

Part VI. Primary Discovery Methods

This section of the report discusses the discovery approaches identified in Figure 1. Each discovery method discussion provides a definition, suggestions on how the discovery method could be carried out by the MCO, and how each method contributes to remediation and improvement efforts. This section also describes the role of the EQRO and the Department with respect to each discovery method.

While several core discovery approaches are described here, discovery is not limited to these approaches. MCOs may use additional means to learn about their performance. In addition, it is important to understand that discovery methods are intended to help MCOs measure their performance—good or bad—and not just to find problems. Providing confirmation that things are going well and learning why good outcomes are being achieved, can be as motivational and as instructive in improving systems performance as learning about problems.

Discovery Method 1: Clinical and Functional Indicators

BACKGROUND

A core set of clinical and functional indicators could provide focus to the efforts of all staff who work in the long-term care program and its quality management system. These outcomes could be selected, defined, and developed through collaboration between the Department and the MCOs in the Quality Management Council. Initially, the Quality Management Council could continue to work with indicators developed during the QCTH project, and over time could refine these and develop additional indicators. The Department could then calculate these indicators and provide them to MCOs and stakeholders on a regular basis.

Clinical and functional indicators are statistical measures designed to provide perspective on the program's success in helping members to achieve and maintain their best possible health and functional status.

Examples of potential clinical indicators include:

- Preventable hospitalizations;
- Falls;
- Influenza vaccination rates; and
- Incidence of skin ulcers, wounds, decubiti

Examples of potential functional indicators include:

- Number of members with substantial declines in ability to carry out activities of daily living (ADL) or independent activities of daily living (IADL);
- Change in escalating behaviors over time; and
- Change in need for overnight supervision

The clinical and functional indicators are best displayed in easy-to-interpret graphs or tables. Calculating the same indicators for all MCOs, would make it possible for MCOs to compare their performance with the performance of their peers, providing a point of reference in the absence of established benchmarks. Repeated calculations of the same set of indicators over time would make it possible for MCOs to determine whether they are improving, staying the same, or declining.

MCOs currently develop and calculate internal performance indicators for their own use; this should always be encouraged. However, the Department, which currently has staff or access to staff with sophisticated statistical and analysis skills and will always have access to functional-screen and Medicaid data from all MCOs, is better situated to calculate the core set of clinical and functional indicators than is any individual MCO. . Of course, As other sources of data become available, the Department and the MCOs may consider additional or alternative indicators based on those data.

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Department staff would work closely with the MCOs during the selection process for each indicator in the core set. Factors to be considered include the priorities of CMS and other stakeholders, data availability, consumer needs, program goals, applicability to local program administrators, measurability, benchmarking and presentation of findings. The Department, of course, will always be free to develop any other performance indicators it deems useful.

CURRENT USE OF CLINICAL AND FUNCTIONAL INDICATORS

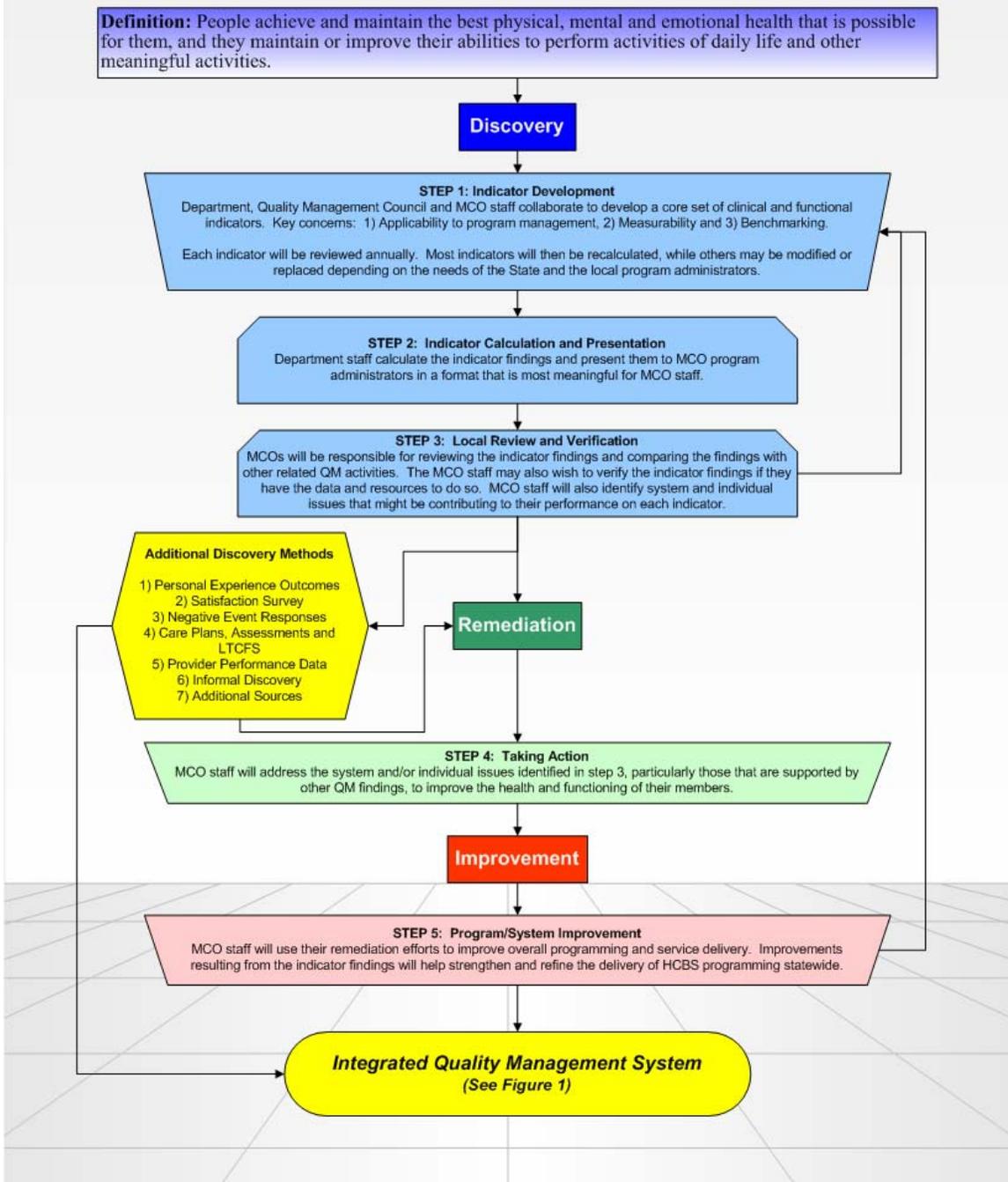
Currently, there is no consistent approach to development and use of clinical and functional indicators among Wisconsin's long-term care programs. For example, the Family Care staff produce routine reports of changes in the program's members' limited activities of daily living (ADLs) and instrumental activities of daily living (IADLs), while the Wisconsin Partnership Program (WPP) uses Agency for Healthcare Research and Quality (AHRQ) algorithms and other evidence-based indicators to define and calculate indicators of physical health using encounter data. Under its contract with the Department for the COP-W and CIPII program, The Management Group (TMG) develops "county profiles" for each county biennially. These profiles, while not strictly quality measures, do include some measures that can provide indications of program quality.

THE CLINICAL AND FUNCTIONAL INDICATOR PROCESS – FIGURE 2

Figure 2 below outlines how clinical and functional indicators would operate within the quality management system.

Figure 2

Clinical and Functional Indicator Quality Management System



As illustrated by the figure, the Department, the EQRO and MCOs would all contribute to the clinical and functional indicator system, as follows:

ROLES AND RESPONSIBILITIES

Role of the Department

Building on work done in the QCTH project (see Appendix D), the Department should collaborate with the Quality Management Council to refine and further develop a core set of clinical and functional indicators. Over time and with experience, the core set of indicators should evolve – what is measured, how the measures are risk-adjusted, and the standards by which the measures are judged.⁷ The Department/MCO-Quality Management Council collaboration could guide interpretation of the indicators and their use in setting priorities for quality efforts.

Department data staff would be responsible for mining existing data, calculating the indicators, and generating reports to share with MCOs and program staff. Department program staff will want to review the findings, and they are best situated to do the analysis necessary to establish benchmarks. While primary responsibility for remediation would rest with the MCO, Department program staff would contact the MCO if it perceives significant issues related to an MCO's clinical and functional indicator results.

Role of the EQRO

The EQRO could validate the quality indicator data reported by the MCOs. The EQRO is also well-situated to offer suggestions and guidance on the production, use and presentation of the quality indicators. The EQRO could calculate the indicators under contract with the Department, assuming some of the Department's responsibilities as described above. The EQRO could also track the indicators over time and contribute to the design of a standardized reporting format for each indicator.

Role of the Managed Care Organization

Each MCO is responsible for most of the primary data collection necessary to calculate the clinical and functional indicators, through activities such as administering functional screens and creating encounter data, which are collected primarily for other purposes. Additional data collection may be required of the MCOs, however, the system proposed here anticipates that the indicators would be derived from existing data. In addition to efficiency considerations, experience has shown that data collected for management and operations purposes tends to be more accurate and timely than data collected solely for the purpose of monitoring quality.

