Part I. Preface

This report outlines recommendations for quality management of Wisconsin's evolving managed home and community based long-term care system. It is intended to provide readers with an understanding of quality management, as well as a practical orientation for operating quality management systems. The report will:

- Define and describe "quality management;"
- Discuss the challenges in implementing quality management systems within the organizations and systems where they will need to operate;
- Present the recommended quality management system in some detail, describing how the system would work to measure and improve program performance and distinguishing local and Department-level quality management responsibilities;
- Recommend leadership and organizational structure for quality management systems.

Background

This report is the product of the Quality Close to Home (QCTH) project, an initiative to design Wisconsin's approach to long-term care quality management. The QCTH project, which started in mid-2004, was funded through a Systems Change grant from the Centers for Medicare and Medicaid (CMS) to the Division of Disability and Elder Services (DDES) of the Department of Health and Family Services (the Department). DDES identified a number of factors supporting development of a comprehensive quality management system for home and community based long-term care programs:

- CMS had recently strengthened its requirements for quality management of home and community based long-term care programs.
- DDES recognized that there were significantly differing approaches to quality management among Wisconsin's long-term care programs—Family Care, Wisconsin Partnership Program (WPP or Partnership), Community Options Program Waiver (COP-W), and Community Integration Program (CIP). While some of this variation was explained by the different nature of the programs—for example, Family Care and Partnership are managed-care programs, while COP-W and CIP are fee-for-service—there were no consistent approaches to assure that consumers of all programs were receiving an acceptable quality of service.
- Particularly in the COP-W/CIP counties, local quality management efforts varied widely from county to county. The Department assumed primary responsibility for quality management for these programs, and the counties, who administered the programs, were not expected to maintain their own quality management programs.

To assist in the project, DDES contracted with APS Healthcare and The Management Group (TMG). DDES also sought to assure broad participation in development of QCTH recommendations:

- At the onset of the project, APS/TMG conducted extensive interviews with quality managers in local long-term care programs, learning about their current quality management practices and their suggestions for improving quality management systems.
- Similarly, APS/TMG interviewed Department-level representatives of Family Care, Partnership, COP-W and CIP programs to make sure that the Department's current role in quality management was thoroughly understood.
- DDES met regularly with the Stakeholder Committee of the Wisconsin Long-Term Care Council to discuss the QCTH project and get feedback and suggestions.
- DDES established a Local Advisory Panel (LAP) consisting of representatives of Family Care, Partnership, CIP and COP-W programs. The LAP met periodically over the course of the project to provide suggestions and to respond to draft recommendations developed by DDES and APS/TMG.
- LAP members were also involved as working partners in system development through a series of workgroups focusing on specific aspects of the quality management system, such as consumer outcomes measurement and quality indicators.
- QCTH established an interactive website using the "Basecamp" program to support on-going communication between project participants. The Basecamp system was used to share and critique documents and to host multi-party, on line discussions of particular issues.

Since the inception of the project, the emphasis has shifted slightly in response to a major policy initiative in Wisconsin. Because Wisconsin operated both fee-for-service HCBS programs (operated with federal 1915(c) waiver authority) and managed-care long-term care programs (operated with federal 1915(b) waiver authority), the original QCTH project mission was to develop more consistent quality management systems across the managed-care and fee-for-service systems. However, this mission changed in 2005 when the Department launched a Long-Term Care Reform Initiative.

The goal of the Long-Term Care Reform Initiative is statewide expansion of managed care. Planning is actively underway—not just in quality management, but in all aspects of organizing, financing, and operating—to replace Wisconsin's CIP and COP-W fee-for-service programs with managed-care programs, within five to seven years. In response to this initiative, the Department shifted the focus of the QCTH project mission to design of a quality management system of what will become managed long-term care programs in all counties. It is likely that the expanded managed-care programs will operate with combined (b) and (c) waiver authority. Therefore, the quality management system is designed to comply with federal expectations for programs operating with (c) waiver authority.

Key Principles

Work on this project has been guided by the following key principles:

PURPOSE OF QUALITY MANAGEMENT

The primary purpose of the quality management system is to maintain and improve the quality of long-term care services and supports for consumers.

