

Appendices

Appendix A: Personal-experience outcomes

PERSONAL-EXPERIENCE OUTCOMES IN LONG-TERM CARE

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of our long-term care system. The following statements and definitions demonstrate the areas of life that people in long-term care programs have identified as being important to their quality of life. They are stated in the first person to emphasize the importance of the personal voice and experience of the individual. These statements provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs.

Choice

When people participate in human service systems, they often feel a loss of control over their lives as professionals or others in authority get involved. In our long-term care system we strive to empower program participants (members/consumers) to have choices—to have a "voice" or say about things that affect their quality of life and to make decisions as they are able. People with cognitive disabilities are supported to actively participate in the ways they are able, and their decision-makers (guardians or POA) keep their perspectives in mind for making decisions. The following statements reflect some of the ways in which the system can help support people to maintain control over their lives.

I decide where and with whom I live.

One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.

I make decisions regarding my supports and services.

Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.

I decide how I spend my day.

Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible.

Personal Experience

A person's day-to-day experience would meet his or her expectations of a high quality life. People who participate in a long-term care programs need to feel they are 'citizens', not parts of a 'program' and that they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take them over or get in the way of the experience.

I have relationships with family and friends I care about.

People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.

I do things that are important to me.

My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.

I am involved in my community.

Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.

My life is stable.

My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me (paid and unpaid) is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I think I am reasonably well prepared.

I am respected and treated fairly.

I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.

I have privacy.

Privacy means that I have time and space to be by myself or with others I choose. I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me a sense of dignity.

Health and Safety

Health and safety is an essential and critical part of life that can affect many other areas of a person's life. The following outcome statements represent the person's right to determine what is important to him or her in these areas, and what risks he or she is comfortable with. It's about what the person feels he or she needs to meet personal priorities. It is **not** an assessment of whether or not the person's circumstances meet others' standards for good health, risk, or safety.

I have the best possible health.

I am comfortable with (or accepting of) my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to me to make informed decisions about my health.

I feel safe.

I feel comfortable with the level of safety and security that I experience where I live, work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, I have access to those that can support me in making those determinations.

I am free from abuse and neglect.

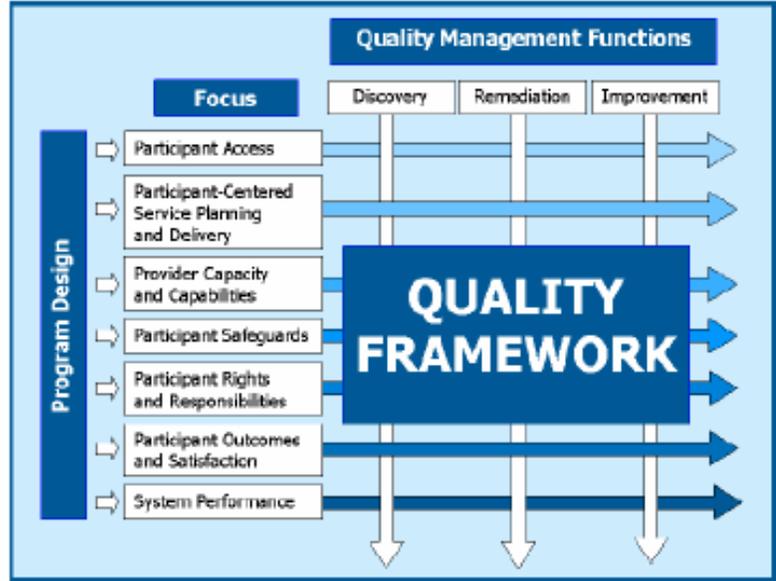
I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.

Appendix B: CMS HCBS Quality Framework

HCBS QUALITY FRAMEWORK

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

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



Quality management encompasses three functions:

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

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

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

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

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

Appendix C: Respect Outcomes

Relationships. Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment to make choices. Individual choice is the foundation of ethical home and community-based long-term support services.

Services to meet individual need. Individuals want prompt and easy access to services that are tailored to their unique circumstances.

Physical and mental health services. Intended to help people achieve their best level of health and functioning.

Enhancement of participant reputation. Services maintain and enhance participants' sense of self-worth and community recognition of their value in every way possible.

