13(1): January 2008: 53-56.
[83] Miller, Edward Allen and William G. Weissert. "The Commonwealth Fund Survey of Long-Term Care Specialists." *Medical Care Research and Review*, Aug. 2010 67(4 Suppl.):3S–15S. Accessed July 11, 2013, http://www.commonwealthfund.org/Publications/Literature-Abstracts/2010/Aug/Survey-of-Long-Term-Care-Specialists.aspx
[84] Kane, Rosalie. "Balancing Risk and Safety." (Presentation at the *Beyond Olmstead: Community-Based Services for All People with Disabilities* workshop in Chicago, Illinois, July 11-13, 2001).
[85] Emphasis added. Minnesota Department of Human Services, "Empowering Choice." Minnesota Department of Human Services. "Minnesota's Olmstead Plan: Archives" Accessed July 18, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_archive.
[86] Span, "The Safety Dance."
[87] Agency for Healthcare Research and Quality. "Long-term Care for Older Adults: A Review of Home and Community-based Services Versus Institutional Care," November 7, 2012. Accessed June 9, 2013,

---

http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1276&pageaction=displayproduct

[88] Miller and Weissert, “The Commonwealth Fund Survey.”

[89] Emphasis added. Department of Homeland Security: Risk Steering Committee. “DHS Risk Lexicon.” September 2010. Accessed June 20, 2013, http://www.dhs.gov/xlibrary/assets/dhs-risk-lexicon-2010.pdf.

[90] Ibid.

[91] Carlson, Eric M. “Protecting Rights or Waiving Them? Why 'Negotiated Risk' Should Be Removed from Assisted Living Law,” August 19, 2006. *bepress Legal Series*. Working Paper 1585. http://law.bepress.com/expresso/eps/1585/

[92] Chambers, Robert. “Consistent Decision Making by Regulators.” Council on Licensure, Enforcement and Regulation, Lexington, KY. Accessed June 20, 2013, http://clear.wildapricot.org/resources/09consistent.pdf.

[93] Pooler, Ann. “Managing Risk at the Member Level Cost Effectively.” Accessed June 21, 2013 http://www.dhs.wisconsin.gov/rfp/DLTC/1701/6RISK-Guidelines.pdf; see more excerpts in Appendix M.

[94] Congressional Budget Office. Letter to Sen. Orrin Hatch regarding tort reform. October 9, 2009. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf

[95] Rothstein, Mark. “Health Care Reform and Medical Malpractice Claims,” *Journal of Law Medical Ethics* Vol. 38, Issue 4 (Winter 2010): 871-874. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3077940/

[96] Mello, Michelle M and Allen Kachalia. “Evaluation of Options for Medical Malpractice System Reform.” A report to the Medicare Payment Advisory Commission. January 29, 2010. Accessed June 9, 2013, www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf.

[97] American Tort Reform Association. “MN Reform.” Accessed April 21, 2013, http://www.atra.org/legislation/MN.

[98] See a different (but overlapping) breakdown of “traditional” and “innovative” reforms in Mello and Kachalia, “Medical Malpractice System Reform.”

[99] Budetti and Waters, “Medical Malpractice Law.”

[100] PR Newswire. *National Clarus Poll Reveals That a Large Majority of US Voters Think Legal System Increases Cost of Health Care* (survey by Common Good). Website viewed at: http://www.prnewswire.com/news-releases-test/nationwide-clarus-poll-reveals-that-a-large-majority-of-us-voters-think-legal-system-increases-cost-of-health-care-155365335.html.

[101] Mello and Chandra, “The Cap Doesn’t Fit.”

[102] National Arbitration Forum. “Mediating and Arbitrating Long Term Care Disputes.” January 2005. Accessed, June 12, http://www.healthlawyers.org/Members/PracticeGroups/HLL/Toolkits/Documents/C_Mediating_Arbitrating_LTC_Disputes.pdf

[103] Budetti and Waters, “Medical Malpractice Law.”

[104] Mello and Chandra, “The Cap Doesn’t Fit.”