INTEGRATION

Quality management in the home and community-based long-term care system is best done as a partnership between the local care-management agency and the Department. This means that:

- The Department and the local agencies each focus on the quality management activities that each does most effectively. The Department does not complete or correct the local quality management tasks; similarly, the local agencies rely on DHFS to complete its quality management tasks.
- Quality management discovery provides an honest assessment of quality as a basis for improvement rather for than punishment or sanctions. Punishments and sanctions for discovered weaknesses are last resorts, to be considered only after corrective efforts are unsuccessful or fail to take place.

EMPHASIS ON LOCAL QUALITY SYSTEMS

- Quality management is most effective and efficient when it is done as close to the consumer as possible. Quality management cannot rely primarily on reviewers from the Department; managers and staff of the local care-management agencies are much better situated to efficiently and effectively discover the level of quality that is being achieved and take action to maintain or improve it .
- The quality management system would provide timely, detailed and relevant feedback to people working in the long-term care system, including people who work directly with consumers and other program managers.

EFFICIENT USE OF RESOURCES

- An efficient quality management system uses data and information that are already being collected for other program purposes. For example, information from assessments and care plans, from grievances and complaints, and from billing records can contribute towards the quality management system.
- Until additional resources become available, we can work on quality management practices that can be supported by reallocating time and resources we're spending on less useful endeavors. Also, if quality management is done well, it will result in fewer emergencies, smoother operations, and overall time savings in the long run.

Part II. What Is Quality Management?

This report outlines an approach to quality management of home and community based long-term care programs. This section focuses on important definitions and background to help the reader understand generally what is meant by "quality" and "quality management systems."

Defining Quality: Process vs. Outcomes

QCTH has defined quality primarily as the *results* the program provides for the people it serves. By focusing on *results,* we have defined quality in terms of consumers' outcomes, rather than compliance with process requirements.

Traditionally, quality assurance programs have focused on process. Following are examples of ways in which quality could be measured if the focus were on process rather than outcomes.

- Were forms filled out properly and within the required timeframe?
- Did the case manager meet all required contacts with the consumer?
- Was the consumer informed of his or her appeal rights?
- Were services documented properly with the correct service codes?
- Do all providers meet licensure and certification requirements?

Many process measures are very important—indeed, a program that is poorly administered and lacking good processes is unlikely to achieve consistently good results. Good processes do not in themselves assure that quality results are achieved. It is possible for long-term care programs to technically comply with program requirements without adequately addressing the fundamental needs of the people they serve.

Therefore, a good quality management system needs to focus on the results, or outcomes, that are produced for consumers. These include measures of the consumers' health and well-being—clinical and functional outcomes such as the incidence of health problems and levels of functional abilities. In addition, the Department has identified 12 'personal-experience outcomes' as a primary basis for defining quality[1]. Personal-experience outcomes are individually defined by each consumer and provide both care managers and quality reviewers with a sense of each individual's quality of life.[2]

- I decide where and with whom I live.

[1] These outcomes were developed by the DHFS Quality Cross Unit Functional Team, the Stakeholder Participation Committee of the Wisconsin Council on Long-term Care Reform, and the QCTH Local Advisory Panel, using outcomes from several different programs: the Family Care, COP, and CIP programs, and a set of outcomes developed for providers of dementia services. The 12 outcomes were later endorsed by the Bureau of Long-term Support's Joint Steering Committee. Appendix A includes more detail about these outcomes.

[2] More information about personal, clinical and functional indicators can be found in Part V, under Discovery Method 2 – Personal-experience outcome Interviews.

- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends I care about.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

The quality management system is designed to measure the extent to which consumers are achieving their desired clinical, functional, and personal-experience outcomes, and to improve the program's performance in supporting outcome achievement.

Defining Quality Management

Quality management is, first of all, a management function rather than a planning, policy or design function, or a direct service to consumers. The National Association of Healthcare Quality defines quality management as:

> "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."

To understand this definition, it is helpful to consider its individual components:

PLANNED, SYSTEMATIC APPROACH

Quality management is planned and purposeful—it is a carefully structured, formal system designed to generate and analyze evidence of performance, and to use that evidence to correct problems and improve outcomes.

CONTINUOUS MONITORING

The quality management system involves continuous monitoring to assess systems performance. This monitoring—also referred to as discovery—takes a number of forms. The goal is to systematically gather evidence that will provide insight on system performance.

