#07-25-04

Bulletin

September 4, 2007

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- LTCC Administrative Contacts
- Managed Care Organizations
- Tribal Health Directors

ACTION/DUE DATE

Please submit HCBS quality plan via web survey and the provider inventory by email attachment.
Web-based Survey is due: October 15, 2007 .
Provider Inventory is due: October 1, 2007.

EXPIRATION DATE

September 4, 2009

Submission of the Annual Quality Assurance Plan for Home & Community Based Service Programs for CY08

TOPIC

Annual Plan for Quality Assurance for Home and Community Based Services (HCBS).

PURPOSE

Notify county agencies, tribal health directors and health plans administering home and community based waiver programs, or Long Term Care Consultation or Alternative Care programs that an updated annual plan for quality assurance, monitoring, and assessment is due and can be submitted via a web-based survey for CY2008.

CONTACT

Quality Assurance: Jolene Kohn at (651) 431-2579 or at Jolene.Kohn@state.mn.us
Annual Quality Plan: Sarah Myott at (651) 431-2571 or at Sarah.M.Myott@state.mn.us

SIGNED

LOREN COLMAN
Assistant Commissioner
Continuing Care Administration

Annual Quality Assurance Plan
Home & Community Based Services Programs
CY 2008

The Home and Community-Based Quality Assurance Plan (HCBS QA Plan) is submitted annually by each county, tribe or managed care organization (MCO) (collectively referred to as "lead agencies") administering the following programs: Long Term Care Consultation, Alternative Care, Elderly Waiver, Community Alternatives for Disabled Individuals Waiver, Developmental Disabilities Waiver, Traumatic Brain Injury Waiver, and Community Alternative Care Waiver.

Purposes of the HCBS QA Plan

The purpose of the HCBS QA Plan is to ensure the communication of federal and state requirements and expectations from the state to lead agencies managing HCBS programs and to provide a mechanism for the lead agency to document and explain how it meets those requirements and expectations through practices, policies, and activities. In addition, the document provides the state with an important tool to help monitor quality assurance at the lead agency level.

Community Social Service Act Repeal

In the past, the HCBS QA Plan was submitted as part of the Community Social Services Act (CSSA) Biennial Plan as a convenience to counties. While CSSA legislation was repealed in the 2003 Legislative Session, the state still has an obligation to communicate quality assurance expectations to HCBS program administrators. In addition, HCBS programs are now administered and managed by tribal governments and MCOs under contract with the department. All lead agencies must continue to provide documentation that quality assurance practices, policies, and activities necessary to achieve desired program outcomes are in place for those HCBS programs they administer.

Web Survey: Submission of the CY 2008 Annual HCBS QA Plan

In order to streamline both submission of the HCBS QA Plan and the department's ability to efficiently summarize the lead agency responses, this plan has been translated into a web-based survey.

Part I. Contact Information: Requests information about agency assignments for each program. This information is used to update phone contact and mailing lists, as well as to provide a contact person if there is a need for follow up on this plan.

Part II. Quality Assurance Assessment & Plan: In order to complete the HCBS QA Plan, the lead agency must assess and verify that they have practices, procedures, and policies in place necessary to carry out listed quality assurance activities and are implementing programs appropriately at the local level.

County and Tribal Lead Agencies: Fee-for-Service HCBS Purchasing and Delivery
The county and tribal lead agency web-based survey can be accessed and completed at http://survey.dhs.state.mn.us/snap/Aging/QAPlans/MNQACountytribe/qaplancountytribe.htm

Attachment A represents the work planning version of the survey to be submitted by each county and tribe managing fee-for-service HCBS programs. An electronic copy of Attachment A will be forwarded to the Long Term Consultation Administrative contact. The current list of these contacts will also be forwarded as an electronic attachment; please review and ensure the appropriate staff receive this bulletin and all attachments. If information needs to be updated, Attachment B can be forwarded to Diane.Mangan@state.mn.us.

