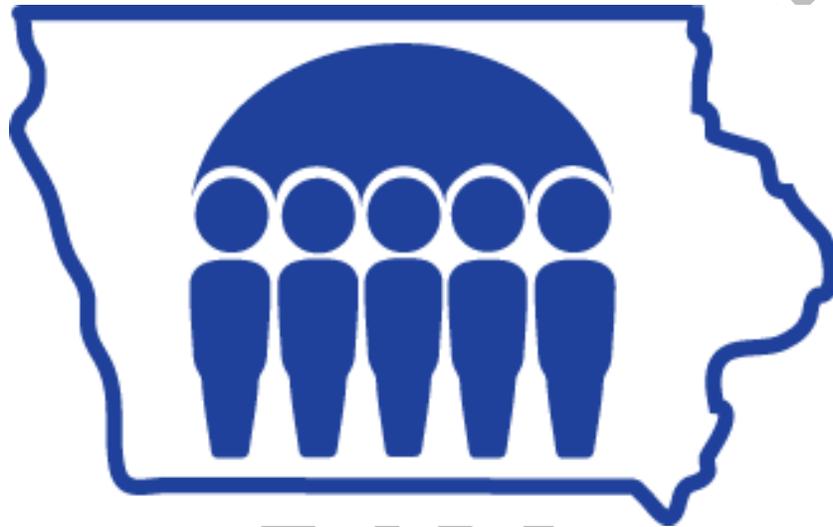


Iowa Department of Human Services



Iowa Mental Health and Disability Services Outcomes and Performance Measures Committee Report

December 14, 2012

WORKING DRAFT

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Introduction

In 2011, the Iowa Department of Human Services, the Iowa State legislature, and thousands of stakeholders engaged in a mental health and disability services redesign effort that is advancing how services for people with disabilities are organized, administered, financed, delivered and evaluated. Senate File 525 intended to create a system that ensures equitable access to a uniform and integrated array of core services; services that are based on best practices and are cost effective; and services that meet the goals of Olmstead and support Iowans with disabilities to achieve the quality of life they desire in their communities. This redesign effort resulted in [interim](#) and [final reports](#) that provided recommendations regarding how to administer services and funding in a regional structure, the guiding vision and principles for the system, and the provision of best practice services across disability groups that are built upon a framework of continuous quality improvement. The reports were followed by legislation (Senate File 2315) signed by Governor Branstad effectuating several of the redesign actions.

The Outcomes and Performance Measures Committee (OPMC) was established by Senate File 2315 “to make recommendations for specific outcomes and performance measures to be utilized by the mental health and disability services regional services system.” Membership for the committee was composed of stakeholders and consumer representatives across disability groups, as well as two members of the senate and two from the house of representatives (see Appendix ?? for a list of committee members). As required in SF 2315, this report summarizes the work of the Outcomes and Performance Measures Committee conducted between July and December 2012, and includes recommendations to guide the Department of Human Services activities over the course of calendar year 2013. A final report will be submitted to the governor, general assembly, and policymaking bodies on or before December 16, 2013.

Outcomes and Performance Measures Committee Approach

Senate File 2315 outlines the following scope of work for the OPMC:

“The committee's recommendations shall incorporate the outcome measurement methodologies previously developed by the mental health and disability services commission. To the extent possible, the committee shall seek to provide outcome and performance measures recommendations that are consistent across the mental health and disability services populations addressed. The committee shall also evaluate data collection requirements utilized in the mental health and disability regional service system to identify the requirements that could be eliminated or revised due to the administrative burden involved or the low degree of relevance to outcomes or other reporting requirements.”

In contemplating this charge, the OPMC recognized that as this system is developed, policy and decision makers have an obligation to evaluate how the system is performing and if it is producing desired outcomes. This obligation stems from two key concepts: 1) that consumers and family members depend on the State, counties (and Regions in the near future), and providers to provide quality services that will meet their needs and help them live meaningful, productive lives in integrated settings; and 2) that tax payer dollars will be used as efficiently as possible.