Secondary Discovery

The MCO should review the indicators presented by the Department or EQRO, and identify areas of concern, such as where performance is below other MCOs, below internal MCO targets, or lower than in previous time periods. Follow up in these areas should consist of secondary discovery to determine whether the data are accurate and if so whether other sources of quality management information, such as personal-experience outcomes, satisfaction survey results, negative event

⁷ Risk adjustment is a process to predict health care expenditures based on previous diagnoses or demographic characteristics.

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records, care plan reviews, or provider data shed additional light on the severity, scope, or causes of the indicated problem. The secondary discovery could then continue to identify the root causes of the discovered quality issues and initiate the remediation process.

BEGINNING REMEDIATION AND IMPROVEMENT - CLINICAL AND FUNCTIONAL INDICATORS

Remediation efforts will need to build on insight and understanding created by the discovery process. For example, if an MCO notices an increase in the percentage of members with declining ADLs, the MCO could explore available data to determine whether the poor results were concentrated in one subgroup of its members or a few of its care-management teams, and then rely on other information (clinical records, interviews, whatever it takes) to identify the causes of the unexpected performance levels. The MCO should note the evidence that supports, refutes or explains the indicator results, so that MCO staff can use the insight and information to develop a remediation strategy to improve performance in the area of concern.

The remediation process may require the development of a plan of remediation at the MCO's own initiative or between the Department and the MCO. For example, if the MCO notices a higher than normal percentage of its members is entering the hospital for preventable diabetes-related conditions, they could construct a plan to improve preventative diabetes care. Remediation and improvement within the broader quality management system are discussed in greater detail in *Part VI: The Fully Integrated Quality management System*.

Federal requirements direct the MCOs annually to assess the effectiveness of their own quality management systems and direct the Department to review each MCO's compliance with requirements relating to their quality management efforts. To enable both the MCO and the Department to assess the local quality management efforts, it will be important for the MCO to document its discovery efforts and findings. Recorded discovery results can be used to assess the effectiveness of the remediation efforts and improve the overall quality of services provided by the MCO.

DATA INFRASTRUCTURE

Existing data to support the development of clinical and functional indicators comes from two main sources: Eligibility, claims and encounter data, funneled through the Medicaid Management Information System (MMIS); and functional status data, collected via the functional screen. Data are also available through the Human Services Reporting System (HSRS), although that system is likely to be phased out within the next few years.

Each data source poses unique challenges for the development of consistent quality indicators. Currently, Family Care and WPP sites submit encounter data via encounter data reporting systems specific to each program. Wisconsin Medicaid also has an encounter reporting system for its general Medicaid managed-care population. The waiver sites provide services via the fee-for-service system. Therefore, utilization and claims data are captured and accessed directly through the MMIS. The lack of uniformity between these data sources contributes to a cumbersome indicator calculation process that is difficult to automate.

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All MCOs will be moving to an encounter-based data collection and submission system. Uniform encounter reporting would improve the indicator calculation process. However, the development of an encounter data system is a complex and time-consuming process, usually taking several years until fully consistent data are collected from all reporting agencies. In the meantime, existing data sources will have to be combined to calculate many of the clinical and functional indicators.

AUTOMATION

Once indicators are developed, automating the recalculation on process—that is, creating and running programs that would automatically update the indicators periodically to reflect new information—could provide efficiencies and improve consistency. However, this process is not likely to be possible until several years into the managed-care expansion initiative.

The Department has for several years required the Family Care CMOs to submit their encounter data online in a standardized format. It took several years for each CMO to develop and operationalize their encounter reporting systems and additional time to meet the Department's reporting requirements.

Calculating the indicators may be more complex in regions where the MCOs adopt a WPP model. WPP sites integrate Medicaid and Medicare funding to provide both primary and acute services, as well as long-term care services to their members. The Department does not have direct access to the expenses/services paid by Medicare. As a result, data used to generate the indicators may be incomplete from these sites. Fully implemented encounter systems among the MCOs would eventually address this issue.

Discovery Method 2: Personal-experience outcome Interviews

MCOs that are creating person-centered care plans, as the Department now requires of Family Care CMOs and is likely to require of expansion MCOs, assess personal quality-of-life outcomes and corresponding supports as a component of the initial assessment and on at least an annual basis. However, the state currently has no single accepted method of assessing quality-of-life outcomes. The 12 personal-experience outcomes recently adopted by the Department provide a basis for assessing quality-of-life consistently across all MCOs, which would improve reliability of the care plans and could provide valuable quality management information for one of the central missions of the system: to support the members' quality of life.

These 12 personal-experience outcomes can be assessed in conversational interviews. The Department is currently planning to develop an interview tool, data collection and scoring methods in 2007, with significant participation from the Quality Management Council.

BACKGROUND

One of the primary goals of Wisconsin's long-term care (LTC) system is to ensure that consumers are achieving personal-experience outcomes. Conceptually, outcomes are goals, accomplishments and circumstances that are valued by people. Outcomes may take many different forms including clinical and functional outcomes. Often, people must work on these basic outcomes in order to meet their larger personal goals. For example, an elderly man wanted to play catch with his grandson. However, he had been using a wheelchair since he suffered a serious fall six months ago. He and his doctor worked out a strategy, which involved physical therapy and regular exercise to help him take unassisted steps and improve his upper body strength. By working through a series of clinical and functional goals, the man was eventually able to achieve a desired personal-experience outcome of playing with his grandson. While the presence or absence of clinical and functional indicators may be assessed by others, only the individual can assess whether his or her desired personal-experience outcomes are present.

Wisconsin's use of personal outcomes began in the 1980's with the inception of the RESPECT Outcomes,⁸ which have served as a guide for all subsequent LTC programs. Each LTC program currently has a distinct set of outcomes with unique corresponding discovery and scoring methods. Wisconsin's long-term care consumers, staff, and stakeholders worked with the RESPECT outcomes, during the work that led up to the creation of the Family Care program, to create a new set of 14 personal-experience outcomes that were known as the 'Family Care outcomes.' The COP waiver program also developed some closely related outcomes measures, and the CIP waiver program incorporated some outcomes statements into the tool used during quality reviews conducted by state staff. A separate grant-funded project produced another similar set of outcomes to be used in care planning by providers of services to people with dementia.

However, because the RESPECT Outcomes form the philosophical framework for all these efforts, and because many aspects of quality-of-life are nearly universally

⁸ See Appendix C for the list of RESPECT Outcomes.

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important, the outcomes used by the different LTC sections exhibit significant overlap in their content. For example, all sets of outcomes inquire about a person's living situation, physical health, and community involvement. Additionally, most methods of assessing outcomes learn that information from a conversational interview with the program participant or the participant's representative. In every case, conducting the outcomes interviews for quality management purposes has been a Department-level activity, conducted either by Department employees (for CIP 1A and 1B) or Department contractors (the Council for Quality conducted Family Care and WPP outcome interviews, and TMG conducted COP-W and CIP-II outcome interviews.)

Although each program has variations on the theme, most outcome interviews performed for quality management purposes follow a similar formula. The interviewer meets the consumer wherever he or she would like to get together. Most of the time, that is the consumer's home, but occasionally the consumer prefers to meet in a public place or at a provider agency. The interview is structured but conversational. Keeping in mind that there is a list of outcomes and specific information gathering questions to get through, the skilled interviewer loosely guides the discussion to ensure all topics are covered. Interviews usually last about an hour, and in that time, the interviewer would learn what is important to the consumer, what aspects of his or her life are going well, and where there may be concerns.

After meeting with the consumer, the reviewer typically conducts a follow-up interview with the consumer's primary support provider. This is usually the care manager, although it may occasionally be a caregiver at a group home, an employment specialist, or a nurse. The purpose of this interview is to gain an understanding of the supports being provided to help the consumer achieve his or her outcomes. As with the outcome interview, there are lists of topics to cover, but the discussion would remain loose and conversational. The support provider is not being tested on his or her knowledge of the consumer. Instead, the interviewer is looking for awareness of the consumer's support needs, as well as actions taken to address them.

Previous efforts to use information from outcome interviews for quality management purposes have not achieved strong results. Early attempts to analyze and use the data collected in Family Care outcomes interviews foundered as potential users of the information were unfamiliar with the content of the interviews, and therefore did not understand what the data represented. Care managers and quality managers within the MCOs reported that feedback from the interviews was not sufficiently detailed, too subjective, or too vague to be helpful. Often too much time lapsed between the interviews and when the results were given to the local program.

DEFINING A CORE SET OF OUTCOMES

As part of the Quality Close to Home initiative, a workgroup, comprised of Department staff, local program administrators, care managers and TMG staff, convened to make recommendations regarding the method used to discover and monitor the extent to which members experience the quality of life they prefer. The primary charge was to create a set of core outcomes that the Department could use across programs, with the understanding that minor changes may be needed to make them applicable to each target group. The workgroup, with input from several consumer and stakeholder groups, developed twelve

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outcomes and corresponding definitions that the LTC system could utilize to assess personal-experience outcomes. This information would then be used for two primary purposes: care planning and quality management.