Community and family participation. Participants are supported to maintain and develop friendships to participate in their families and communities.

Tools for independence. People are supported to achieve maximum self-sufficiency and independence.

Appendix D: Clinical and Functional Indicators Recommended for the Core Set

As part of the QCTH Project the Department established a clinical and functional indicator quality workgroup. The workgroup included representatives from the Department and local program administrators in the waiver, Family Care and Partnership counties, as well as staff from APS Healthcare and The Management Group (TMG). The mission of the workgroup was to identify and develop clinical and functional indicators of quality for use in the statewide quality management system, and suggest how those indicators could be used to maintain and improve quality.

The workgroup examined a list of over 850 program outcomes and indicators pulled from approximately 20 sources, including the National Committee for Quality Assurance (NCQA), Agency for Healthcare Research and Quality (AHRQ), the National Core Indicators Project (NCI) via the Human Services Research Institute (HSRI), the Medstat Group Participant Experience Surveys (PES) and the State of Wisconsin DHFS, among others. The original list was narrowed to include only those outcomes/indicators relevant to clinical and functional wellbeing. The resulting lists of 179 clinical outcomes/indicators and 9 functional indicators were used as the basis for further workgroup discussions.

As a starting point, workgroup members brainstormed a list of relevant clinical and functional indicators based on the list described above. Workgroup members focused on available data, national acceptance, practicality, relevance for local program administration and applicability to all target populations including the frail elderly, people with physical disabilities and people with developmental disabilities. The results of this discussion are presented in Table 1 below.

Table 1: Quality Close to Home (QCTH) Clinical and Functional Workgroup: Clinical and Functional Indicators		
Count	Clinical	Functional
1.	Influenza (incidence, vaccination)	Substantial decline in three or more activities of daily living. (OASIS)
2.	Pain (pain management)	One-year change in need for assistance with ADLs. (FC Dashboard)
3.	Diabetes	One-year change in need for assistance with IADLs. (FC Dashboard)
4.	Depression/Mental Health	Improvement in bathing, laundry, dressing, grooming, eating, speech/language, dressing lower body, dressing upper body, meal preparation, transferring and toileting, etc. (OASIS)
5.	Immunizations (adults/kids)	Unexpected nursing home admissions. (OASIS)
6.	Skin Ulcers/Wounds/Decubiti	One-year change in need for health-related services: exercise/motion. (FC Dashboard)
7.	Birth Weight	Escalating behaviors: change over time, not

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		prevalence. (P. 14 LTCFS)
8.	Falls	Need for overnight supervision (LTCFS)
9.	Pneumonia (incidence, vaccination)	Some measure of competence – decline or improvement. Possible prevalence of participants determined to be incompetent across programs, target groups and/or county/region.
10.	AODA	Change in cognition
11.	Drug Interactions	Discharges to nursing homes
12.	Lack of Exercise	
13.	Preventable Hospitalizations	
14.	Diet	
15.	Lack of Insurance	
16.	Medication Compliance	
17.	Medical (drug) Management	
18.	Mortality	
19.	Vehicular Accidents	
20.	Suicide	
21.	Incontinence	
22.	UTIs	
23.	Behavioral Issues (adults/kids)	
24.	Smoking	
25.	Blood Pressure	
26.	Dental	
27.	Primary Care Visits	
28.	Self-Breast Exams	
29.	Asthma	
30.	ER Visits	

Based on available data and applicability to the target populations, the workgroup selected one clinical and two functional indicators from this list to be calculated as a test of the process. The QCTH project produced the first two functional indicators using currently available data from the functional screen and the Medicaid Management Information System (MMIS) eligibility and claims data. These indicators calculated declining ADLs and IADLs.

Preliminary work was conducted on two clinical indicators: disenrollments to nursing homes among existing COP, CIP, WPP and FC participants, and preventable hospitalizations.

Current Findings

The process used to calculate the first two functional indicators combined data from the MMIS and functional screen. The basic assumptions used to generate the study population are described below. The detailed process used to calculate the indicators has been shared with Department staff.

Functional Indicators

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1) A decline in 3 or more activities of daily living (ADLs) in any 11-13 month period. 2) A decline in 3 or more instrumental activities of daily living (IADLs) in any 11-13 month period.