The OPMC built upon the reform framework developed in the redesign process, as well as previous efforts, to provide several recommendations for DHS to begin to implement an outcomes and performance monitoring system that can be used to drive performance and decision making. A great deal of work has been done by various groups in Iowa to shape the vision, values and principles and work plans to guide transformation of the State's mental health and disability services system. These groups include:

- MHDS Commission
- Mental Health Planning Council
- Olmstead Consumer Task Force
- Iowa Disability Advocates Network
- Governor's Developmental Disabilities Council
- Family to Family Health Information Center/Family 360 Initiative

Their work has resulted in a set of powerful principles and outcomes that OPMC has built upon and used as a framework for its recommendations in this report. Below are the Iowa Olmstead principles:

[Iowa Olmstead Principles: A life in the Community for Everyone](#)

1. **Public awareness and inclusion**...Iowans increasingly recognize, value, and respect individuals with mental illness or disabilities as active members of their communities.
2. **Access to services and supports**....Each adult and child has timely access to the full spectrum of supports and services needed.
3. **Individualized and person-centered**....Communities offer a comprehensive, integrated, and consistent array of services and supports that are individualized and flexible.
4. **Collaboration and partnership in building community capacity**....State and local policies and programs align to support the legislative vision of resiliency and recovery for Iowans with mental illness, and the ability of Iowans with disabilities to live, learn, work, and recreate in communities of their choice.

5. **Workforce and Organizational Effectiveness**....Investing in people through appropriate training, salary and benefits improves workforce and organizational effectiveness.
6. **Empowerment**....Communities recognize and respect the ability of people (1) to make informed choices about their personal goals, about the activities that will make their lives meaningful, and about the amounts and types of services to be received; and (2) to understand the consequences and accept responsibility for those choices.
7. **Active Participation**....Individuals and families actively participate in service planning; in evaluating effectiveness of providers, supports and services; and in policy development.
8. **Accountability and results for providers**....Innovative thinking, progressive strategies and ongoing measurement of outcomes lead to better results for people.
9. **Responsibility and accountability for government**....Adequate funding and effective management of supports and services promote positive outcomes for Iowans.

[Consolidated Redesign Workgroup Recommendations on Global Outcomes](#)

In the redesign process, the various workgroups, including the ID-DD, Mental Health and Children's Disability Services workgroups, worked together to develop consensus on a uniform set of outcome and performance measures that could form the basis for system monitoring, quality improvement and accountability throughout the state. The recommended measures at the systems, consumer and family level are listed below.

[System Outcomes](#)

- Help Iowans increasingly recognize, value, and respect individuals with mental illness and/or disabilities as active members of their communities.
- Provide each adult and child with timely access to the full spectrum of supports and services needed, including for those who have co-occurring disabilities.
- Offer a comprehensive, integrated and consistent array of services and supports that are individualized, person-centered, flexible, and culturally informed.
- Ensure that state and local policies and programs align to support the legislative vision of resiliency and recovery for Iowans with mental illness, and the ability of Iowans with disabilities to live, learn, work, and recreate in communities of their choice, thereby reducing Iowa's current reliance on high-cost institutional settings.
- Invest in people through appropriate training, salary and benefits to improve workforce and organizational effectiveness.
- Recognize and respect the ability of people (1) to make informed choices about their personal goals, about the activities that will make their lives meaningful and about the amounts and types of services to be received; and (2) to understand the consequences of,

and accept responsibility for, those choices.

- Ensure that individuals and families actively participate in service planning, in evaluating effectiveness of providers, supports and services and in policy development.
- Encourage the use of innovative thinking and progressive strategies that lead to better results for people.
- Provide adequate and flexible funding and cost effective management of supports and services that promote positive outcomes for lowans.
- Ensure that children and adults receive the necessary services and supports to achieve their optimal educational potential.