Care managers and Interdisciplinary Teams (IDTs) would use the outcomes to help the member design an individualized plan of care. Using outcomes in this way does not necessarily require a rigorous, formal tool or method. In terms of quality management, the local program would use the data gathered from interviews with members to evaluate how well they are helping members achieve their personal-experience outcomes. Determining outcomes for the purpose of quality management will require a reliable, valid tool and administration method.

The 12 Personal-experience outcomes are⁹:

1. I decide where and with whom I live.
2. I make decisions regarding my supports and services.
3. I decide how I spend my day.
4. I have relationships with family and friends I care about.
5. I do things that are important to me.
6. I am involved in my community.
7. My life is stable.
8. I am respected and treated fairly.
9. I have privacy.
10. I have the best possible health.
11. I feel safe.
12. I am free from abuse and neglect.

In addition to measuring outcomes achievement, care managers and quality reviewers would identify supports in place to help individual members achieve their outcomes. These could include MCO-provided supports and supports from other sources, including informal supports. Information on supports is a necessary step in care planning. Systemically, it provides information to help the MCO understand why outcomes are or are not being achieved, and to begin to suggest strategies for addressing problem areas

The Department plans to release an RFP in 2007 to contract with a consultant to develop an outcome interview tool and an accompanying training program. In designing the tool, it will be important to assure that the tool is both valid (it measures what it is intended to measure) and reliable (results are consistent across reviewers.)

ROLES AND RESPONSIBILITIES – MEMBER OUTCOME INTERVIEWS

Role of the Managed Care Organization

The MCOs are required to create and rely upon member-centered care plans, which require the identification of each member's desired outcomes. Although a standardized method of assessing outcomes is not inherently necessary, standardization of critical processes such as this often improves quality. Adoption of

⁹ See Appendix A for complete list of outcome definitions.

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a standardized method would also enable use of the interview results in quality management activities. With a uniform method of assessing personal-experience outcomes, MCOs could assume primary responsibility for collecting personal-experience outcome information for quality management purposes. Locally administered outcome interviews have several potential benefits in addition to providing timely and relevant information to assist in care planning. It is easier for MCO staff than for Department or EQRO staff to contact members for interviews. It avoids the considerable travel expense of conducting interviews using a centralized pool of interviewers to conduct interviews Department-wide.

However, conducting the interviews at the MCO level presents a new set of issues. For example:

- The MCO would need to ensure that the people conducting interviews have had effective, standardized training on outcome concepts, interviewing techniques, and the actual outcome tool.
- The MCO would need to ensure interviewers remain reliable in their application of the tool. Interviewers within an agency may experience “drift,” which would impact the quality of data they are gathering even though they may all score the interviews similarly.
- Although accurately assessing the presence and effectiveness of supports for their members’ desired outcomes is a central part of the care managers’ job, care managers may find it difficult to objectively evaluate the supports they provide when that information is to be used for quality management purposes. Acknowledging that potential bias, MCOs could weigh the benefits of using care managers’ assessments of supports for quality management purposes, and perhaps initiate a peer review system or other third party to discover the presence or absence of necessary supports for quality management information.
- Based on past experience of LTC programs in implementing outcome interviews, MCOs should anticipate that considerable effort will be needed to educate staff and assure that the organization is ready to collect and use outcomes data. MCOs should devote a significant effort to preparing, educating and training their staff on the benefits and use of personal-experience outcomes in creating member-centered care plans and in quality management discovery.

While MCOs are waiting for a state-endorsed outcome tool and data collection method to be developed, there are activities they can conduct to help ensure a smooth transition to the new system. For example:

- Staff could be trained on outcome concepts, and learning the basics about using outcomes in member-centered care management and care planning.
- Assessment and care plan forms could be examined to ensure they include member-centered elements, and that they inquire about the 12 outcome areas. The MCO can examine care plans for areas where personal-experience

outcomes are being incorporated, and for gaps that may occur when outcomes are mentioned in the assessment but not carried over into the care plan.

Role of the Quality Management Council

The Quality Management Council could provide input and recommendations for the creation of the personal-experience outcomes interview tool. Additionally, they would periodically review the local and statewide aggregate results from member outcome interviews for the purpose of improving the way member outcomes are discovered and used.

Role of the Department

The Department should develop the outcomes tool, assure that MCOs receive training on the tool, and determine the most appropriate methods for ensuring consistency among interviewers. MCOs will need to retain primary responsibility for training and overseeing care managers. The logistics of training several hundred care managers, and then monitoring them to ensure adherence to the model, are challenging. However, over time the MCOs can incorporate the standardized assessment method into the care managers' training programs. One suggested solution for ongoing monitoring might be for the MCO to develop a small team of people responsible for conducting formal personal-experience outcome interviews to be used for quality management purposes. The small teams could undergo more training and testing at regular intervals to ensure their capacity. Care planning and discussions about personal-experience outcomes should remain the responsibility of the care managers and members.

Methods

The MCO could conduct personal-experience outcome interviews with members at the time of their initial assessment and at annual reviews, covering all 12 outcomes annually. The information gathered from the interviews could serve both as the foundation of care plans and as information the MCO can use for quality management discovery. The MCO could choose from a number of different methods to ensure these requirements are met, and that information is gathered as efficiently as possible. For example:

- The LTC supervisor or quality manager could review all or a sample of each care manager's initial outcome interview results during the course of a calendar year. This evaluation would include information learned during the assessment and subsequent home visits, and may require the review of the assessment document as well as case notes. The reviewer would check to make sure all 12 of the outcomes were discussed and recorded, and that the care plan builds upon the strengths, goals, and needs identified during the outcome interview.
- The same process could be applied to interviews conducted as part of an annual review. The MCO would establish a standard for lapse time between when a formal outcome interview is conducted and when the data from that interview is made available for use by the MCO for quality management.

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MCOs could collect data about personal-experience outcome interviews, and, in addition to using the information for internal quality management, provide it to the Department or EQRO, either annually or upon request. Examples of this information may include:

- The frequency with which a particular outcome is achieved or not achieved.
- Increases or decreases in individual personal-experience outcome achievement.
- Increases or decreases in achievement of particular outcomes as compared to previous reviews.

Role of the EQRO

The EQRO will likely continue to conduct annual site visits, at which time they could review a sample of the personal-experience outcome interviews conducted by MCO staff. Additionally, they could interview a sample of members using the same 12-outcome tool, and carry out some form of assessment of the MCO interviewers' reliability. This could be done in several ways, including written or oral testing, or shadowing a care manager during an interview. The EQRO could also conduct targeted outcome interviews based on findings from other types of quality management discovery.

These reviews could serve to validate the MCO's findings from initial and updated interviews, as well as provide the Department with an objective view of the local efforts to ensure quality of the assessment process. The Department could review the results from the EQRO and other quality management information, and in consultation with the MCO, identify outcome or support areas that may need remediation or improvement efforts.

BEGINNING REMEDIATION AND IMPROVEMENT - PERSONAL-EXPERIENCE OUTCOME INTERVIEWS

The information learned from the personal-experience outcome interviews is important, but cannot stand alone in the task of identifying the areas in need of remediation or opportunities for improvement. Other data sources can verify and help to better explain the data from the interviews. These sources include:

- Clinical and functional indicators
- Satisfaction survey results
- Negative events
- Provider quality information
- Critical incident reports

The MCO could look at the data it collects on both individual and systemic levels. At the *individual* level, the outcome interview might discover a problem limited to one member, staff person, or provider. For example, a member may report being very unhappy with the amount of time he spends in the community, or one care manager routinely forgets to ask members questions related to abuse and neglect.

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At a *systemic* level, the data may indicate issues with agency policy, protocol or practices. For example, during a review of outcome interview results, the MCO may notice that several elderly people are no longer meeting outcomes related to feeling safe. The MCO could take that information, paired with anecdotal information and negative event reports to determine whether falls are a growing source of injuries and concern among their members.

An MCO could use several different strings of data it already possesses to deal with complaints, safety concerns, or other potentially serious report individually and systemically. For instance, a young MCO member with a developmental disability might report during an annual outcome interview that she does not like the provider who stays with her at night. The interviewer could ask more questions and discover that the provider playfully mocks the member's speech. This information is reported back to the MCO, which could plan immediate remediation for this individual's concerns. The MCO could then examine negative event records for similar issues regarding this provider or other providers from the same agency. Data from the last round of satisfaction surveys, as well as previous outcome interview results could reveal other instances of dissatisfaction with this particular provider or agency. With this evidence in hand, the MCO would be in a good position to approach the provider agency and negotiate improved hiring, training, and discipline standards and practices.