- **Expressed as:** Percentage of program participants showing a decline in 3 or more ADLs or IADLs.
- **Original Source:** Family Care Dashboard and the Outcome and Assessment Information Set (OASIS) tool from CMS.
- **Definitions:** Using the Long Term Care Functional Screen (LTCFS) data, a decrease in ADLs or IADLs (i.e., moving from a bathing score of “0” to a “1” or from a “1” to a “2”) is considered a decrease in functioning.
- **Issues:** The waiver counties have only been using the functional screen for approximately one year; therefore, many program participants will not have two qualifying screens to use in the calculation.
- **Data Sources:** Medicaid Eligibility Data (FC and WPP), HSRS Data (Waivers), Medicaid Claims Data (WPP) and functional screen Data.

The table below illustrates sample findings and a sample reporting format for the declining ADLs and IADLs functional indicators. The table lists the findings by MCO and target group. Further breakouts are possible depending on the needs of the State and the MCOs.

Number and Percent of Program Participants with >=3 Declining ADLs or IADLs By Target Group and Site/County Most Recent Screen in 2004 or 2005																
Program/MCO	Total Population	Frail Elderly					Physically Disabled					Developmentally Disabled				
		Total FE	ADLs	%	IADLs	%	Total PD	ADLs	%	IADLs	%	Total DD	ADLs	%	IADLs	%
Program	6,247	4,553	619	13.6%	231	5.1%	705	31	4.4%	13	1.8%	986	8	0.8%	8	0.8%
MCO 1	3,392	3,391	488	14.4%	176	5.2%	1	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%
MCO 2	1,233	415	41	9.9%	17	4.1%	395	16	4.1%	10	2.5%	420	6	1.4%	6	1.4%
MCO 3	742	355	45	12.7%	20	5.6%	111	6	5.4%	0	0.0%	276	1	0.4%	2	0.7%
MCO 4	636	305	33	10.8%	13	4.3%	137	7	5.1%	2	1.5%	194	0	0.0%	0	0.0%
MCO 5	231	85	12	14.1%	5	5.9%	60	2	3.3%	1	1.7%	86	1	1.2%	0	0.0%

Clinical Indicator (not calculated)

Total number of preventable hospitalizations for *acute Ambulatory Care Sensitive Conditions* (e.g., pneumonia, dehydration, perforated Appendix and urinary tract infection (UTI)).

- **Expressed as:** Number of hospitalizations for acute conditions/100 member months.
- **Original Source:** SSI/Managed Care in Milwaukee.
- **Definitions:** 1) Agency for Healthcare Quality and Research (AHRQ) Prevention Quality Indicators (PQI), current version 3 (V.3). The most current SPSS version is V.2.
- **Data Sources:** Medicaid Claims Data (FC, Waivers and WPP), Medicaid Eligibility Data (FC and WPP), HSRS Data (Waivers) and WPP Encounter Data (WPP)

Appendix E: Draft Consumer Satisfaction Survey

Draft Consumer Satisfaction Survey and field-testing results

The following draft survey was field tested in Washburn County during April and May 2006. The county sent out 155 surveys and received responses from 94 program participants, resulting in a 60% response rate. Surveys were sent with a cover letter and a stamped return envelope. The field-testing focused on the following questions:

- Are questions 4 (The people who are paid to help me listen to me.), 6 (The people who help me speak in a way that I understand.), and 7 (I feel comfortable asking questions of the people who are paid to help me.) addressing different issues or will respondents see them as essentially asking the same thing and give the same answer for all of them? Can respondents answer questions 4, 6, and 7 at a general level, or are these questions that can be answered only when asked about specific services or specific staff?
- Are questions 2 (I have as much say as I want in making decisions about my services.) and 8 (I get to choose the people who are paid to help me.) essentially the same?
- Are questions 3 (I would recommend this program to a friend.) and 9 (I am happy with the services I get.) duplicative?
- Will respondents use question 10 (If you have any concerns or problems that haven't been taken care of, please tell us about them.) to provide new information or will it be used more to repeat concerns already known to the program?
- Will these questions work with guardians, or will a guardian version be needed?
- Will it be possible for local programs to report results by target group?