Individual Outcomes

- People make choices about their lives including with whom and where they live.
- People have support to participate in their communities.
- People have friends and relationships.
- People have support to find and maintain meaningful, competitive, community integrated employment.
- People have transportation to get them where they need to go.
- People are safe from abuse, neglect, restraint, seclusion, injury, and coercive interventions.
- People receive the same respect and protections as others in the community.
- People secure needed health services and are supported to maintain healthy habits.
- People's treatment, including medications, is managed effectively and appropriately.
- People receive information about their disability and the services and supports they need in easily understood language.
- People are actively engaged in planning their services and supports.
- People are supported to be self-determining and to manage and direct their own services.
- People are supported to advocate for themselves.
- People have timely access to services and supports in the community that aid in preventing and resolving crises in a least restrictive, person/family-centered and minimally disruptive manner.
- People receive the necessary services and supports to achieve their optimal educational potential.

Family Outcomes

- Families have equal access to needed services and supports, including crisis intervention and respite, regardless of where they live and the nature of their family member's disability.

- Families receive accurate and accessible information and counseling regarding the nature of their family member's disability and relevant services and community resources.
- Family voice is sought and choices are respected and considered by the family-inclusive service team.
- Families have the information and support necessary to assist in the development of a plan for their family member.
- Families that choose to self-direct flexible budgets can do so (for families with children).
- Families receive supports necessary to keep the family together.
- Families get the services and supports they need to make a positive difference in their lives and the life of their family member with a disability.
- Families use integrated community services and participate in everyday community activities.
- Families are supported to maintain connections with and participate in the treatment of family members with disabilities not living at home.
- Families have a primary decision-making role in the care of their (dependent) children, as well as the policies and procedures governing care for all children.
- Families are given accurate, understandable and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for (dependent) children and their families.

Taken all together, the Iowa *Olmstead* principles and the outcome and performance measurement recommendations made by the Redesign workgroups provide a comprehensive template that was used by OPMC to guide its deliberations and consensus-building. OPMC worked over the course of five meetings and a conference call to begin to narrow this information into a more manageable set of Domains and measures that can be developed into tools by DHS.

OPMC Success

The OPMC discussed its charge, how it would define its own success, and how it could be most effective in helping DHS move forward. The committee recognizes that the actual work in implementing an outcomes and performance measurement system lies ahead. Rather than develop the actual tools that DHS would use, OPMC believed it could most instruct the types of information that DHS should collect and evaluate while leaving the development of specific tools, measures and questions to those with expertise in outcomes and performance measurement.

The OPMC defined what would constitute the success of its efforts as follows:

1. That the actual performance measures and tools that are implemented reflect the types of outcomes and information that should be collected and evaluated. In this report, the OPMC provides clear recommendations regarding the **DOMAINS** and **TYPES** of outcomes and performance measures that DHS should collect.
2. The OPMC recognized that the desire to comprehensively collect information should not become a barrier to collecting any outcomes and performance measures. Rather than recommend an overwhelming framework of measures, the OPMC recognized that this is the beginning of establishing a system of continuous quality improvement, and that the committee should not bog down DHS with a set of expectations that are unrealistic given resource capability. The committee generally agreed that DHS must start with a set of expectations that can realistically be implemented.
3. The OPMC expects that outcomes and performance measures are reflective of co-occurring disabilities.
4. That there is shared ownership of continuous quality improvement framework among the State, Regions, Providers, the Medicaid managed care organization, consumers and families.
5. The OPMC anticipates that the types of outcomes and performance measures recommended in this report will provide clear expectations for regions and the provider community. In addition, the committee expects that future decision making by DHS, the regions, the Medicaid managed care organization and providers will be based upon information resulting from the outcomes and performance measures system.
6. That accountability throughout the system becomes clearer, including to the legislature.
7. That there is acknowledgement, including through the availability of funding, that training on outcomes and performance measures is important to this process.
8. That the use of outcomes and performance measurement is portrayed and perceived through a continuous quality improvement lens and not as punitive.