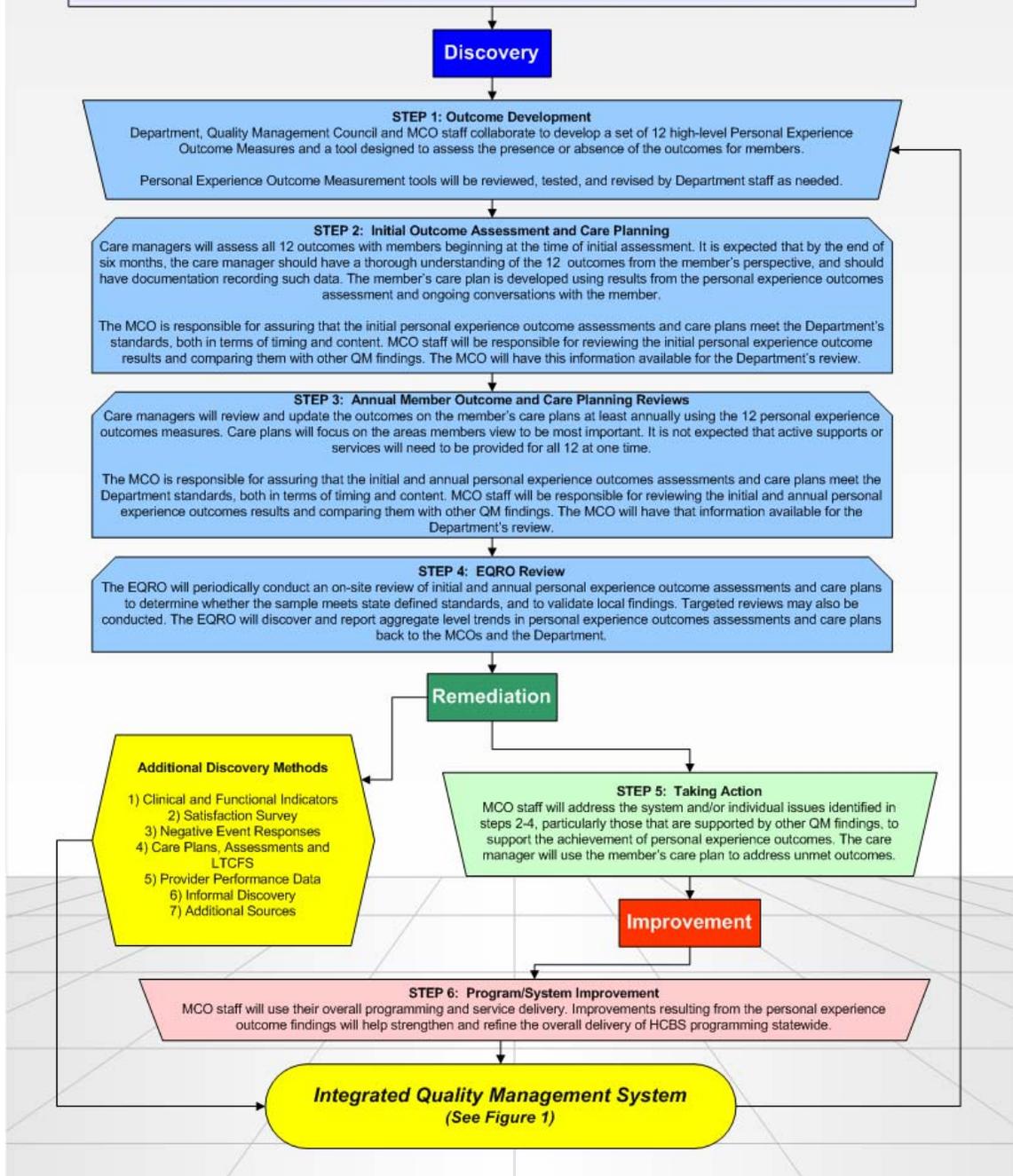
SYSTEM DESIGN –PERSONAL-EXPERIENCE OUTCOME MEASURES

Figure 3 below outlines how personal-experience outcome measures would operate within the quality management system.

Figure 3

Personal Experience Outcome Measures Quality Management System

Definition: People achieve and maintain the personal quality of life with which they are comfortable.



Discovery Method 3: Member Satisfaction Surveys

While satisfaction surveys are generally recognized to be relatively imprecise measures of quality or performance, they provide an effective way to help members understand that their feedback is welcomed and helpful, and a way to elicit feedback from members who might not otherwise speak up. The Department currently requires Family Care MCOs to conduct member satisfaction surveys on an annual basis, and Partnership sites do so without a specific requirement. These practices should continue.

MCOs and the statewide quality management system could benefit from a set of core questions common to all surveys. Individual MCOs could have the option of adding additional questions to meet their specific needs. The satisfaction survey could consist of statements to which the member responds on a 5-point scale, with a “5” indicating strong agreement with the statement, and a “1” indicating strong disagreement with the statement.

The Quality Management Council can take responsibility for developing the core set of questions. Appendix E includes a set of core questions, developed by a Quality Close to Home project workgroup, which could serve as the first set of core questions, to be refined over time.

BACKGROUND

Service organizations have long engaged in a variety of approaches to assess the extent to which their consumers are satisfied with the services they receive. These approaches range from short written questionnaires handed to consumers at the time a particular service is delivered to in-depth in-person interviews covering all aspects of a service delivery system. In addition, many ‘satisfaction’ surveys collect information about more than just satisfaction with services. Surveys are also used to learn whether certain services were delivered, to assess quality-of-life outcomes (e.g., Are you in good health?) and to gather other useful information directly from members or other stakeholders.

Long-term care programs in Wisconsin use a variety of approaches to obtain feedback directly from consumers, with surveys being administered at both the Department and local level. At the local level, the assessment of consumer satisfaction occurs through the ongoing contact between staff and consumers as well as the administration of surveys and structured interviews. Currently, the use of surveys varies greatly among local programs. Those programs that do conduct surveys use the results mainly to confirm information gained from staff contact with consumers.

Federal regulations for 1915(b) and (c) waivers do not require administration of satisfaction surveys. However, the CMS Quality Framework suggests that quality management systems include discovery about consumer satisfaction. DHFS contracts with the Partnership and Family Care programs require administration of an annual satisfaction survey.

The main purpose of satisfaction surveys is to identify areas of satisfaction or dissatisfaction. Since respondents typically express high levels of satisfaction when

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responding to satisfaction surveys, even in situations where other quality measures might indicate that quality is not being achieved, it is potentially misleading to use satisfaction survey results as a sole measure of quality. Expressions of dissatisfaction, however, often point to problems of one sort or another, and can be rich sources of information. Administered properly, satisfaction surveys can be used to solicit individual concerns, complaints, or questions that might not otherwise be raised by members.

Statewide aggregation and benchmarking depends on being able to gather relatively consistent information from each MCO, but information that is useful at an aggregate level needs to be no more specific than high-level information about satisfaction with the overall service package or about services that are used by all members, such as care management. Local agencies may make use of much more specific feedback about individual services and providers. For this reason, a core set of questions focusing exclusively on satisfaction is suggested, with the expectation that local agencies could add additional questions for their own use.

ROLES AND RESPONSIBILITIES –MEMBER SATISFACTION SURVEYS

Role of the Managed Care Organization

MCOs administer consumer satisfaction surveys of their enrollees on at least an annual basis. Participants in the QCTH project expressed some concern that members were subject to too-frequent satisfaction surveys, receiving them from the Department, the MCO, a number of individual services providers and occasional other sources, such as federal reviewers and academic researchers. For this reason, the QCTH participants believed that any statewide satisfaction-survey questions should be included in the MCOs' surveys rather than have a satisfaction survey administered directly by the Department.

The MCO could select the method for administering the survey — by mail, in person, or by telephone. While MCOs would have wide discretion in the method they choose for conducting and analyzing surveys, they will need to be aware of the implications of their choice of method. Sample size, survey presentation, response rate, and other factors can potentially bias the results. Survey recipients can be randomly selected from the entire membership or targeted to a particular subpopulation. The sample size may vary within reasonable statistical parameters; the Quality Management Council could provide a forum in which MCOs could exchange information on effective survey methods. Each MCO could provide the Department with the results of its annual member satisfaction survey at least once a year.

Role of the EQRO

The EQRO could review MCOs' administration of satisfaction surveys. The EQRO review could determine whether survey objectives are clear and the whether data collection and analysis enables the findings to be generalized across the population.

Role of the Quality Management Council

The Quality Management Council could determine the core set of questions to be used by all the MCOs. MCOs could share their individual findings with the Quality Management Council, and the Council could regularly review aggregated statewide findings and monitor the usefulness of the satisfaction survey to the MCOs. The Council would be well-situated to suggest changes to the core questions annually or as needed to increase clarity or usefulness of the survey. The Council may want to weigh question changes against the benefits of longitudinal data collection.

Role of the Department

The Department should provide leadership for the identification of the core satisfaction questions and recommend best practices in conducting satisfaction surveys. Annually, the Department should compile the results of the satisfaction surveys and provide the results to the MCOs who can then compare their results to those of other MCOs. The Department could also review results to identify areas in which MCOs may be experiencing lower-than-desired member satisfaction, and explore those areas with the MCO.