[105] Hall, Peter and John Micek. “’Fair Share’ bill headed to Gov. Corbett.” *The Morning Call*. June 27, 2011. Accessed June 9, 2013, http://articles.mcall.com/2011-06-27/news/mc-pa-tort-reform-impact-20110627_1_deep-pocketed-defendants-tom-corbett-fair-share-bill Carpey, Stuart A. “Warning: “(Un)fair Share Act” Passes.” *Avvo*. Accessed June 12, 2013, http://www.avvo.com/legal-guides/ugc/warning-unfair-share-act-passes. Anderson, Richard. “Your View: New Law Brings Fairness to Malpractice Suits.” September 13, 2011. *The Morning Call*. Accessed June 12, 2013, http://articles.mcall.com/2011-09-13/opinion/mc-tort-reform-anderson--yv-20110913_1_malpractice-suits-legal-system-civil-lawsuit

[106] Mello, “Medical Malpractice System Reform.”

[107] Lemendort, Douglas. Director, Congressional Budget Office. Letter to Honorable Orrin G. Hatch, October 9, 2009. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf

[108] Mello, Michelle and Chandra, Amitabh. “The Cap Doesn’t Fit.” *The New York Times*, July 12, 2009. Accessed June 12, 2013, http://www.nytimes.com/2009/07/12/opinion/12mello.html?_r=0.

[109] In this study, traditional reforms include caps on noneconomic damages, pretrial screening panels, attorney fee limits, joint and several liability reform, collateral source rule reform, and statutes of limitations. “Innovative reforms” include schedule of noneconomic damages, health courts, disclosure and offer programs, safe harbors for adherence to evidence-based practice guidelines.

---

[110] The National Consumer Voice for Quality Long-Term Care. “The Dangers of Tort Reform for Long-Term Care Consumers.” Accessed June 8, 2013, http://www.theconsumervoice.org/advocate/tortreform.

[111] Jenkins, Robert, Janet O’Keeffe, Paul Carder and Karen Brown Wilson. “Study of Negotiated Risk Agreements in Assisted Living: Final Report.” February 13, 2006: Washington, DC. Retrieved June 8, 2013 at: http://aspe.hhs.gov/daltcp/reports/2006/negrisk.htm.

[112] Ibid.

[113] Ibid.

[114] Kane, Rosalie. 2001

[115] *US Senate Special Committee on Aging: Assisted Living Roundtable,* 112th Cong. (Responses to Questions for the Record by Howie Groff on March 15, 2011). Accessed June 9, 2013, http://www.ahcancal.org/ncal/advocacy/Documents/11%20NCAL%20Howie%20Groff%20Responses%20to%20Aging%20Committee%20AL%20Roundtable%20Qs%20w%20attachments.pdf

[116] *US Senate Special Committee on Aging: Assisted Living Roundtable,* 112th Cong. (Responses to Questions for the Record by Howie Groff on March 15, 2011). Accessed June 9, 2013, http://www.ahcancal.org/ncal/advocacy/Documents/11%20NCAL%20Howie%20Groff%20Responses%20to%20Aging%20Committee%20AL%20Roundtable%20Qs%20w%20attachments.pdf

[117] Carlson, "Protecting Rights or Waiving Them?"

[118] Kane, Rosalie. 2001

[119] Laws of Minnesota 2013, Chapter 108, Article 8, Sec.60 Sub a(2))

[120] Lemendort, Douglas. Director, Congressional Budget Office. Letter to Honorable Orrin G. Hatch, October 9, 2009. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf

[121] This paragraph was added to the report in response to comments MDH submitted to MMB on a draft of the report. Some of the suggestions for further study come directly from MDH’s comments, and some are expanded upon or adapted from them.

[cxxii] Ny, Terence, Alice Wong and Charlene Harrington. “Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans.” Center for Personal Assistance Services. Accessed June 22, 2013, http://www.pascenter.org/olmstead/.

[cxxiii] 527 U.S. § 581 1999.

[cxxiv] Olmstead v. L.C., 527 U.S. at 607; as cited in US Department of Justice, Civil Rights Division, “Statement of the Department of Justice on Enforcement of the Integration mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.,” Accessed June 5, 2013, http://www.ada.gov/olmstead/q&a_olmstead.htm.