An electronic work planning version of the survey forwarded to the Long Term Care Administrative contact. It is recommended that county or tribal staff use the work planning version of the HCBS QA Plan to prepare the formal responses for completion of the web-based survey. You may also choose to complete this work plan document first and use it as your record of your lead agency's responses to the survey. Although you may use this document for planning and recording your lead agency's response, **you must still submit your answers through the web-based survey.** It is estimated the survey will take 45-90 minutes to complete with some previous preparation.

It is recommended that one staff person enter the responses directly into the web-based survey. You may also choose to print a copy of your online survey response, but may find some limitations with this. Note the instructions on the web survey with respect to printing each page if the agency wants a record of the electronic survey responses.

Please complete the web survey no later than October 15, 2007. If you have trouble using the survey tool, please contact Sarah Myott at 651-431-2571, or at Sarah.M.Myott@state.mn.us.

Managed Care Organizations

Managed care organizations under contract with the department to manage HCBS programs will receive communication from the Special Needs Purchasing division at the department regarding the web address for the health plan version of the survey, as well as work planning documents similar to Attachment A.

MCOs are also required to complete the web survey no later than October 15, 2007. If you have trouble using the survey tool, please contact Sarah Myott at 651-431-2571, or at Sarah.M.Myott@state.mn.us.

Part III. Provider Capacity: Contract Inventory

In order to have more detailed information available at the state level regarding HCBS provider capacity and consumer choice, the 2008 plan includes a separate inventory to be completed by all lead agencies of all contracted HCBS providers. Attachment C is a sample of the inventory to be completed by counties and tribes. This inventory will **not** be submitted as part of the web-based survey, but is required as part of documentation of assurances captured in the Annual Quality Plan related to provider capacity and consumer choice in HCBS programs.

This inventory worksheet will be forwarded to the Long Term Care Consultation Program Administrative contact as an Excel spreadsheet and is to be completed and returned as an email attachment to Sarah Myott at Sarah.M.Myott@state.mn.us **no later than October 1, 2007.** This earlier submission will also allow this information to be included in the county and tribal profile data that will be provided by the state as part of the upcoming "Gaps Analysis" survey to be posted on the web in October 2007.

Managed care organizations (MCOs) will receive a similar spreadsheet as an attachment to the communication from the Special Needs Purchasing Division referenced above. Each MCO will complete an HCBS provider inventory for each program the MCO is under contract to manage, by county. MCOs are asked to complete this spreadsheet and return as an email attachment to Sarah Myott at Sarah.M.Myott@state.mn.us **no later than October 15, 2007**.

The Federal Quality Framework for HCBS

Using federal requirements developed as part of a quality framework and federal reviewers' guide published as a final working draft for states in February, 2004, the HCBS QA Plan organizes quality assurance activities around "focuses" related to:

1. Participant Access
2. Participant-Centered Services Planning and Delivery
3. Provider Capacity and Capabilities
4. Participant Safeguards
5. Participant Rights and Responsibilities
6. Participant Outcomes and Satisfaction
7. Systems Performance

The lead agency performs roles and carries out responsibilities for quality assurance activities in all domains outlined above. The HCBS QA Plan uses these responsibilities and focus areas or domains to help assess and organize those agency activities.

The federal quality framework for assessing HCBS quality can be found at http://www.cms.hhs.gov/HCBS/04_CMSCommunications.asp#TopofPage
While most items included in this self-assessment and planning document have appeared in

previous HCBS quality assurance plans submitted by lead agencies, the items were reorganized in 2005 and rewritten to reflect the work at the federal and state level regarding quality assurance in community-based settings. In addition, there are new items related to lead agency self-evaluation and self-assessment of performance.

It is hoped that completion of the Provider Inventory and the Quality Assurance plan will assist lead agencies in developing their quality assurance programs, as well as provide assurances to the Department of Human Services that federal requirements for implementing and monitoring the provision of waiver services and consumer health and safety and choice are met.