In general, there was little variation across all responses to the questions. Excluding the “Not Applicable” response and those instances where no score of any kind was provided, 95% of all scores were either four or five. However, responses for three sets of questions that were seen as potentially redundant varied enough to indicate that respondents did not see them as asking the same thing. 33% of respondents did not have the same answer for questions 4, 6, and 7. 53.2% did not have the same answer for questions 2 and 8. 31.9% did not have the same answer for questions 3 and 9.

Over 8% of respondents used the open-ended question to mention new concerns unique to their case. An additional 14.9% of respondents used the open-ended question to express their appreciation for their services or to praise particular staff. There was no noticeable differences in the surveys responded to by guardians as opposed to those responded to by the participants themselves. Washburn County used a simple color-coding process to keep track of which surveys went to each of the target groups.

It should be noted that managers and staff in both Washburn and St. Croix counties were critical of the use of the smiley-face icons in the survey. The survey was field tested in the form presented below, but each MCO can determine how their survey will look.

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The following are statements about how you may feel about the services you are receiving and the people who help you. Please circle the words that fit the way you feel.

1. I am satisfied with the work that my (care manager) does for me and with me.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

2. I have as much say as I want in making decisions about my services.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

3. I would recommend this program to a friend.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

4. The people who are paid to help me listen to me.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

5. I get the help I need when I need it.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

6. The people who help me speak in a way that I understand.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

7. I feel comfortable asking questions of the people who are paid to help me.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

8. I get to choose the people who are paid to help me.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

9. I am happy with the services I get.



(1)Never (2)Almost never (3)Sometimes (4)Most of the time (5)Always (6)Not Applicable

10. If you have any concerns or problems that haven't been taken care of, please tell us about them.

If you would like to speak to someone regarding your concerns or problems, please call

Appendix F: Roles in Discovery

Responsible Party	Roles and Responsibilities
Discovery Method 1 – Clinical and Functional Indicators	
MCO	<ul style="list-style-type: none"> • Collect necessary data from sources such as functional screens and encounter data • Calculate locally selected clinical and functional indicators • Review the indicators presented by the Department or EQRO • Identify areas of concern • Conduct secondary discovery to determine whether the data are accurate, and if so, whether other sources of information provide additional insight • Make data available to the Department at their request
Department	<ul style="list-style-type: none"> • Collaborate with the QM Council to refine and develop a core set of clinical and functional indicators to be calculated at the state level • Provide clear and useful specifications for any quality indicators to be calculated at the local level • Guide interpretation of the indicators and their use in setting priorities for quality efforts • Mine existing data • Calculate indicators • Generate reports to share with MCOs and program staff • Analyze data and establish benchmarks • Contact MCO if there is a significant issue requiring remediation
EQRO	<ul style="list-style-type: none"> • Validate quality indicators reported by MCOs • Offer suggestions and guidance on the production, use, and presentation of the quality indicators • Calculate the indicators under contract with the Department • Track indicators over time • Contribute to the design of a standardized reporting format for each indicator
Discovery Method 2 – Personal Experience Outcome Interviews	
MCO	<ul style="list-style-type: none"> • Regularly identify each member’s desired outcomes • Collect personal-experience outcome information for quality-management purposes and make that data available to the department upon request • Ensure the people conducting interviews have had effective, standardized training on outcome concepts, interviewing techniques, and the outcome tool • Ensure interviewer reliability in the application of the tool • Prepare, educate and train staff on the benefits and use of personal-experience outcomes
Department	<ul style="list-style-type: none"> • Develop the outcome tool, instructions, and training materials