Current Iowa Outcomes Climate

Building a culture that measures and evaluates performance is an indicator that the system strives to achieve meaningful outcomes. This is an ongoing struggle for human services agencies throughout the country, and tends to be exacerbated during economic downturns such as the one the United States has been experiencing for the past several years. However, it is also during times like these that the use of outcomes and performance measures are critical to disability services and financing systems in order to inform decision making regarding the services that are producing desired outcomes versus those that are not.

Like other systems, Iowa DHS collects a lot of information. Some of it is required by federal funding agencies like the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Some of it is required by various State agencies or offices, including the Department of Management's State Budget Division, Iowa's Legislative Services Agency, the Division of Mental Health and Disability Services, the Department of Inspections and Appeals (DIA), and the Iowa Medicaid Enterprise.

Most of this information is generated and collected at the provider level, and may come from various sources, including:

- Service coordination monitoring
- Record reviews
- Risk assessment results
- Satisfaction surveys
- Waiver audits
- Incident management data
- Complaint data
- Paid claims and financial audits
- Mortality reviews

Currently, information is collected and some of it is utilized for some decision making purposes. These include:

- Budgeting at the State and County level
- Network and service plan development by the Medicaid managed care provider
- Agency/program licensure and accreditation
- OTHERS??????????

However, an organized approach to drive the system based upon performance and outcome measures does not currently exist, largely because of lack of resource availability across levels. It is important to note that there are costs associated with collecting, analyzing and using information to guide decision making at the Department, county and provider levels; there will be costs to Regions, too. Costs typically include staff time and expertise associated with collecting and analyzing information and the necessary information technology infrastructure to collect and analyze data (i.e. Electronic Health Records, manual surveys). Resources to measure and evaluate systems and services tend to be the first to be scaled back during difficult financial times, and the last to be ramped up when economic times are better. A challenge for Iowa will be whether it invests in the components necessary to implement and sustain a meaningful outcomes and performance monitoring system. Consideration will need to be given to ensuring there are sufficient staff resources at the DHS, regional, and provider level, as well as start-up and on-going funds associated with electronic information technology.

The absence of an organized, systematic and sustainable performance measurement system results in less than optimal accountability at all levels. For example, service recipients have few mechanisms to know if the services they are receiving are effective compared to other providers. Counties (and future Regions) have limited ability to know if the services they are funding are producing desirable outcomes. DHS is uncertain if counties are funding best practices. The Iowa legislature is uncertain if the funding it allocates works its way into the best services that produce the best outcomes.

Iowa's situation is similar to other states in that the use of outcomes and performance measures to drive decision making has taken a back seat. However, the findings and recommendations in the Redesign process identified the need for Iowa to move in this direction, and the Iowa legislature signaled its support by creating the OPMC. The work of OPMC constitutes the initial steps in the process of establishing a continuous quality improvement framework for mental health and disability services in Iowa.

Recommendations

A. Recommended Framework for DHS

[Iowa Mental Health and Disability Services Dashboard Report:](#)

The OPMC developed potential outcomes and performance measures that can be incorporated into an ***Iowa Mental Health and Disability Service Dashboard Report*** that can be used as a snapshot to demonstrate the performance and effectiveness of Iowa's mental health and

disability services system. DHS should update this report and make it available to the public on a regular basis. Over time, DHS should broaden the scope and comprehensiveness of its continuous quality improvement system.

Within this Dashboard approach, DHS should collect and evaluate information at the service recipient¹ and system level. At the service recipient level, information should be collected directly from service recipients and their families² through the use of a survey tool.