Home and Community-Based Programs Included in This Plan:

Alternative Care Program: State-funded home and community-based services program similar to the Elderly Waiver for persons 65 and older with nursing facility level of care needs (AC)

Community Alternative Care Waiver: Home and community-based waiver program for persons with hospital level of care needs (CAC).

Community Alternatives for Disabled Individuals Waiver: Home and community-based waiver program for persons under 65 with nursing facility level of care needs (CADI)

Elderly Waiver: Home and community-based waiver program for persons 65 and over with nursing facility level of care needs (EW).

Long Term Care Consultation Program: Program providing a variety of services available to all citizens regardless of age, disability, or eligibility for Minnesota Health Care Programs.

DD Waiver: Home and community-based waiver program for persons with developmental disabilities or a related condition with ICF/MR level of care needs.

Traumatic Brain Injury Waiver: Home and community-based waiver program for persons with a brain injury and either nursing facility level of care (TBI-NF) or neurobehavioral hospital level of care needs (TBI-NB).

SPECIAL NEEDS
This information is available in other forms to people with disabilities by contacting us at (651) 431-2500 (voice) or toll free at 1 (800) 882-6262. TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

ANNUAL QUALITY ASSURANCE PLAN

For HCBS Purchased and Delivered
Under Fee-For-Service by Counties and Tribes
For 2008

WORK PAPER

Each county or tribe (Lead Agency) administering Home and Community-Based Services (HCBS) must annually complete and submit a plan for quality assurance (the QA Plan). Completion of the QA Plan will assist Lead Agencies in assessing the adequacy of their quality assurance strategies and activities. Submission of the QA Plan provides assurances to the Department of Human Services ("the Department" or "DHS") that state and federal requirements related to the design and implementation of HCBS programs are met, and that the provision of waiver services and consumer health and safety are monitored.

When submitted, the QA Plan provides administrative verification that the Lead Agency:

- Is implementing the HCBS programs according to requirements
- Is carrying out delegated quality assurance, monitoring, and assessment activities necessary to achieve desired HCBS program outcomes
- Has policies and practices in place to ensure the health and safety, and participation and choice-making of enrollees participating in the HCBS program.

Introduction
In order to complete the QA Plan, the Lead Agency must assess and verify that there are practices, procedures, and policies in place necessary to carry out listed quality assurance activities, and that the Lead Agency is implementing HCBS programs appropriately. While not required to be attached to the QA Plan when submitted, the Lead Agency must be able to provide tangible evidence to verify their answers to each question on this survey. Requirements addressed in this QA Plan will be verified in the course of other DHS quality management activities, such as community support care plan audits, lead agency visits, and routine requests for information by DHS.

Survey Instructions
We request only one completed survey from each lead agency. The average time to complete the survey will vary from 45-90 minutes.

Please answer **"yes"** or **"no"** to each statement about quality assurance activities as they are implemented by the Lead Agency. Brief summaries of these activities can also be recorded on the QA Plan.

For items answered "No", the Lead Agency must complete a section outlining their proposal to meet the requirement. This proposal must include the strategy for addressing each component, specific time lines, and objectives and/or methods. DHS will work cooperatively with Lead Agencies to address these items when possible.

For open-ended questions, please note that on the web-based survey, you will only have **500 characters** of space for your response. Please take this into consideration as you are completing this working paper.

You will be required to answer all items on the web-based survey. The exceptions are when a question is labeled as "optional".

Items preceded by an asterisk * indicates activities recommended by DHS but not required under the federal HCBS quality protocol.

The term "consumer" encompasses the person to whom services are being delivered. In cases where consumers are not able to make their own decisions or speak for themselves, the term "consumer" refers to their legal representative.

Contact Information:

The focus areas or domains contained in the QA Plan are organized to reflect federal and state requirements regarding quality assurance in community-based settings. The person whose name appears below will be considered the contact person for questions about the quality assurance plan for all domains unless otherwise indicated below.

Name of Person Completing the QA Plan:

A.1 First Name _____

A.2 Last Name _____

A.3 Name of Lead Agency _____

A.4 County or Tribe _____

A.5 Address_____

A.6 Phone_____

A.7 Email_____

A.8 Is the person listed above the contact for all contents of this QA Plan (i.e. all HCBS programs administered by the Lead Agency)?