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Responsible Party	Roles and Responsibilities
	<ul style="list-style-type: none"> • Assure MCOs receive training on the tool • Determine the most appropriate methods for ensuring consistency among interviewers • Develop methods for collecting, compiling, and reporting data on outcomes across MCOs • Provide leadership toward development of methods of using outcomes information in quality management, including benchmarks
EQRO	<ul style="list-style-type: none"> • Conduct annual site visits • Review a sample of the personal-experience outcome interviews conducted by MCO staff • Interview a sample of members using the 12-outcome tool • Assess MCO interviewer reliability • Conduct targeted outcome interviews based on findings from other types of QM discovery
Discovery Method 3 – Member Satisfaction Surveys	
MCO	<ul style="list-style-type: none"> • Select survey administration method and sample size • Develop local version(s) of member satisfaction survey • Administer consumer satisfaction surveys at least annually • Make survey data available to the Department upon request • Review MCO satisfaction survey results to identify any areas where member satisfaction is low or significantly reduced
Department	<ul style="list-style-type: none"> • In conjunction with the QM Council, create a core set of satisfaction questions to be used by every MCO • Tabulate the results for the core set of satisfaction questions, and make these aggregate results available to MCOs and stakeholders
EQRO	<ul style="list-style-type: none"> • Review MCO’s administration of satisfaction surveys • Determine whether survey objectives are clear and whether data collection and analysis enables the findings to be generalized across the population
Discovery Method 4 – Analysis of Negative Events Affecting Members	
MCO	<ul style="list-style-type: none"> • Assure that members, providers and MCO staff are all aware of the reporting expectation surrounding negative events, and that they comply with these expectations and requirements • Create a comprehensive database for recording negative events • Design a process for prompt initial review and investigation of each reported event to determine the causes of the event and any necessary corrective action • Record the planned response to each reported event. • Ensure planned remediation is successful • Regularly analyze the events database to discover patterns of minor events that may suggest systemic problems. • Develop a critical incident policy • Summarize and aggregate critical incident records in

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Responsible Party	Roles and Responsibilities
	accordance with Department guidelines, and make that information available to the Department upon request
Department	<ul style="list-style-type: none"> • Establish standards for negative-event identification, response, and reporting • With the EQRO, review the MCOs’ records of critical-incident response to assess whether the MCOs’ activities were adequate and appropriate • Generate and disseminate reports, to MCOs, of successful responses to negative events
EQRO	<ul style="list-style-type: none"> • Review the MCO’s system and record of negative-event activities to assess the adequacy of the MCOs responses
Discovery Method 5 – Managing the Quality of Assessments, Care Plans, and Service Delivery	
MCO	<ul style="list-style-type: none"> • Assure assessments and care plans are completed in a timely manner, and contain all required information • Collect specific data indicating the quality of assessments, care plans, service delivery, and choice of providers and make that data available to the Department upon request • With the QM Council, determine what changes warrant a care plan update • Develop and implement quality-management practices that assure care plans are updated as needed • Monitor whether direct services are actually being provided to members • Develop a network of providers for all available services
Department	<ul style="list-style-type: none"> • Direct EQRO activities • Identify areas of potential concern • Work with MCOs to assure the development and implementation of remediation strategies for both individual and systemic issues
EQRO	<ul style="list-style-type: none"> • Examine assessments and care plans during annual site visits and in the course of investigation other quality issues • Validate the internal quality checks the MCO conducts • Provide the MCO and the Department with an objective view of the local quality-management system • Submit findings of care plan reviews to the MCO and the Department
Discovery Method 6 – Monitoring the Quality of Provided Services	
MCO	<ul style="list-style-type: none"> • Monitor provider compliance with waiver regulations and create a record of these findings • Monitor the provider network to ensure that it is sufficient to offer adequate services to its members and maintain a record of these findings • Develop and implement a process to credential and re-credential providers in its network

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Responsible Party	Roles and Responsibilities
	<ul style="list-style-type: none"> • Oversee the functions and responsibilities delegated to its subcontractors • Evaluate provider performance on an ongoing basis • Identify deficiencies or areas for improvement • Take corrective actions with providers. • Collect information regarding the quality of provided services, and make that information available to the Department upon request
Department	<ul style="list-style-type: none"> • Direct EQRO activities • Coordinate efforts with the Bureau of Quality Assurance to ensure compliance with provider standards
EQRO	<ul style="list-style-type: none"> • Conduct periodic reviews to ensure the MCO is monitoring provider compliance and is establishing mechanisms to ensure compliance

Appendix G: Quality Management System Reference Guide

Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance

¹⁶ This document should be viewed as a reference guide to assist newly developed MCOs and existing waiver counties in understanding and creating quality management systems. The local programs are not limited to these examples, and are in fact, encouraged to develop additional quality management strategies to meet their needs.