ANALYSIS

The quality management system provides for analysis of evidence to assess systems performance and to identify the root causes of any problems that are identified.

CORRECTION

When problems are identified, they are corrected. Systems are in place to ensure that there is follow-through on fixing the problems, and that the solutions actually work. In addition, problems are not treated in isolation. There are efforts to identify and address

systemic issues that might be affecting multiple consumers or having broad impacts throughout the system.

IMPROVEMENT OF PERFORMANCE

In addition to just fixing problems, there are carefully planned, evidence-based efforts to improve the quality of system performance. These efforts increase the likelihood of desired outcomes by continuously improving the quality of care and services provided. *Ultimately, program performance is defined by the results of the program for the people it serves.*

What Quality Management is Not

In attempting to define quality management, it is helpful to describe what quality management is not:

DOING WORK WELL

Quality management does not mean just doing a job well. While most people strive to do their work as well as possible, this does not constitute quality management. *Rather, quality management measures and analyzes the results of people's work.*

TECHNICAL ASSISTANCE

Quality management is not training or technical assistance. *Training or technical assistance may be strategies resulting from the findings of the quality management system, used to remedy a problem or improve systems performance. However, training or technical assistance do not in themselves constitute quality management.*

ANECDOTAL EVIDENCE

While anecdotal evidence may provide context and useful information, an approach to systems improvement that relies solely on anecdotal evidence or crisis response is not a quality management system. *Quality management is grounded in systematic, ongoing efforts to gather evidence of systems performance.*

PROGRAM DESIGN

Quality program design is not quality management. Systems can be designed to help ensure quality wherever possible. For example, Wisconsin's long-term care functional screen builds in quality by automatically flagging entries that appear incorrect based on the screen's logic.

However, even the best design requires monitoring to discover whether it is working as intended and is getting the expected results. A quality management system helps to identify problems in program design, and may suggest changes in program design to help improve program outcomes and performance.

Discovery, Remediation and Improvement—The Heart of Quality Management

The quality management system described in this report is built around three key elements: Discovery, Remediation and Improvement. These elements are also the basis of the CMS Quality Framework (See Appendix B). The CMS Quality Framework was developed to guide quality management efforts for fee-for-service home and community based long-term care programs. However, it also provides a useful framework for developing quality management systems for managed-care long-term care programs.

DISCOVERY

CMS defines discovery as "collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement." Discovery typically would involve multiple strategies for collecting evidence of program performance, including:

Discovery Strategies

Learning Directly from Consumers. Since program quality is defined primarily by the results it provides for the people it serves, asking them directly about their experiences with the program can provide direct and valuable insight.

Learning from Performance Indicators. There are measurable indicators that can provide perspective on program performance. For example, if a goal of a program is to prevent reductions in consumers' functional capacity, an indicator that tracks functional status over time could provide useful information on the program's effectiveness. If a program wants to assure access to primary care services, it may track the extent to which consumers receive selected services (flu shots, mammograms, etc.).

Learning about Consumers' Experience. There are multiple sources of information about consumers' experience that can provide insight about program performance. They include systematic reporting from program staff about their observations, and information learned from complaints, grievances and incident reports.

Discovery efforts are systematic and ongoing. Evidence obtained from multiple discovery-related activities is analyzed to identify strengths and weaknesses of program performance.

Stages of Discovery - Primary and Secondary

Primary Discovery consists of gathering and monitoring relatively high-level evidence, even in the absence of suspected or known problems. For example, routine surveys, regularly calculated performance indicators, and routine inspections can provide reassurance that operations are being carried out as planned and are having the desired results, or may provide the initial "red flags" to indicate that there may be a problem.

Primary Discovery will sometimes identify problems that require immediate solutions. For example, if primary discovery reveals a serious health or safety problem concerning one individual, the problem needs to be resolved at once. However, it is important to determine whether problem has systemic roots and if so, what they are. This deeper analysis is known as secondary discovery.

Secondary Discovery involves digging deeper to determine why a problem occurred and to identify what, at a systems level, allowed the problem to happen. Only by identifying and addressing the system-level roots of problems is it possible to prevent future problem recurrence. Secondary discovery may involve further collection of data and information to get a deeper perspective on why a problem has occurred.