____Y ____N (IF Y, skip to the next section)

A.9 If no, Second Name
_____

A.10 Phone_____

A.11 Email_____

A.12 For which programs is this other person a contact?
_____

QUALITY FOCUS AREAS

HCBS Quality Framework: All states participating in 1915(c) (Medicaid) waiver programs must provide assurances concerning the quality of care and services provided through these programs as a condition of federal approval of the state waiver plan. The Center for Medicare/Medicaid Services (CMS) organizes these assurances into a Quality Framework that focuses attention on participant-centered desired outcomes along seven dimensions:

I **Participant Access:** ***Individuals have access to home and community-based services and supports in their communities.***

II **Participant-Centered Service Planning and Delivery:** ***Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.***

III **Provider Capacity and Capabilities:** ***There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.***

IV **Participant Safeguards:** ***Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.***

V **Participant Rights and Responsibilities:** ***Participants receive support to exercise their rights and in accepting personal responsibilities.***

VI **Participant Outcomes and Satisfaction:** ***Participants are satisfied with their services and achieve desired outcomes.***

VII **System Performance:** ***The system supports participants efficiently and effectively and constantly strives to improve quality.***

The QA Plan is organized around the desired outcomes as outlined above; Lead Agency responsibilities and activities related to the implementation of the HCBS programs in accordance with state and federal requirements are listed under these outcomes.

The federal framework and related materials can be reviewed at:
http://www.cms.hhs.gov/HCBS/04_CMSCommunications.asp#TopOfPage

I Participant Access: *Individuals have access to home and community-based services and supports in their communities.*

Long Term Care Consultation Program Requirements: Under the provisions of Minnesota Statute Section 256B.0911, qualified professionals provide Long Term Care Consultation (LTCC) services to enrollees. LTCC service includes assessment of individual needs and strengths in order to make recommendations regarding long term care services. One of the results of this assessment activity is the determination of the level of care. This determination process provides access to HCBS services, and is also required for public payment of institutional services.

Indicate whether the Lead Agency LTCC staff does the following:

Information and Referral

B.1 _____Yes ____No Provides information and referral about long term care options

B.2 _____Yes ____No Carries out education activities related to the availability of HCBS

B.3 _____Yes ____No Provides early intervention activities

B.4 _____Yes ____No Provides information about the availability of assistance in applying for Minnesota Health Care Programs

Nursing Facility Admissions and Relocation Assistance

B.5 ____Yes ____No Conducts telephone or in-person screenings for nursing facility admission

B.6 ____Yes ____No Visits people under 65 admitted to facilities within timelines as outlined in law

B.7 ____Yes ____No Completes nursing facility level of care determination

B.8 ____Yes ____No Completes Level I screening for mental illness or mental retardation as required under state and federal law for facility admissions

B.9 ____Yes ____No Provides relocation assistance to assist people in returning to community settings after facility admission

Community

B.10 ____Yes ____No Provides face-to-face assessment to all citizens requesting such assistance

B.11 ____Yes ____No Completes in-person assessments within 10 working days of referral

B12. ____Yes ____No Completes Level I screening as part of community assessment

B.13____Yes ____No Develops community support plans for all citizens requesting such assistance

B.14 ____Yes ____No Provides information to the person about freedom of choice between institutional and community-based services

If you answered "no" to any of questions B.1-B.14 above, you will be asked to: *Provide a proposal or strategy to address this requirement, including timeline and persons responsible.* (These follow up questions are numbered B.15-B.28 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions B.1-B.14 (You will be asked separately about each question to which you answer "no"):

Access to Publicly-Funded Home and Community-Based Waiver programs: In addition to the requirements under the LTCC program itself, the LTCC assessment process, DD screening, level of care determination, additional assessments and support planning help establish service eligibility for several home and community-based waiver programs.