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I am free from abuse and neglect.</p> <p>I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.</p>	<ul style="list-style-type: none"> The MCO would have a system in place to discover whether individual members are experiencing abuse or neglect. Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews, and whenever appropriate to provide the necessary support to help members achieve the outcome. The assessment and care plan would include a list of diagnoses. The MCO could compare those to diagnoses often associated with abuse or neglect (depression, post-traumatic stress disorder). The MCO would track clinical indicators, such as: the prevalence of specific mental health diagnoses (depression, post-traumatic stress disorder) by county or target group. The MCO would also look at increases in these diagnoses at an aggregate level; the number of emergency room visits for specific conditions (broken bones, falls, lacerations, dehydration, decubiti, and other wounds); the number of visits to the member's primary physician for the above listed occurrences. The MCO would have policies surrounding the discovery, reporting, and remediation of negative events such as abuse or neglect, with particular focus on the cause of the incident. 	X	X		X		X	

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I feel safe.</p> <p>I feel comfortable with the level of safety and security that I experience where I live, work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, I have access to those that can support me in making those determinations.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The MCO would track clinical indicators, such as: The number of emergency room visits for specific conditions (broken bones, falls, lacerations, dehydration, decubiti, and other wounds); the number of visits to the member's primary physician for the above listed occurrences. • The MCO would track functional indicators, such as the amount of durable medical equipment purchased for improving functioning and overall safety. • The MCO would have policies surrounding the discovery, reporting, and remediation of negative events such as falls, with particular focus on the cause of the incident. 	X			X	X	X	

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>My life is stable.</p> <p>My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me (paid and unpaid) is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I think I am reasonably well prepared.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The assessment and care plan would capture information about the people currently assisting the member, any advanced directives the person may have, and financial information. • MCOs would track clinical and functional indicators among its membership, such as: the rates of preventable nursing home or hospital admissions for diagnoses like diabetes or depression; the number of suicide attempts per 100 members; incidence of AODA problems; member or changes over time in the need for assistance with ADLs and IADLs. • MCOs would administer annual satisfaction surveys, and note in particular, the questions related to this outcome. (I get the help I need when I need it. The people who help me work well together.) • The MCO would have policies surrounding the discovery, reporting, and remediation of negative events such as abuse or neglect, with particular focus on the cause of the incident. • The MCO, along with provider agencies would track worker longevity, turnover rates, and continuity to help measure member stability. 	X	X	X	X	X	X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I am respected and treated fairly.</p> <p>I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • MCOs would have systems in place to track negative events in the form of grievances filed by members (issues related to providers) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. • MCOs would administer annual satisfaction surveys, and note in particular, the questions related to this outcome. (I get along well with my case manager. The people who are paid to help listen to me. The people who help me speak in a way that I understand. I feel comfortable asking questions of the people who are paid to help me.) • MCOs would examine data from outcome interviews and provider records explaining why members chose to change, fire, or remain with particular providers. 	X	X	X			X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I decide how I spend my day.</p> <p>Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • MCOs would administer annual satisfaction surveys, and note in particular, the questions related to this outcome. (I have as much say as I want in making decisions about my services. I get the help I need when I need it.) • MCOs would have systems in place to track negative events in the form of grievances filed by members (issues related to providers) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. • Provider contract language would clearly delineate the need for flexibility and accommodation. 	X	X	X			X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I decide where and with whom to live.</p> <p>One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The MCO's assessment and care plans would capture information about the member's current living arrangement. • MCOs would have systems in place to track negative events in the form of grievances filed by members (no choice in roommate or living situation) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. 	X	X				X	

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I do things that are important to me.</p> <p>My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The MCO's assessment and care plans would capture information about the member's interests and current involvement in work, school, or volunteer activities. • Provider contract language would specify the need to accommodate the member's interests. 	X	X					X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I have relationships with friends and family I care about.</p> <p>People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-gone support and watch out for my best interests.</p>	<ul style="list-style-type: none"> Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. The MCO's assessment and care plans would capture information about the member's informal support network, involved family and friends, and other people central to the member's life. 	X	X					