OPMC debated whether to use existing survey instruments that are used in various settings across the country (e.g. National Core Indicators (NCI), Mental Health Statistics Improvement Program (MHSIP)), and recommends the development of an Iowa-specific tool for outcomes and performance measurement. The committee wants to ensure that outcomes are evaluated across several Domains, and many existing tools address a more limited scope of outcomes. Consistent with the legislation, the committee also wants to employ a cross disability approach to outcomes evaluation, and existing tools also tend to be disability specific. The committee is also concerned that applying several different tools could overwhelm respondents, and that randomly applying several different tools to subsets of the population would become too complex. While developing an Iowa-specific tool will require piloting to test its reliability and validity, the committee felt this approach would best meet the system's objectives.

Information may be collected at the system level from providers, Regions, the Medicaid managed care provider and DHS through various mechanisms, including:

- Service coordination monitoring
- Record reviews
- Risk assessment results
- Satisfaction surveys
- Waiver audits
- Incident management data
- Complaint data
- Paid claims and financial audits
- Mortality reviews

¹ For purposes of this report, OPMC considers family members as service recipients also.

² Surveys for family members may be provided when clients have acknowledged family member involvement and provided an appropriate consent, or for family members who have identified themselves as being a family member of someone with a disability.

Domains:

The OPMC identified six Domains that encompass a broad spectrum of potential outcomes that should be evaluated. These Domains should exist indefinitely while the types of questions or information that is collected may change over time. Below are the Domains identified by the OPMC:

- a. Access to Services:** The OPMC felt that access to services is a critical component to engaging in and receiving quality services. Too often, individuals with disabilities experience poor access to services for a variety of reasons, including insufficient funding resulting in absence of services or waiting lists, inconvenient location, rigid eligibility criteria, etc. By evaluating measures in this Domain, the OPMC expects that the system will use findings to continue to inform ways to improve access to services.
- b. Life in the Community:** The OPMC agrees that every lowan should have the ability to live a life in the community, and that there are indicators that exist to measure the degree to whether Regions, programs and services support individuals' ability to live successfully in the community. Within this Domain, the OPMC identified three subsets that information should be collected – *Housing, Employment and Transportation* – that the committee felt are most closely aligned with a life in the community.
- c. Quality of Life and Safety:** The OPMC felt that living in the community should not be an end goal and that one's quality of life and safety are important aspects to measure. Quality of Life and Safety broadly encompass many potential indicators, and the committee identified examples that measure an individual's connectedness to the community, perceived ability to make independent decisions, symptom and disability management, and whether living arrangements were safe.
- d. Person-centeredness:** The OPMC felt that measuring how well the system provides services based on a person-centered orientation was important enough to warrant its own Domain. The committee was particularly interested in understanding potential differences in findings between service recipient responses in surveys and information collected from the provider level.
- e. Health and Wellness:** The OPMC recognized that the health and wellness of service recipients is as important to people with disabilities as coping with the disability itself. Unfortunately, the disabilities services and primary care communities have not paid

enough attention to the health and wellness of people with disabilities. The OPMC felt strongly that DHS should, in collaboration with the primary care community, play a role in measuring and evaluating the health and wellness outcomes for people with disabilities.

- f. *Family and Natural Supports:*** People with disabilities often have strained or damaged relationships with family members, and often lack natural supports that can help them. The OPMC recognized that not all service recipients want to have or restore relationships with families, but that there may be programs, services or other interventions that may help improve these situations which can lead to more positive outcomes. By evaluating measures in a domain like this, the system can better understand regional, provider or programmatic difference and strengths that can help inform how family and natural supports affect the lives of service recipients.

[Instructions for the Types of questions and information to be collected:](#)

As discussed above, rather than develop the actual tools that DHS would use, OPMC believed it could most instruct the types of information that DHS should collect and evaluate while leaving the development of specific tools, measures and questions to those with expertise in outcomes and performance measurement. The suggested measures are not an exhaustive or comprehensive list of potential measures to be collected, and MHDS, Iowa Medicaid Enterprise, and Regions may collect other outcomes and performance measures for management purposes. It is expected that these measures will change over time as the system utilizes this information to drive decision-making. The suggested measures have been collected or adapted from various tools, many of which contained similar measures.