All items in this section are required under the federally approved waiver programs, Minnesota Statutes, sections 256B.0913 (AC), 256B.0915 (EW), 256B.49 (CAC, CADI, TBI), 256B.092 (DD) and Minnesota Rules, Chapter 9525, parts 9525.0004 to 9525.0036 (DD).

Indicate whether the Lead Agency:

C.1_____Y _____N Uses the Long Term Care Consultation Assessment form to complete face-to-face assessments

C.2_____Y _____N Uses the DD screening document when completing

full-team face-to-face assessments

Applies all of the following service eligibility criteria to decisions regarding consumer eligibility for all the waiver programs:

C.3_____Y _____N The person has been assessed using the required assessment tools and processes (such as TBI and CAC assessment tools)

C.4_____Y _____N The person has been determined to meet the level of care requirements (Including, when applicable, hospital, nursing facility and ICF/MR level of care determinations)

C.5 _____Y _____N The person's community support plan indicates the need for a service that is only available through one of the HCBS programs

C.6 _____Y _____N The person's community support plan will reasonably ensure health and safety

C.7 _____Y _____N There is no alternative payer for the HCBS service needed

C.8 _____Y _____N A reassessment is conducted to determine re-eligibility and care plans are subsequently updated at the required minimum frequency (every 6 months for CAC and once per year for other HCBS programs)

If you answered "no" to any of questions C.1-C.8 above, you will be asked to: *Provide a proposal or strategy to address this requirement, including timeline and persons responsible.* (These follow up questions are numbered C.9-C.16 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions C.1-C.8 (You will be asked separately about each question to which you answer "no"):

C.17 Please use this space to make any comments regarding the Lead Agency's activities regarding access to HCBS. (Optional)

Waiting Lists for HCBS Services

C.18 Please indicate the number of people your lead agency has on a waiting list for the following HCBS programs, as of September 1, 2007. If you do not have a waiting list for a program, enter "0".

a. Community Alternative Care (CAC) ___

b. Community Alternative for Disabled Individuals (CADI) ____

c. Developmental Disabilities waiver (DD) ____

d. Traumatic Brain Injury – Neurobehavioral Hospital (TBI-NB) ____

e. Traumatic Brain Injury – Nursing Facility (TBI-NF) _____

C.19 Please use this space to make any comments regarding the Lead Agency's activities regarding waiting lists for HCBS. (Optional)

II Participant-Centered Service Planning and Delivery: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*.

Lead Agency Self-Assessment: The Lead Agency must be able to demonstrate that assessment of strengths and needs is linked to care and community support planning, and that services planned are individualized, appropriate, and preferred.

Indicate whether or not the Lead Agency's community support planning, policies and practices result in a plan with the following characteristics, as required under the approved federal waiver plans. The community support plan (CSP)/Individual Support Plan (ISP):

D.1 _____Yes _____No Is based on and documents assessed needs and strengths of the individual, as expressed by that individual and/or identified in an assessment

D.2 _____Yes _____No Verifies consumer's choice between waiver services and institutional care

D.3 Reflects consumer-identified:

a. _____Yes _____No preferences
b. _____Yes _____No decisions
c. _____Yes _____No strengths
d. _____Yes _____No goals

D.4 _____Yes _____No Documents the range of service options/types that will fulfill the consumer's identified needs (including services available through state plan, formal and informal means)

D.5 _____Yes _____No Documents consumer's choice between service providers

D.6 _____Yes _____No Documents family/informal caregiver concerns and needs, as applicable

D.7 _____Yes _____No Addresses how family/informal caregiver will be supported/needs will be met, as applicable

D.8 _____Yes _____No Includes professional recommendations for supports as well as the person's choice of supports

D.9 _____Yes _____No Documents how the consumer is supported in managing any risks involved with their individual choices and identified needs

D.10 _____Yes _____No Includes the frequency and mode of case management contact

D.11 _____Yes _____No Includes provider(s), service type, frequency, and duration of services to be provided to the individual

D.12 _____Yes _____No Documents that reassessment was completed when significant change occurs, as applicable

D.13_____Yes _____No Documents changes to services that result from a reassessment

D.14 Please briefly describe the materials the lead agency currently provides to consumers to help ensure choice of services and providers and how these materials are provided.