BEGINNING REMEDIATION AND IMPROVEMENT – MEMBER SATISFACTION SURVEYS

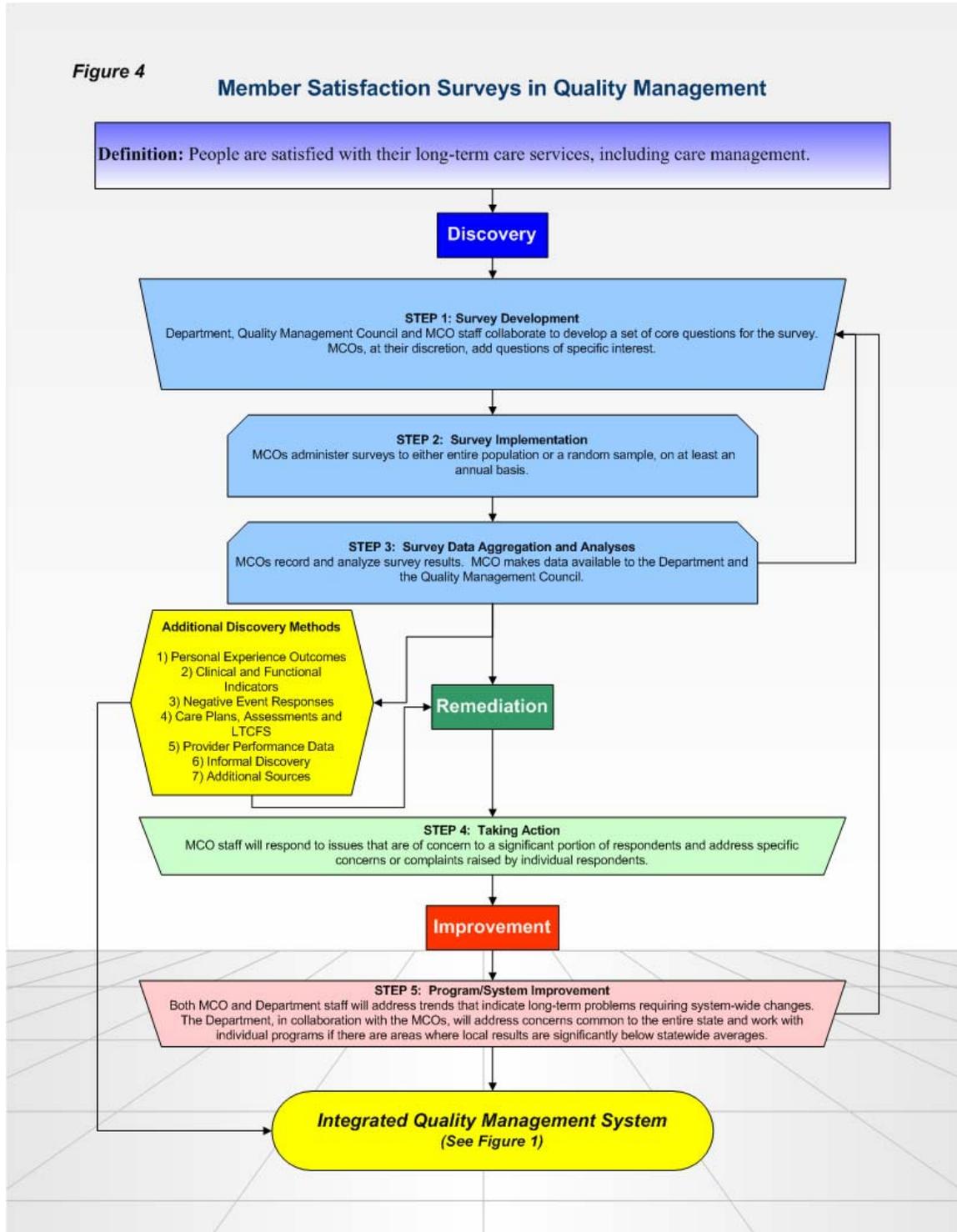
The results of satisfaction surveys, favorable or unfavorable, need to be considered in conjunction with results from other discovery methods. Much information will be anecdotal, coming from only one member, but will need further inquiry regardless. Even when aggregate satisfaction-survey data indicate a concern, some form of secondary discovery should be undertaken. For example, a MCO may discover that members with one of their provider organizations are expressing less satisfaction with services than members with another provider. This may indicate that the first provider needs to change some aspect of its service delivery, but it could also mean that the providers serve different kinds of members, or offer entirely different services. MCO managers would need to look further into the causes of the difference in satisfaction levels before they could assume that the variation is an accurate reflection of the quality of either provider.

The first and possibly most common form of remediation that could be instigated by satisfaction surveys would occur when a MCO responds to a specific concern raised by an individual member. Remediation would also occur when, after secondary discovery, an MCO determines that an individual provider is falling short of expectations and, using the evidence from the survey and from subsequent discovery, the MCO could negotiate a plan of corrective action with the provider. Satisfaction surveys will rarely be the sole impetus for remediation, serving instead to corroborate or challenge concerns that arose from other sources of discovery.

The utility of satisfaction surveys in promoting improvement is hard to assess. The administration of a core set of questions across all MCOs and target groups is an untested approach, at least in Wisconsin. It may take the results of several surveys, with inevitable refinements of the instrument and the process, before the full value of the surveys can be realized.

SYSTEM DESIGN – MEMBER SATISFACTION SURVEYS

Figure 4 below outlines how member satisfaction surveys would operate within the quality management system.



Discovery Method 4: Analysis of Negative Events Affecting Members

Analysis of negative events affecting members provides useful insight into the quality management system. Negative events can take many different forms, including but not limited to:

- Serious incidents involving significant injury or unexpected deaths;
- Medication errors;
- Significant unmet needs ;
- Unsafe physical environments;
- Inadequate supervision or neglect; and
- Minor injuries

MCOs currently rely on several different procedures for identifying and responding to negative events. In managed-care expansion, Wisconsin should build on this experience to ensure that information about these events is used to identify effective ways to remediate discovered problems and to prevent future negative events. In addition to working to improve quality management practices related to critical incidents, the Department should continue its current practice of requesting that the local agencies immediately report incidents with the potential of becoming high-profile situations. The Department, with input from the Quality Management Council, will define what constitutes a “high-profile” situation.

BACKGROUND

The ability to discover, investigate, and resolve events that negatively affect members is essential to maintaining and improving member health and safety, as well as safeguarding member rights. For individual members, having such a system in place helps ensure that they have been informed of their rights, understand what those rights mean, and know how to exercise them. Additionally, the system offers members a sense of safety knowing their issues are addressed in a methodical, structured way. From a broader, MCO perspective, event identification and investigation protocols offer a way to reveal systemic problems that may potentially recur and affect multiple members.

Federal 1915 (b) and (c) waiver regulations are not prescriptive in the area of event reporting. The (c) waiver requires states to provide assurances that they:

- Identify and remediate situations where providers do not meet requirements.
- Continuously monitor the health and welfare of waiver participants, and remediation actions are initiated when appropriate
- On an ongoing basis, identify and address and seek to prevent the occurrence of abuse, neglect and exploitation.

1915 (b) requirements are even less prescriptive regarding critical incidents, including abuse and neglect, requiring that “The state must ensure, through its contracts, that each MCO...oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and...that “(each MCO has) a written agreement (with each subcontracted provider) that...provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.” In addition, each MCO must

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“monitor the subcontractor’s performance on an ongoing basis”, and “if any MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.”

The MCO may learn of negative events in a variety of ways. Events may be reported, formally or informally, by the provider, the member, or the member’s family or guardian. They may be observed by MCO staff.

Certain major events are characterized as *critical incidents*. A critical incident can usefully be defined as:

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, and that meets any of the following criteria:

- *The incident resulted in harm to health, safety or well being of a member or of another person as a result of the member’s actions.*
- *The incident resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of the member’s actions.*
- *The incident resulted in the unexpected death of a member.*

MCO contracts with providers typically would require reporting of critical incidents to the MCO within a defined time period, usually within 24 hours.

While critical incidents are most urgent, most negative events affecting members will not qualify as critical incidents. These include:

- Events described in formal grievances filed by members. Grievances are formal complaints filed according to procedures established by the MCO, and could cover a broad range of topics.¹⁰
- Events described in informal written or verbal complaints to MCO staff from members, families or guardians.
- Observations of events by MCO staff.

The discovery approach described here does not distinguish among events based on how they were originally discovered—whether they were learned about through a formal grievance, or whether they meet the formal criteria for being classified as a critical incident. Rather, the discovery approach described here is based on the following principles:

- Learning about a range of events, from minor events to major events, is key to quality management efforts.

¹⁰ Grievances are defined in the Family Care contract as “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.

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- It would be important for the MCO to have procedures in place for investigating events and prioritizing follow-through.
- It would also be important for the MCO to have systems in place for reviewing and analyzing events to identify patterns and possible systemic issues.