Secondary Discovery is a critically important part of the quality management system. Identifying a solution based on primary discovery alone may well lead to a situation where the wrong problem is fixed, or the solution that is selected does not really address the root cause of the problem.

REMEDIATION

CMS defines remediation as "Taking action to remedy specific problems or concerns that arise." Once the root cause of a problem is known, action can be taken to address it.

Remediation Strategies

Are Appropriate to the Problem - In developing remediation strategies, it is important to assure that the strategy is appropriate to solve the identified problem. For example, "staff training" is selected as a response to many problems. However, depending on the specific problem, improvements in supervision, better and more accessible written documentation, or reorganization of program functions may be more effective.

Respond to a Priority Problem - Clearly, not all problems are equal in terms of importance. Remediation efforts would prioritize problems that have the potential to cause the greatest harm. Typically, these would either be problems that could result in major harm to individuals, even if the number of people harmed were smaller, or less major problems that could nonetheless adversely affect a large number of people.

Are Characterized by Follow-Through - Often, quality management fails because there is not sufficient follow-through in remediation efforts. Careful tracking of remediation activities, with assigned responsibilities and due-dates, is essential for effective remediation.

IMPROVEMENT

CMS defines improvement as "utilizing data and quality information to engage in actions that lead to continuous improvement in the program."

Improvement is distinct from remediation in that remediation focuses on correcting problems and bringing program operations up to standard, while improvement focuses on continuously improving program performance, raising it to new, previously unattained levels.

Improvement Strategies

Performance Improvement Projects - Improvement efforts under managed care are required to include 'Performance Improvement Projects' (PIP). As defined by managed-care regulations, PIPs are structured projects that are carefully planned and administered, using data and information to analyze program performance and identify and test solutions.

PIPs often involve the "Plan-Do-Study-Act" (PDSA) cycle of 1) Plan the change, 2) Do it as a test, 3) Study how it went, and 4) Implement it.

CHARACTERISTICS OF A QUALITY MANAGEMENT SYSTEM

In summary, a quality management system has all of the following characteristics:

- It is deliberate and well-planned
- It is based on systematically acquired evidence
- It analyzes evidence from multiple sources to identify problems and their causes
- It fixes problems that arise, and checks to make sure that selected solutions worked
- It pursues continuous quality improvement through well-planned and structured quality improvement efforts

Part III. Challenges In Quality management System Design

Designing a quality management system for home and community based long-term care services differs from quality management system design in many other settings, and is inherently challenging for a number of reasons, including:

THE "PRODUCT" IS A SERVICE, NOT AN OBJECT

It is more straightforward to develop quality management techniques for physical products, which can be weighed, measured, and tested for endurance.

LONG-TERM CARE SERVICES ARE HIGHLY INDIVIDUALIZED

Long-term care services produce different results for every consumer, making it more difficult to set benchmarks and other targets for quality.

THE SERVICE INVOLVES MANY PLAYERS

Many individuals contribute to the quality of long-term care services, including care managers, program administrators, service providers and the consumer him or herself. The large number of people involved, each operating relatively independently, makes it challenging to find causes of problems and to implement improvements.

LONG-TERM CARE TAKES PLACE IN PRIVATE

Much long-term care is provided in private residences and is of a highly personal nature. It is not always possible to conduct inspections, like inspecting a factory. Furthermore, there is no single correct way of doing things; individuals' preferences about how they receive care in their own residences must be honored.

THE CONSUMER OF THE SERVICE IS PART OF THE SERVICE

The consumer is not separate from the service, but is an integral part of determining where, when and how it takes place. The person participates in the planning and production, and consumes the services as they are produced.

OUTCOMES OF LONG-TERM CARE ARE AMORPHOUS

The desired outcomes of long-term care, such as living a meaningful life day-in and day-out despite a disability, are difficult to measure.

LONG-TERM CARE IS HIGHLY REGULATED

Both federal and state governments regulate long-term care. Local government regulations and union contracts may also have implications for program operations. In trying to measure and improve quality within their programs, long-term care program managers need to assure that operations are consistent with the full range of regulations that govern them—while not losing sight of the ultimate objective of providing high quality results for the consumers.

Despite these complexities, it is possible to develop and maintain an effective quality management system for long-term care. To be effective, the system would integrate data and information from multiple sources, and would systematically pursue remediation and improvement. The next part of this report describes how such a system can work.