If you answered "no" to any of questions D.1-D.13 above, you will be asked to: *Provide a proposal or strategy to address this requirement, including timeline and persons responsible.* These follow up questions are numbered D.15-D.27 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions D.1-D.13 (You will be asked separately about each question to which you answer "no"):

D.28 Please use the space below to comment on your organization's process for participant-centered service planning. (Optional)

III Provider Performance and Capacity: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*

Performance of Providers: States must be able to provide evidence to CMS that there are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants. Lead agencies carry out activities that support achievement of these desired outcomes. The next items ask that you provide evidence that provider agencies, including Housing with Services providers, which serve the waiver population meet the following provider requirements.

For the following items, please briefly describe the policies and practices your lead agency has used <u>within the last two years</u> to:

E.1 Ensure that a provider meets applicable state and federal standards

E.2 Monitor contracted service providers that are not required to be licensed or certified by the state

E.3 Monitor and review provider performance (If providers are selected for review, how are they selected, and who completes the review?)

E.4 Document the delivery of services to conform with an individual's plan of care

E.5 Maintain financial accountability

E.6 Provide oversight on behalf of individual consumers as needed or requested

E.7 Identify inadequate provider performance (please also describe the follow-up process, including persons responsible for taking actions)

Provider Capacity: Continuing Care is interested in gathering more complete information about provider capacity and competence.

For the next four items, please describe any processes the Lead Agency may have used <u>in the last two years</u> to enhance HCBS capacity and consumer choice between providers:

E.8 Assessment of the need for service providers with special knowledge, skill or background (for example, to provide support to people with dual diagnosis or communication limitations)

E.9 Recruitment of service providers

E.10 Recruitment of culturally competent providers

E.11 Please use the space below to make any additional comments regarding Provider Capacity and Performance. (Optional)

IV Participant Safeguards: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*

Lead Agency Self-Assessment: Assess the adequacy of the quality assurance system in your Lead Agency for ensuring the health and safety of waiver participants.

Indicate whether the Lead Agency:

F.1 _____Yes _____No Monitors the health and safety of the person

F.2 _____Yes _____No Evaluates unsafe home conditions

F.3 _____Yes _____No Evaluates need for supervision

F.4 _____Yes _____No Incorporates personal risk management in support planning

F.5 _____Yes _____No Has face-to-face or telephone contact with the person as indicated in the community support plan

F.6 _____Yes _____No Has communication procedures in place for the provider to follow in order to contact the Lead Agency or case manager regarding a consumer

F.7 _____Yes _____No Ensures providers have a plan for person's backup assistance when providers aren't available and lack of immediate care would pose a serious threat to health and welfare (This assurance is intended to be in place at the individual client level and to reflect individualized planning)

F.8 _____Yes _____No Ensures providers have a contingency plan for emergencies when the lack of immediate care would pose a serious threat to health and welfare (This assurance is directed at community-wide emergencies such as those posed by inclement weather)

If you answered "no" to any of questions F.1-F.8 above, you will be asked to: *Provide a proposal or strategy to address these requirements, including timeline and persons responsible.* (This follow up question is numbered F.9 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions F.1-F.8:

Indicate whether the Lead Agency has policies and practices that address the following:

F.10_____Yes _____No Prevention of abuse, neglect and exploitation

F.11 _____Yes _____No Screening for abuse, neglect, and exploitation

F.12 _____Yes _____No Identification of abuse, neglect, and exploitation

F.13 _____Yes _____No Reporting of abuse, neglect, and exploitation

(All items above are included in and required under the Vulnerable Adult Act)

F.14 _____Yes _____No Lead agency staff training directly related to abuse, neglect, and exploitation

F.15 _____Yes _____No Communication processes that create an appropriate, efficient feedback loop between Adult Protection and Lead Agency case managers

F.16 _____Yes _____No *Annually verify provider training directly related to abuse, neglect, and exploitation

If you answered "no" to any of questions F.10-F.15 above, you will be asked to: *Provide a proposal or strategy to address this requirement, including timeline and persons responsible.* (This follow up question is numbered F.17 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions F.10-F.15:

Specialized Planning for Health and Safety

F.17 _____Yes _____No *Does the Lead Agency have any particular policy or practice related to ensuring medication management plans are implemented?