METHODS AND ROLES AND RESPONSIBILITIES

Each MCO should develop a system for responding to negative events affecting members. The system should assure that:

- Negative events are clearly defined.
- Members, providers and MCO staff are all aware of the expectation that these events be reported, and how and to whom they should be reported.
- There is a comprehensive database for recording negative events, with clear responsibility assigned for maintaining the database.
- There is a process in place for prompt initial review and investigation of each reported event to determine necessary corrective action and the causes of the negative event. Depending on the nature and severity of the event and the capability of the provider, this investigation could be carried out by the MCO, or by the provider and reviewed by the MCO. The initial review process should result in immediate action for critical incidents and other events that are judged to be very serious or to pose substantial risk.
- The planned response to each reported event is recorded, specific assignments for follow-up are made, and results of the investigation into causes and the remediation actions are tracked and recorded. Methods need to be in place to ensure that planned follow-through is successful.
- The events database is regularly analyzed to discover patterns of events that may suggest systemic problems. For example, quality staff can identify patterns for different types of events such as falls or medication errors, by provider, age of member, or other criteria. The ability to conduct analysis at this level helps quality staff to identify the systems issues that lead to recurring events.

“Near misses” are defined as events with potentially serious health and safety consequences that are prevented from developing into actual consequences as a result of chance or mitigation. Reports of near misses can offer insight into effective practice methods as well as quality management systems. However, due to the potentially serious nature of the events, staff may be hesitant to report them because they may generate full-scale investigations. Ideally, a paradigm shift in how near-miss incidents are viewed would foster an environment where care managers, nurses, and other providers are encouraged to report near misses and in which they are commended for catching potentially serious problems before they cause actual harm.

Critical incidents

For events that meet the criteria of being critical incidents, each MCO should develop a critical incident policy. The policy would describe how the MCO will identify and respond to critical incidents, including timelines, accountability, and communications

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with key parties. The MCO critical incident systems should include the following elements:

- Timeframes within which providers must report critical incidents to designated MCO staff, care managers, nurses or others;
- Procedures to ensure that potential criminal actions are reported to local law enforcement.
- Procedures to ensure that measures that will be taken to prevent further harm to or by the member.
- Provisions to ensure that events are reported, as appropriate, to external authorities, including adult protective services authorities, BQA and/or the Caregiver Registry.

The MCO should summarize and aggregate its critical incidents records in accordance with guidelines that should be established by the Department. Information on critical incidents and the discovered causes could be made available to the EQRO and the Department upon request, or the Department could require that certain types of critical incidents be reported by the MCO to the Department. Recorded information could include:

- The number of critical incidents reported during a specified period;
- The number of unexpected deaths;
- The number of incidents involving actual physical harm, (short of death) and the number of these that were caused by abuse, neglect, or exploitation;
- The number of incidents involving mental or emotional harm to members, and the number of these that were caused by abuse, neglect, or exploitation;
- The number of incidents that required reporting to other relevant systems, and identification of those systems. For example, MCOs would need to report when police, child-welfare, adult protective services, or community mental health Departments were involved with members' critical incident reports;
- For each incident involving harm to or the death of a member, the MCO would summarize the conclusions of the management review and record in quality management records: a) the actions taken in response and b) the identified causes and contributing factors and the strategies for reducing or eliminating future critical incidents.

Roles of the EQRO and the Department

The EQRO could be instructed to review the MCO's system and record of activities related to:

- Recording negative events;
- Carrying out initial investigations of negative events;
- Prioritizing and assigning and monitoring event investigation and follow-up;
- Identifying event trends or patterns to discover potential systemic issues;
- Reporting of critical incidents to appropriate external authorities and the Department; and

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- Compliance with contractual requirements for processing of grievances.

The EQRO could review a sample of the negative events recorded during the year, to assess the adequacy of the MCO's responses to negative events. As the Department and the EQRO conduct these reviews, they may find that MCOs are experiencing common problems and concerns. Presumably, MCOs could share successful remediation or improvement strategies to manage these issues. The Department should create mechanisms to disseminate these findings to the other MCOs who can then replicate these strategies.

BEGINNING REMEDIATION AND IMPROVEMENT- NEGATIVE EVENTS

The extent to which programs aggregate and analyze records varies among programs, and at the present, discovery in this area seems rarely to leads to discovery of systemic causes or to remediation beyond individual cases.

Implementing remediation at the systems level would benefit from consistent and comprehensive aggregation of information. For example, upon receiving a report of a serious fall, the MCO could review negative-event records of the last 12 months to determine whether falls have been associated with particular locations, times of day, member characteristics, or provider organizations. This would be one step in identifying root causes of the recent fall, and may lead to requirements for improvements in provider training, changes in staffing patterns, or other measures to reduce fall incidence.

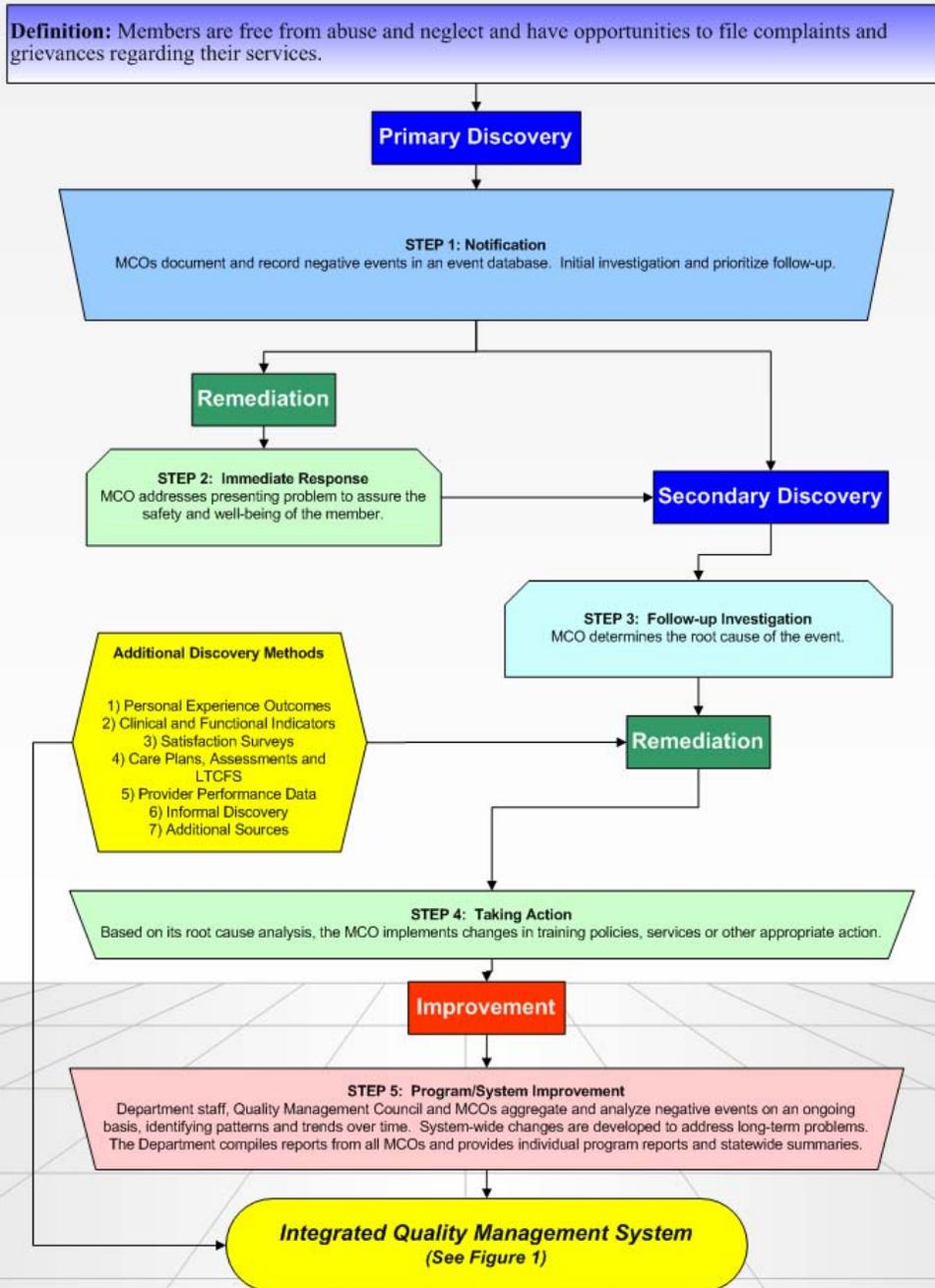
The information gathered through negative event investigations could usefully be supplemented with evidence from other discovery methods. For example, a negative-event investigation might find that several members residing at a particular CBRF have complained about problems with staff, ranging from rude behavior to being left alone in their rooms all day. The MCO would want to examine all records of events related to that particular CBRF. Additionally, they could examine those members' outcome results surrounding respect, fair treatment, abuse, safety, and choosing what to do during the day. Satisfaction survey results may yield information about the caregivers at the CBRF as well. The MCO would also want to do more in-depth interviews with members and CBRF staff. Once that research is completed and analyzed, the MCO would have strong evidence to support negotiating improvements with the CBRF, and to assess the adequacy of the CBRF's efforts to improve its performance.