Appendices A and B are critical documents to this report, and represent the core of the committee's recommendations. Appendix A provides examples of types of questions, by Domain, that the OPMC felt should be part of a service recipient-level tool that DHS should finalize and pilot test with the assistance of experts in research and evaluation. The committee believes that some of the questions may make it into the specific survey instrument, but understands that experts may refine certain questions in order to ensure that the intended question produces reliable and valid results. Appendix B provides examples of the types of information, by Domain, that the OPMC felt should be collected at the system level through provider, Regional and other available information. Several of these are already collected and required as part of federal or national reporting requirements (e.g. penetration rates). Similar to the survey instrument in Appendix A, the committee understands that some of the specific types of information to be collected at the system level may be refined in the final design stage or after the piloting phase.

B. Tool Development, Data Collection & Evaluation, and Sampling Recommendations

The OPMC recommends that DHS remain cognizant that any outcomes and performance measurement system must be meaningful, practical, realistic, and not present an undue financial burden to the system and providers.

In establishing the OPMC, SF 2315 mandates that certain types of information are collected. These include the following:

- Access standards for required core services;
- Penetration rates for serving the number of persons expected to be served, particularly the proportion of individuals who receive services compared to the estimated number of adults needing services in the region;
- Utilization rates for inpatient and residential treatment, including:
 - Percent of enrollees who have had fewer inpatient days following services
 - The percentage of enrollees who were admitted to the following:
 - State mental health institutes
 - Medicaid funded private hospital in-patient psychiatric services programs
 - State resource centers
 - Private intermediate care facilities for persons with intellectual disabilities
- Readmission rates for inpatient and residential treatment:
 - The percentage of enrollees who were discharged from the following and readmitted within 30 and 180 days:
 - State mental health institutes
 - Medicaid funded private hospital in-patient psychiatric services programs
 - State resource centers
 - Private intermediate care facilities for persons with intellectual disabilities
- Employment of the persons receiving services
- Administrative costs
- Data reporting
- Timely and accurate claims payment

Tool Development:

The OPMC went beyond the legislative mandates and developed the Domains and types of survey questions and additional information in Appendices A and B that should be collected. In developing Appendices A and B, the OPMC identified a range of challenges and considerations for DHS in finalizing instruments. The OPMC recommends that DHS:

- Seek the assistance of those with expertise in research and outcomes evaluation to design the actual tools based upon recommendations in this report. The OPMC recommends the need to limit the amount of judgment and bias in questions. Survey and information collection instruments should be piloted in 2013 to ensure that the right type of information is being collected to evaluate the desired outcomes.
- Collect information from a cross disability and co-occurring disorders perspective while not forsaking relevant information associated with specific disabilities. DHS should consider how to collect information that is highly relevant to specific disability groups. For example, some Health and Wellness Domain questions are relevant across all disability groups while questions related to smoking and drugs/alcohol use (Health and Wellness Domain) have much more relevance to the mental health population than other groups.
- Ensure that consumer and family surveys are brief and minimize burden to providers for collecting information. DHS should recognize that providers have varying technological and personnel capabilities.
- Not avoid asking certain types of questions if related services do not exist in Iowa. Information collected is intended to inform decision making. For example, if employment outcomes are poor because there are limited or no employment related services, DHS could use this information to allocate existing funds or request additional legislative appropriations to fill the void.
- Minimize gathering too much information and focus on information that is consistent with the direction of research and best practices. This will enable DHS to sort through the types of questions or information that might be important to some and not others.

Data Collection and Evaluation:

- Collect information from consumers and families directly, as well as through indirect means (e.g. chart reviews, claims for payment) in order to help establish comparative analysis, validity, and reliability.
- Require that the same outcomes and performance measures be collected across the Medicaid and non-Medicaid systems.
- Ensure that the collection of information is not redundant, duplicative or in conflict with other systems that exist or are in the process of being developed (e.g. Health insurance

Exchanges).