F.18 _____Yes _____No *Does the Lead Agency have any particular policy or practice related to ensuring appropriate uses of behavioral services?

F.19 Please use this space to make any additional comments regarding Participant Safeguards (Optional)

V Participant Rights and Responsibilities: *Participants receive support to exercise their rights and in accepting personal responsibilities.*

Indicate whether the Lead Agency ensures the following:

G.1 _____Yes _____No Consumer receives information about their right to be free from maltreatment and how to report it

G.2 _____Yes _____No Consumer receives information about data privacy

G.3 _____Yes _____No Consumer receives information about their rights to appeal Lead Agency decisions regarding services and/or access to programs

G.4 _____Yes _____No Consumer receives information regarding Ombudsman services

G.5 _____Yes _____No Consumer always receives a copy of assessed needs

G.6 _____Yes _____No Consumer always receives information about all HCBS/waiver services

G.7 _____Yes _____No Consumer always receives a copy of service agreements or prior authorizations that includes information about appealing service decisions

G.8 ____Yes _____No Consumer has access to guardianship or conservator services when needed and appropriate

G.9 Please briefly describe the current methods for distributing the information listed in questions G.1-G.7

If you answered "no" to any of questions G.1-G.8 above, you will be asked to: *Provide a proposal or strategy to address this requirement, including timeline and persons responsible.* These follow up questions are numbered G.10-G.17 in the web-based survey)

Use this space for planning any follow up responses you may need to provide for questions G.1-G.8 (You will be asked separately about each question to which you answer "no"):

G.18 Please use the space below to make any additional comments regarding Participant Rights and Responsibilities. (Optional)

VI Participant Outcomes and Satisfaction: *Participants are satisfied with their services and achieve desired outcomes.*

Lead Agency Self-Assessment: The following are possible methods of soliciting consumer input and feedback regarding their satisfaction and experience with HCBS provided by or through the Lead Agency. Several methods of consumer input are acceptable and useful. The Lead Agency is not required to perform all of these specific activities, but should be actively creating opportunities for both ongoing and systematic consumer-level input.

H.1 Please indicate which of these feedback methods your Lead Agency has employed within the last two years: (Select all that apply)

_____ Consumer satisfaction or experience surveys related to the provision of HCBS services
_____ Consumer interviews related to HCBS services
_____ Consumer focus groups related to HCBS services
_____ Other consumer input/feedback strategies
_____ Family/informal caregiver satisfaction or experience surveys
_____ Family/informal caregiver interviews
_____ Family/informal caregiver focus groups
_____ Other family/informal caregiver input/feedback strategies
_____ None (SKIP H.2-H.8 and GO TO H.9)

H.2 Please describe your most recent strategy to gather consumer input, including the methods you employed and how results were used.

Please think about the most recent consumer input effort you discussed in Question H.2 above when answering the following questions.

Did your consumer input strategy ensure that consumers with the following characteristics were provided appropriate assistance and/or accommodation to give them a meaningful opportunity to participate in the feedback process:

H.3 Consumers speaking a language other than English
_____Yes _____No

H.4 Consumers have difficulty reading
_____Yes _____No

H.5 Consumers who have mental or cognitive disabilities
_____Yes _____No

H.6 Consumers who have challenges with communicating
_____Yes _____No

H.7 Consumers with hearing impairments
_____Yes _____No

H.8 Please describe the methods you used to ensure consumers with the above characteristics were able to meaningfully participate in your consumer input process

H.9 Please use this space to make any additional comments regarding Participant Outcomes and Satisfaction. (Optional)

VII System Performance: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

Lead Agency Self-Assessment: Lead Agencies (including counties, tribes, and health plans) and state agencies are frequently engaging in continuous quality improvement efforts, and are also increasing consumer participation in the design, implementation, and evaluation of HCBS and other services.