SYSTEM DESIGN – NEGATIVE EVENTS

Figure 5 below outlines how negative events reporting would operate within the quality management system.

Figure 5

Negative Event Responses in Quality Management



Discovery Method 5: Managing the Quality of Assessments, Care Plans, and Service Delivery

MCOs are contractually required to produce assessments and care plans, and to arrange for effective services for their members. MCO managers should systematically review assessments and care plans to ensure that they are complete and that they reflect member strengths, goals and needs. The MCO will also need to have systems in place to assure that services called for in the care plan are actually being provided, and that care plans are updated when needed.

BACKGROUND

Before any services can be offered, and before any provider contracts can be signed, the preferences, strengths and needs of each individual must be determined. The MCO gathers and applies all of this information through a series of tasks, including conducting a comprehensive assessment, creating a care plan, and providing the home and community based services the consumer requires. Specifically, MCOs are responsible for assuring that the following (c) waiver requirements are completed appropriately:¹¹

Assessments: Consumers of services are given assessments that identify all of their strengths, goals and needs. The assessment would also recognize any unpaid or informal supports available to the consumer, as well as any health or safety risks to which the person may be exposed.

Care plans: Each consumer is provided with a care plan that focuses on the strengths, goals, needs, and supports identified in the assessment. The needs are addressed by either formal or informal supports.

Care plan updates: Individual care plans are updated and revised when warranted by changes in the consumer's needs.

Service delivery: Services are delivered in the type, scope, amount, duration and frequency in accordance with the consumer's care plan. Care plan implementation is monitored.

Choice among qualified providers: Each consumer is given information and support so that he or she can choose among qualified providers for each service being provided.

METHODS FOR ASSESSMENTS, CARE PLANS AND SERVICE DELIVERY

The comprehensive assessment is the starting point for all activities related to service provision. Care plans are created based on the strengths, outcomes, and needs identified in the assessment. A person's assessment and care plan determine the member's cost of care. Service providers are chosen based on the member's preferences outlined in the comprehensive assessment. The quality, timeliness and accuracy of the assessment drive all subsequent activities.

¹¹ These are CMS requirements for 1915(c) waiver home and community based long-term care programs.

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The assessment begins after a person is found eligible for LTC services by the resource center. An IDT, usually including the care manager, nurse and consumer, complete the assessment within a time frame specified by the Department. The assessment process is often long, and may occur over the course of several meetings with the consumer. A comprehensive assessment includes information beyond activities of daily living and medical diagnoses. Looking at the “whole” person involves inquiring about less clinical topics, such as daily routines, religious preferences, community involvement, family dynamics, and personal goals.

Care plans serve as written agreements between the consumer and the MCO about what needs the person has and how those needs are to be addressed. Once again, the consumer, as part of an IDT team, has a primary role in the creation of the plan. The document, which is based directly on the information gathered during the comprehensive assessment, outlines the consumer’s current support network, strengths, personal preferences and outcomes, and the actual services that the individual will need in order to remain in the community.

METHODS – CARE PLANS

The MCOs will need to assure that assessments and care plans are completed in a timely manner and that they contain all important information about the member’s needs, strengths and goals, and that the care plan reflects the assessment.

MCOs would have the flexibility to design the quality management system that works best for them. However, the system that they design would discover and document that: a) assessments and care plans are completed on time and b) assessments and the subsequent care plans cover all of the required content areas and address all of the member’s needs.

The MCO may choose from a number of different quality management approaches to ensure these requirements are met. For example:

- A review of all or a sample of the documents could be created during a specified time period. For example: The supervisor or quality manager of the LTC program could examine 50% of all assessments and care plans produced by each care manager from January through March. The reviewer could look to make sure the documents were completed within the allowed timeframe, that all required information was gathered and documented, and that the care plans build and expand upon the information learned in the assessment. The process could be repeated with assessments and care plans completed from July through September.
- Care managers could conduct peer reviews using the same type of format listed above. For each round of reviews, care managers could evaluate a different peer to help ensure uniformity. The agency’s LTC supervisor or quality manager would be responsible for overseeing the discovery process. The percentages of plans reviewed, as well as the timeframes, could be adjusted to meet the needs of the MCO.

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MCOs would be responsible for collecting specific data about assessments and care plans. This data would be used to drive remediation and improvements at the local level, and would be made available to the EQRO and Department upon request. Examples of this type of information include:

- The rate at which assessments and care plans were completed within a specified timeframe;
- The number of assessments and care plans reviewed;
- The number and types of issues discovered; and
- Specific areas of interest to the MCO or the Department (i.e. the number of people reporting a particular diagnosis; the number of people utilizing a particular service or provider.)

CARE PLAN UPDATES

By their very nature, health, function and personal preferences are dynamic. It is expected that the results of members' assessments and the preferences they report at the inception of their care plans will be subtly, or even dramatically, different given time, illness, and any combination of circumstances. For example, the service and support needs of an elderly woman who relies on her husband as her primary caregiver would look significantly different if her husband is no longer able to care for her. Other factors, such as hospitalizations, changes in living arrangements, or employment can all create notably different service and support needs for the member. Consequently, members' care plans would reflect the ever-changing needs and preferences of the individuals.

The Department, the Quality Management Council and the MCOs should determine and articulate what changes warrant a care plan update. Examples may include, but are not limited to:

- Significant change in medical status;
- Significant change in functional status;
- Change in provider or caregiver;
- Change in eligibility status;
- Change in living situation;
- Hospitalization/institutionalization; and
- Other unplanned events that significantly affect service needs.

MCOs should develop and implement quality management practices that assure care plans are updated as needed. The quality management practices should assure that:

- Updates to a member's plan are completed at the intervals specified by the Department, which usually involves a six-month review;
- Updates are completed within the amount of time specified by the Department. For example, contract language may require the update to be completed within 30 days of the change in the member's status;

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- Updates occur when the member experiences changes that meet the criteria outlined by the MCO and the Department. This may include some items from the list above, as well as events or changes the MCO wishes to track;
- Updates occur when the member expresses a change in preference that would affect service delivery. For example, the member would like to change from his current adult day care provider to a new agency opening across town. This may have implications for the cost, timing, and frequency of not only the adult day care service, but any corresponding transportation and companion services as well.

The MCO can determine the approach it takes to discovery for care plan updates. Examples include variations on the same methods listed above for assessments and care plans. Additionally, care managers could conduct self-evaluations, which would involve having a check list for care managers to determine whether they completed all required fields of a care plan update; whether the update was done in a timely manner; and whether there are precipitating events that could lead to additional updates. Care managers would compare their work to the checklist and record any errors or gaps.

The MCOs could be responsible for collecting specific data about care plan updates, which they would then use to drive remediation and improvement efforts. This data would be made available to the EQRO and Department. Examples include:

- The total number of care plan updates completed within a specified timeframe;
- The total number of care plan updates reviewed;
- The number and types of errors or issues reported; and
- Specific areas of interest to the MCO or the Department (i.e. the number of people reporting hospitalizations within a given timeframe; the number of people requesting changes to or from specific providers.)

METHODS - SERVICE DELIVERY

The MCO will need to monitor to discover whether direct services are actually being provided to members according to the specifications of the care plan. A number of sources of data and information are available to support this effort, including HSRS data, Encounter data, Medicaid claims, Provider billing logs, member interviews, and the members' care plans.

The MCO would design a quality management system to assure services are being provided according to the specifications in the member's care plan. Most importantly, this system could provide prompt reports to the care-management teams to support their monitoring of service delivery. For example, if a member's care plan prescribes supportive home care services, the quality management system needs to discover whether all of the following service delivery components are in place:

- Type – If the member needs someone to clean his home, is that the service he is getting?
- Scope – Is the service meeting all of the member's supportive home care needs?

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- Amount – Is the member getting the actual number of supportive home care hours that were agreed upon?
- Duration – Will the service be provided from the agreed start date until the agreed end date?
- Frequency – Is the provider coming to the member’s home as frequently as the care plan specifies?

The MCO can monitor several different sources of information to determine whether the services are actually being provided in accordance to the care plan. These sources may include:

- The billing system used by the MCO – Do the dollar amounts billed by the provider reflect the amount of services listed on the care plan?
- Provider billing logs – Does the amount of service billed by the provider reflect the correct number of hours agreed upon by the member and the MCO?
- Information learned during conversations with members – Do members believe they are receiving services as agreed upon in the care plan?
- The care plan – Does the care plan reflect the service needs and preferences as agreed upon by the care team, including the member?

The MCO is responsible for collecting data related to service delivery and using that data to inform remediation and improvement efforts. The data would also be available to the EQRO and Department. Examples may include:

- The number and types of services provided by the MCO;
- The number of providers for each service;
- Usage averages for each service;
- Specific instances where services were not being delivered according to the care plan; and
- The number of times differences have occurred between the services promised and services rendered.