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I make decisions regarding my supports and services.</p> <p>Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • MCOs would administer annual satisfaction surveys, and note in particular, the questions related to this outcome. (I have as much say as I want in making decisions about my services. The people who are paid to help me listen to me. I get the help I need when I need it. I get to choose the people who are paid to help me. I am happy with the services I get.) • MCOs would have systems in place to track negative events in the form of grievances filed by members (service denials; lack of choice in providers/services; provider-specific complaints) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. 	X	X	X			X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I have privacy.</p> <p>Privacy means that I have time and space to be by myself or with others I choose, I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me a sense of dignity.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • MCOs would have systems in place to track negative events in the form of grievances filed by members (provider-specific complaints) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. • Provider contract language could specify the need to respond to and accommodate members' requests and preferences. 	X					X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I have the best possible health.</p> <p>I am comfortable with (or accepting of) my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to me to make informed decisions about my health.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The MCO's assessments and care plans would capture information about diagnoses, doctors, medications, dental care, and mental health status. • The MCO would track several health-related clinical indicators, such as: pain management, the occurrence of influenza, diabetes, immunizations, mental health diagnoses, falls, pneumonia, etc. • The MCO would track several health-related functional indicators, such as: declines in three or more ADLs, improvements in ADLs/IADLs, need for overnight supervision, decline or improvement in cognitive function, etc. • The MCO would have policies surrounding the discovery, reporting, and remediation of critical incidents such as suicide attempts, with particular focus on the cause of the incident. 	X	X		X	X	X	X

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Outcome & Definition	Examples of Best QM Practice ¹⁶	Discovery Data Sources Related to this Outcome						
		Outcome Interviews	Assessments & Care Plans	Satisfaction Surveys	Clinical Indicators	Functional indicators	Negative Events	Provider Performance
<p>I am involved in my community.</p> <p>Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.</p>	<ul style="list-style-type: none"> • Care managers would be expected to ask members specific questions related to this topic at the time of the initial assessment, at six-month reviews and whenever appropriate to provide the necessary support to help members achieve the outcome. • The MCO's assessment and care plan would capture information about the member's activities, religious affiliation, and preferences. • MCOs would have systems in place to track negative events in the form of grievances filed by members (provider-specific complaints, transportation issues) and to remediate issues surrounding these grievances at both an individual member level and at a systemic level. 	X	X				X	X

Appendix H: Glossary

Appeals: A formal request for review of a denial, limitation, or reduction of services

Benchmarks: Points of reference that can serve as standards for measurement of performance

Clinical indicators: Statistical measures designed to provide perspective on a member's physical or medical condition

Complaints: Same as grievances (below)

Consumer: A recipient of long-term care services

Consumer outcomes: Same as Personal-experience outcomes (below)

Critical incidents: An event, incident, or course of action or inaction that is either unexpected or that is associated with alleged abuse, neglect, or other crime, or a violation of member rights

Department: The Department of Health and Family Services

Discovery: The systematic gathering of evidence

Functional indicators: Statistical measures designed to provide perspective on a member's ability to care for themselves, particularly regarding activities of daily living

Grievances: Expressions of dissatisfaction about any matter other than an "action". Actions include appeals of MCO decisions such as denial, limitation, or reduction of services, MCO refusal to pay for services, etc.

Improvement: Utilizing data and quality information to engage in actions that lead to continuous improvement in the program

Member: A recipient of services from a Managed Care Organization

Near misses: Events with potentially serious health and safety consequences that are prevented from developing into actual consequences as a result of chance or mitigation

Participant: A recipient of services from fee-for-service waivers

Personal-Experience Outcomes: The needs, values, preferences, and priorities that individuals have identified as being important to their quality of life

Primary discovery: High-level evidence gathering designed to provide early indicators of potential problems

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Quality management: A planned, systematic approach to the monitoring, analysis, and correction and improvement of performance, which increases the likelihood of desired outcomes by continuously improving the quality of care and services provided.

Remediation: Taking action to remedy specific problems or concerns that arise

Risk adjustment: A process to predict health care expenditures based on previous diagnoses or demographic characteristics

Root cause analysis: A process designed to identify not only what and how an event occurred, but why it happened

Secondary discovery: Identifying what wasn't working at a systems level that allowed a problem to happen