I.1 Please outline any Lead Agency activity undertaken or completed within the last two years related to the accomplishment of any of the goals addressed in this survey. For example, your Lead Agency may have completed a recruitment effort for culturally competent providers, or changed your contracting process based on feedback from consumers. Lead Agencies may also use this space to comment on any Performance Improvement Projects directly related to HCBS (Optional).

I.2 Please use this space to comment on Lead Agency Systems Improvement Efforts. (Optional)

I.3 Does the Lead Agency assure compliance with documentation, maintenance and retention of client records requirements under the Minnesota Records Retention Law for five years from the date of the last activity on the record? (Required by MN Rules, Chapter 9505.2160 through 9505.2245).

_____Yes _____No

Thank you for completing the QA Plan Survey for Waiver Services. We appreciate the time you have spent. Results will be analyzed and shared with other Lead Agencies and within divisions at DHS. Thank you for your participation!

Attachment B

LTCC CONTACT UPDATE
September 2007

Please complete the information below to ensure that the Department's mailing and telephone lists for LTCC contacts are accurate. A new listing will be compiled and emailed to all Administrative Contacts.

DO NOT SUBMIT if the information also forwarded with this Attachment is correct.

County or Tribe _____

County or Tribal Address _____
_____
_____

LTCC Administrative Contact Information

Name_____
Address (if different) _____
_____

Phone _____ Email
Fax _____

LTCC Intake Contact

Name_____
Address (if different) _____
_____

Phone _____
Email _____
Fax _____

Nursing Facility Billing Contact

Name_____
Address (if different) _____
_____

Phone _____
Email_____
Fax _____

Instructions: For each of the following services, please enter the number of contracts your Lead Agency currently has with providers for each HCBS programs. The shaded cells indicate the service is **NOT** available under a particular HCBS program. At the bottom of the table, please enter the number of UNDUPLICATED providers for each HCBS program. Please return this completed inventory as an email attachment to Sarah.M.Myott@state.mn.us **no later than October 1, 2007**

Services	AC	EW	CADI	CAC	TBI	DD
Adult Day Care/Adult Day Care Bath						
Assisted Living Plus/Customized Living Plus						
24 hour Assisted Living/Customized Living						
Assistive Technology						
Behavior Programming						
Caregiver Training/Education						
Chore Services						
Companion Services						
Consumer Training & Education						
Crisis Respite						
Fiscal Support Entities (for CDCS)						
Day Program Supported Employment						
Day Training & Habilitation						
Family Training and Counseling						
Adult Family Foster Care						
Child Family Foster Care						
Cognitive Rehabilitation Training						
Corporate Foster Care						
Home Delivered Meals						
Home Health Aide (including extended)						
Homemaker Services						
Housing Access Coordination						
Independent Living Skills						
Independent Living Skills Therapies						
In-Home Family Support						
Live-In Personal Caregiver Expenses						
Private Duty Nursing (including extended)						
Modifications and Adaptations						
Night Supervision						
Nutrition Therapy						
OT, Extended Home Health						
Personal Support						

Services	AC	EW	CADI	CAC	TBI	DD
PCA Services (including extended)						
PT, Extended Home Health						
Prevocational Services						
Relocation Services Coordination						
Skilled Nurse Visits						
Residential Care						
Respiratory Therapy						
Respite Care, In Home						
Respite Care, Out of Home						
Specialist Services						
Speech Therapy						
Structured Day Program						
Supplies and Equipment						
Supported Employment						
Supported Living Services						
Transitional Services Program						
Transportation						
24 Hour Emergency Assistance						
	AC	**EW**	**CADI**	**CAC**	**TBI**	**DD**
Total UNDUPLICATED number of providers for each program:						