Part IV. Federal Regulatory Framework for Quality Management

Home and community-based long-term care programs operate under federal waivers from standard Medicaid requirements. The COP-W and CIP programs operate under the authority of 42CFR 1915(c), which covers fee-for-service HCBS programs. These regulations will be referred to as c-waiver regulations. The Family Care program operates under both c-waiver authority and managed-care waiver authority under 42CFR 1915(b). The managed-care regulations will be referred to as b-waiver regulations. The Wisconsin Partnership program currently operates under 42CFR 1115 authority, which is a special regulatory provision for demonstration programs.

It is anticipated that most of the expanded managed long-term care agencies will operate under combined b-waiver and c-waiver authority, under contract with the Department of Health and Family Services.

CMS requires that (c) waiver programs operate quality management systems that measure the extent to which the programs are fulfilling certain assurances. It further requires that the programs take effective action whenever assurances are not being met. The waiver application and supporting materials contain more than 80 assurances that states are required to provide in their waiver applications and that, therefore, their quality management systems are to measure and assure. However, Appendix H to the 1915(c) waiver application, which outlines quality management system requirements, identifies 18 key assurances in 6 categories:

Level of Care:

- An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- Enrolled participants are reevaluated at least annually or as specified in the approved waiver.
- The process and instruments described in the approved waiver are applied to determine level of care.
- The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

Individual Plan:

- Individual Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- The state monitors plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of Individual Plans.
- Individual Plans are updated/revised when warranted by changes in the waiver participant's needs.
- Services are delivered in the type, scope, amount, duration, and frequency and are delivered in accordance with the Individual Plan.
- Participants are afforded choice:
    - Between waiver services and institutional care;

- Between/among waiver services and providers.

Qualified Providers:

- The state verifies on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state identifies and rectifies situations where providers do not meet requirements.
- The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Health and Welfare:

- The state, on an on-going basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

Administrative Authority:

- The Medicaid Agency or operating agency conducts routine, on-going oversight of the waiver program.

Financial Accountability:

- State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

The quality management system described in this report focuses primarily on CMS assurances in the individual plan, health and welfare, and administrative authority categories. Recommendations for quality management of level-of-care assurances were addressed in an earlier stage of the QCTH project, which recommended a quality management strategy for the Long-Term Care Functional Screen.[3] The assurances related to the quality of direct-service providers are primarily the responsibility of the DHFS Bureau of Quality Assurance (BQA) and are not the focus of this report, although this report does include quality management recommendations related to provider performance. [4] The Quality Close to Home project was not charged with developing a quality management system for financial accountability.

In addition to focusing on key CMS assurances, the recommended comprehensive quality management system places considerable emphasis on consumer outcomes and satisfaction, in accordance with the importance Wisconsin places on consumer perspective.

[3] APS Healthcare and The Management Group *Design Elements for a Quality Management System for Long-Term Care Functional Screening*, June 2005

[4] See Discovery Approach 6—Monitoring Providers (p.52) for a discussion of BQA's responsibilities in this area.

B-waiver quality management requirements are included in 42CFR Section 438, subpart D – Quality Assessment and Performance Improvement and subpart E – External Quality Review.

Subpart D requires that:

- The state has a written strategy for assessing and improving the quality of managed-care services provided by managed-care organizations.
- The state incorporates quality standards and expectations into its contracts with managed-care organizations.
- The state would assure that managed-care organizations providing services are meeting standards described in the regulations in the following major areas:
    - Availability of services
    - Adequate capacity and services
    - Coordination and continuity of care
    - Coverage and authorization of services
    - Provider selection
    - Enrollee information
    - Confidentiality
    - Grievance systems
    - Subcontractual relationships and delegation
    - Practice guidelines
    - Health information systems

Subpart E includes requirements for annual external quality reviews of each managed-care organizations. It requires the development of external quality review protocols, and sets out the qualifications and mandatory and optional activities of external quality review organizations.

In recognition of Wisconsin's expectations that home and community-based long term care will be provided mainly by local managed-care organizations in the future, the remainder of this report will describe quality management systems for managed care organizations. However, none of the activities described in this report are inappropriate or impossible for local programs that provide care management in fee-for-service waiver programs.