[cxxv] *Jensen et al v. Minnesota Department of Human Services, et al.* Court File No. 09-cv-1775. For general information on state-operated services, see also: Office of the Legislative Auditor, “Evaluation Report: State-Operated Services.” Accessed June 20, 2013, http://www.auditor.leg.state.mn.us/ped/2013/sos.htm.

[cxxvi] Olmstead Planning Committee. “About the Olmstead Plan.” Accessed June 21, 2013. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_about

[cxxvii] Executive Order 13-01.

[cxxviii] National Association of State Directors of Developmental Services, reporting on Joint Press Release of DHS and Plaintiffs – June 23, 2011. Accessed June 12, 2013, http://nasddds.org/pdf/CSR/JONT%20PRESS%20RELEASE.PDF.

[cxxix] Minnesota Statutes 2012 § 256B.097, Subd. 1 (a).

[cxxx] Minnesota Department of Human Services, “State Quality Council.” Accessed June 6, 2012, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_165559.

[cxxxi] Minnesota Statutes 2012 § 256B.097, Subd. 3d (3, 4)

[cxxxii] Olmstead-related groups are discussed in the next section.

[cxxxiii] Turner, Barb. “Risk/Choice” Presentation to the Minnesota State Quality Council on August 17, 2012. The PowerPoint presentation is available at: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_171174.pdf.

[cxxxiv] Ibid. The Risk Task Force’s mission is to “formulate proposals, develop political will and –over time- forge agreement among stakeholders to change state laws, rules and practices that transform Minnesota’s current one-size-

---

fits-all protection standards and liability-driven practices to a system that provides the appropriate balance between protections and maximum individual choice and freedom for persons receiving disability services."

[cxxxv] State of Minnesota Olmstead Planning Committee. "Draft Vision and Principles Statement." Accessed June 5, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158264. Two principles directly addressing risk are (*emphasis added*): (1)In order to support self-direction and to maximize independence, individuals with disabilities will be **empowered to make choices** for themselves on matters in their lives, just as non-disabled individuals do, including on issues which involve risks. Quality of life is enhanced when individuals with disabilities **gain more control in their lives including deciding whether to take a risk**. (2)The goals when developing individual services and supports will include accessibility, quality, person-centered planning and wherever possible, **individually-controlled decision-making**. An accurate ongoing and comprehensive system of **assessment** of an individual's abilities and functional limitations will be available to facilitate the individual in making choices about supports and services.

[cxxxvi] State of Minnesota Olmstead Planning Committee. "Empowering Choice – Recommendations-Final Draft" Accessed June 5, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158264.

[cxxxvii] Ibid. The ADA Title II (state and local governments) regulatory restriction permitting exclusion of a person with a disability only if the disability would pose a direct threat to others and not to self is found at 28 C.F.R. § 35.109. Similar ADA language applicable to private places of public accommodations, including social service agencies, may be found at 42 U.S.C. § 12182(d) (3) and 28 C.F.R. § 36.208.

[cxxxviii] MnCHOICES is a new state tool and process for assessment, and is discussed in later in this report (see section on *Assessment and Plans*).

[cxxxix] See the OPC's risk recommendations in Appendix I and the full report is at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=158264

[cxl] Dayton, Mark. Executive Order 13-01. "Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Creation of Minnesota's Olmstead Plan." January 28, 2013. http://mn.gov/governor/images/EO-13-01.pdf

[cxli] State of Minnesota Olmstead Subcabinet. "Putting Olmstead's Promise into Practice: Minnesota's Olmstead Plan. Draft-June 2013." Accessed June 19, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177099.

[cxlii] Minnesota Department of Human Services, "Empowering Choice."

[cxliii] Hall-Lande, J.; A. Hewitt, M. Bogenschutz, and T. Laliberte. "County Administrator Perspectives on the Implementation of Self-Directed Supports," *Journal of Disability Policy Studies*, Feb. 16, 2012. P. 247–256.

[cxliv] Assistant Attorney General Thomas E. Perez, Testimony Before the U.S. Senate Committee on Health, Education and Pensions, June 21, 2012. P. 5.