- Ensure that surveys are conflict-free, meaning that service recipients are not put in a position to answer questions about outcomes and quality of services by those who provide or direct their services. The use of trained or certified peer specialists should be considered for this role.
- Be careful not to make blanket comparisons across regions because they are not equal (e.g. geography, demographics).
- Not confuse licensing standards with outcome measurement. Licensing standards are designed to ensure that minimum standards are met for providers to be eligible to deliver services. Outcomes and performance measurement systems are designed to measure, evaluate and drive performance to meet intended outcomes.
- Collected and share information as frequently as practical but no less than on a monthly basis.
- Not collect so much information that the ability to deliver services is compromised.

Sampling:

- Establish a representative sample size across the State and Regions to ensure that there is sufficient information to yield reliable and valid results.
- If we were to look at surveying all people in different disability populations in one pool for the whole state, we'd have to have 400 completed valid surveys based on numbers served in FY 2012.
- We don't know what the regions are going to do. [But we drew up 17 hypothetical regions for this exercise](#), and sent it through a sample size calculator. If we were to survey by region, we would need 4,783 completed surveys.
- We have one region with 18 counties already, and one with four counties. Services are still delivered locally as before redesign. To the extent that regionalization improves capacity, you might even have a larger population to serve.
- If consumers are divided across 17 hypothetical regions **and** by population group (MI, ID, BI, DD) then 11,602 people would need to be surveyed.

Discussion:

- What if we start with the 400 and scale up over time as needed?
 - Then you can't compare region to region and that's required.
- Do we need equal representation from each group, or proportional? A region may be doing better for one group than another.
- The law says we need to be able to drill down. We need to be able to compare multi-occurring disorders, including substance abuse, and regions.
- What if you use the trending data (4,800) to tell you if you need to do the full 11,000?
- If we take a population sample at 95 percent confidence level over three (3) years, the total number is around 1,800 for the HCBS waiver.
 - It would be nice to get a really good snapshot for the first assessment of all those groups and regions, and then do three-year cycles after that. If you have the resources for it.
- We could go back to legislature and say here is what it will cost to get what we want. If we want to really see what consumers are getting we have to get to the 11,000 level.
- It concerns me that the regions could be evaluated on a performance based contract without any consumer input. We need to at least acknowledge this in the report. That the letter of the law could be met, but not the spirit of the law.
 - Part of the success is that the performance based contract will include consumer involvement.
- What I am hearing is that the whole state sample size might be helpful to us in a test environment, to help build the instrument itself; mid-size to include the consumer and family voice in effectiveness and efficiency of service delivery. This would be a minimum for region by region. We should have as a goal to gather this for all populations (11,000) and identify the additional resources needed.
- And results of all of this discussion are subject to expert advice.
- We had conversations with some experts; the idea was maybe the size of region affects the sample size.
- Same proportion of people served. So, oversample the smaller regions.
- We have some experts at CMS and CDD. Subdividing the survey into sections complicates this even more.
- Moving this forward is dependent on resources.

Next Steps

This report is intended to be the platform for DHS to finalize and pilot test a survey tool and

information collection mechanisms to begin the implementation of a continuous quality improvement system in Iowa.

It is anticipated that DHS may need to work with experts, possibly at the University level, to finalize the specific questions, types of information, survey tools, sampling size. It is also anticipated that DHS may need to rely on these experts to evaluate and interpret the results of the pilot process in order to inform the final tools that DHS will use to collect information.

DHS should share its progress with the OPMC over the course of Calendar Year 2013 so that the committee can support and advise on its progress. DHS should also report publicly on its implementation progress.

DHS should develop a proposed budget to implement an outcomes and performance measurement system. The budget should reflect the cost of staffing at the State, Regional and provider levels and the technology infrastructure needed.

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Appendix

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