[cxlv] The ADA Title II (state and local governments) regulatory restriction permitting exclusion of a person with a disability only if the disability would pose a direct threat to others and not to self is found at 28 C.F.R. § 35.109. Similar ADA language applicable to private places of public accommodations, including social service agencies, may be found at 42 U.S.C. § 12182(d)(3) and 28 C.F.R. § 36.208.

[cxlvi] Crisis respite, SILS, residential services, DTH and supported employment services are licensed under Minnesota Statute § 245B. Supported employment funded under the CADI or BI waivers is not subject to licensure under § 245B.

[cxlvii] Minnesota Health Care Reform Task Force. "The Minnesota Accountable Health Model." Accessed June 20, 2013, http://mn.gov/health-reform/health-reform-in-Minnesota/.

[cxlviii] Minnesota Department of Health. "Health Reform Minnesota: About Minnesota's Health Care Homes (aka Medical Homes)." Accessed June 6, 2013, http://www.health.state.mn.us/healthreform/homes/about/.

[cxlix] Minnesota Department of Human Services. "Adult mental health reform 2020 steering committee and workgroups." Accessed June 6, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_171741#P40_3299

[cl] Minnesota Department of Human Services. "Reform 2020 Section 1115 Waiver Proposal" and "Reform 2020: Pathways to Independence waiver proposal-November 2012." Accessed June 6, 2013,

---

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_169839#.

[cli] Members represented DHS, other agencies and many private organizations created five subgroups. Minnesota Department of Human Services, "Steering committee and workgroups."

[clii] Minnesota Health Care Reform Task Force, "Health Care Reform Task Force." Accessed June 21, 2013, http://mn.gov/health-reform/health-reform-in-Minnesota/health-care-reform-task-force/.

[cliii] Minnesota Department of Health, "Eliminating Health Disparities Initiative (EHDI) Community Grants Program." Accessed June 22, 2013, http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

[cliv] Ibid.

[clv] Association of State and Territorial Health Officials, "Minnesota: Building on a Strong Foundation." Accessed June 21, 2013, http://www.astho.org/uploadedFiles/Programs/Access/Maternal_and_Child_Health/Disability_Case_Studies/Minnesota%20Case%20Study%2020111206.pdf.

[clvi] In general, "several" refers to 5 to 10 interviewees, "many" refers to 10+ and "a few" refers to 2 to 4.

[clvii] Some providers may already have access to risk/insurance pools (e.g., Minnesota Statutes 2012 § 245.814, Insurance for foster home providers).

[clviii] Interviews suggest that sometimes promoting more client choice/risk requires more staffing (to monitor risk, promote options, help person implement choices) and sometimes it requires less staff (e.g., using technology to monitor the person part of the day instead of 24-hour in-person supervision).

[clix] These excerpts were taken directly from the guidelines cited above; however, subtitles and emphasis were added (bold); changed text to use acronym for long term care; and made some minor formatting changes (e.g., type of bullets used). Pooler, Ann. "Managing Risk".

[clx] Mello, Michelle. "Understanding Medical malpractice Insurance: A Primer." The Robert Wood Johnson Foundation: Research Synthesis Report No. 8: January 2006. Accessed June 20, 2013, http://www.rwjf.org/content/dam/farm/reports/reports/2006/rwjf17974.

[clxi] American Tort Reform Association, "MN Reforms."

[clxii] Meaning of "collateral sources": "Fairness concerns have also arisen over the longstanding practice of letting injured persons collect the full amount of judgments in lawsuits even if part of their losses also are paid for by insurance or some other source. These other sources of payment are often referred to as "collateral sources." The argument for not reducing a plaintiff's award by amounts received from collateral sources rests in part on the view that a negligent defendant should not benefit from actions that the plaintiff has taken to protect him or herself." Budetti, Peter and Waters, Teresa. "Medical Malpractice Law in the United States." Kaiser Family Foundation: May 2005. Accessed June 20, 2012, http://kff.org/health-costs/report/medical-malpractice-law-in-the-united-states/.

[clxiii] American Tort Reform Association, "MN Reforms."