METHODS - CONSUMER CHOICE OF PROVIDERS

Having choices about service provision entails having more than one or two services and qualified providers from whom to choose. Each MCO is responsible for the development of a network of providers for all available services. Care-management teams have primary responsibility for explaining available services and providers to the members. This may be done in a formal or informal manner, but there should be documented records of these conversations in the participants’ files. These explanations occur at regular intervals – perhaps at the six-month reviews, if not more frequently. The MCO must also offer members the option to self-direct their supports, consistent with contract requirements.

Having choices about providers can be viewed from two different perspectives:

- *The MCO perspective* – This view provides easier means with which to measure and collect quantifiable data. Examples include: The number of qualified

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providers in a network; the number of people participating in self-directed supports; the number of services available. This concrete view of choice is important, but is not sufficient by itself. Choice is best defined when used in conjunction with the member perspective.

- *The Member perspective* – The members believe they have truly been given options regarding the types of services they receive, and who provides those services. This perspective is not as dependent upon hard numbers, and can be achieved regardless of whether there are four or forty providers in a network. The primary point of this perspective is that the member – not the MCO – defines choice.

Finding and retaining an adequate qualified provider network can be a challenge for MCOs. Rural, sparsely populated areas of the state may not be able to offer the number of options found in urban areas, and member preference may reduce the number of available providers. However, the MCO's quality management system would still assure that choice is measured by:

- The extensiveness of the local provider network
- The member's definition of choice.

The MCO could use several different methods to discover and document whether adequate choices are being provided to members.

- The MCO could review its provider networks, including counts of available services and providers, to determine whether the network meets the Department's criteria for offering options;
- The MCO counts of the number of members using the self-directed supports option, and monitors the types of services they are self-directing; and
- Care managers or other MCO staff interview members about their perceptions of the choices they are offered related to services and the service providers. These interviews are conducted at regular intervals in order to provide the MCO with baseline and longitudinal data.

The MCO is responsible for collecting data related to member choice of providers, and using that data to inform remediation and improvement efforts. The data would also be available to the EQRO and Department upon request. Examples may include:

- The number of members interviewed about choice of providers.
- The number of members who file complaints or grievances related to choice of providers, and the nature of the complaints.
- The numbers of providers available for each service the MCO provides.
- The number of new providers added to the provider network during a specified period of time.
- The number of members who are self-directing services, and the number and types of services they are self-directing.

BEGINNING REMEDIATION AND IMPROVEMENT - ASSESSMENTS, CARE PLANS AND SERVICE DELIVERY

The information MCOs can learn from monitoring assessments, care plans and their service delivery system is best interpreted in conjunction with information from other discovery methods. Tying together data from a variety of sources provides the MCO with a clearer picture of on the quality of the care-planning efforts. To illustrate this point, assume for example, an MCO began to notice a significant lack of transportation services listed on care plans. By using the many data sources that it already possesses, the MCO can begin to whittle down the number of potential causes:

- The MCO discovers that the assessment does not include that line of questioning, therefore, the care managers are not routinely asking about the need for transportation during the assessment process.
- By examining its provider network, the MCO discovers there is only one contracted transportation provider located in one particular geographical area, which happens to contain 40% of the MCO's members. This provider does not have the capacity to adequately serve all members residing in that area.
- Analysis of personal-experience outcome interviews leads to the discovery that members are utilizing informal supports for transportation services, but those providers are not listed on care plans.
- The MCO analyzed the results of the member satisfaction survey, and found there were several written comments that related directly to the lack of transportation services in one region served by the MCO.

Role of the Quality Management Council

The Quality Management Council could serve as a useful forum for exchange of best practices for care-plan review, could review aggregated results from the MCOs' quality management systems related to assessments, care plans and service delivery, and could recommend areas in which MCOs can focus quality improvement efforts.

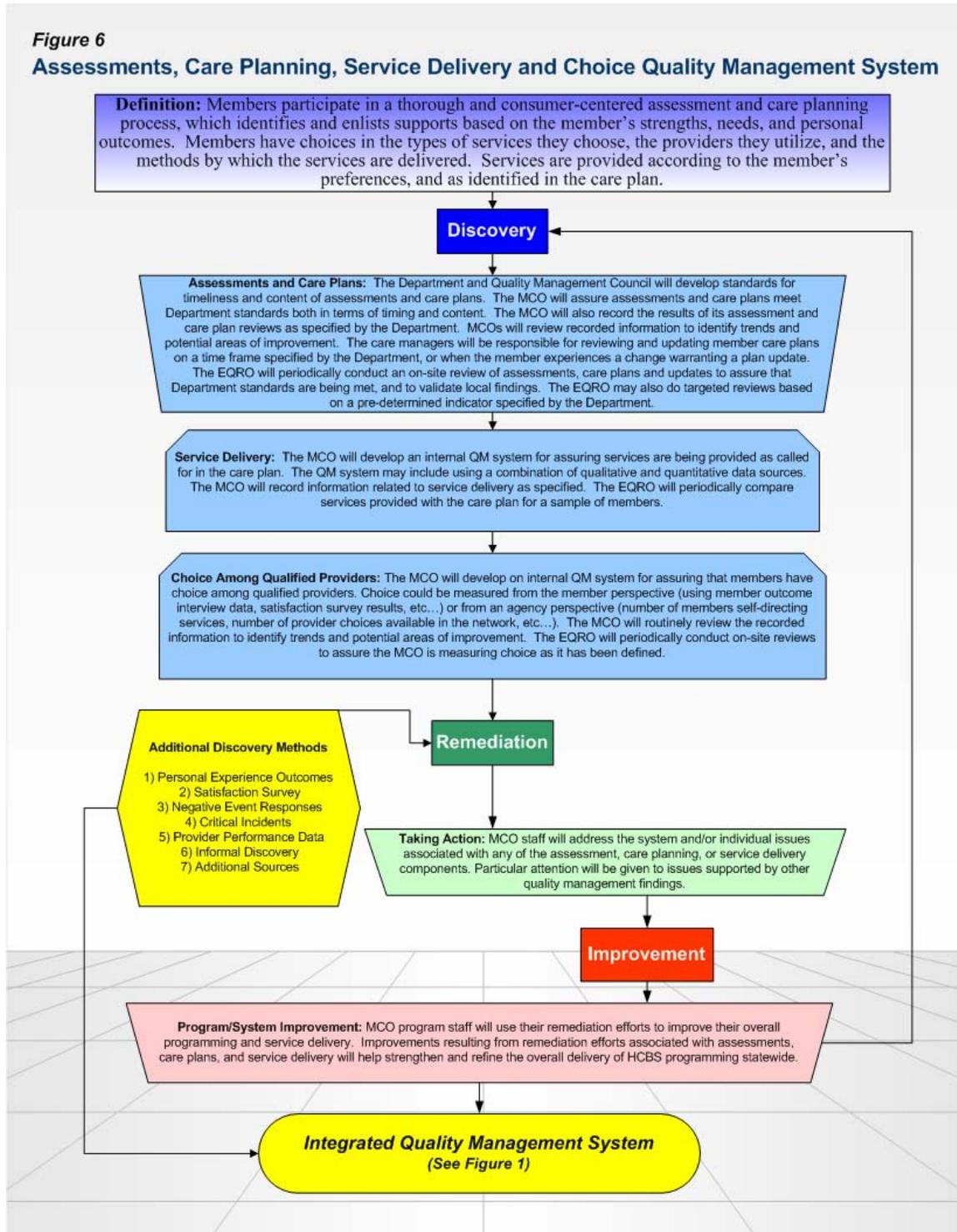
ROLES OF THE DEPARTMENT AND EQRO

As currently occurs for existing Family Care and Partnership MCOs, the EQRO would examine assessments and care plans during annual site visits and in the course of investigating other quality issues. These reviews would both identify quality issues and their causes. The EQRO care-plan reviews could look for many of the same criteria the MCO has discovered: completeness and timeliness of assessments and care plans; continuity between the assessment and care plan; gaps in services; care plan updates; member preference of providers; and evidence that services are actually being provided. Findings from the EQRO could validate the internal quality checks the MCO conducts and provide the MCO and the Department with an objective view of the local quality management system.

The EQRO submits the findings of its care-plan reviews to the MCO and the Department. The Department, upon receiving the review results from the EQRO, identifies areas of potential concern and works with the MCO to assure that the MCO develops and implements remediation strategies for both individual and systemic issues.

SYSTEM DESIGN - ASSESSMENTS, CARE PLANS AND SERVICE DELIVERY

Figure 6 below outlines how the review of assessments, care plans and service delivery would operate within the quality management system.



Discovery Method 6: Monitoring the Quality of Provided Services

BACKGROUND

Direct service providers have tremendous influence on the quality of services received by long-term care consumers. Providers deliver the broad scope of long-term care services, ranging from in-home personal and supportive care services, to group living environments such as community based residential facilities (CBRF), transportation, vocational, and therapeutic services. Even if a member's care plan contains all the appropriate types and amounts of services to meet the member's needs and support his or her outcomes, good results will not be achieved if the quality of the services that are actually provided is poor.

FEDERAL AND STATE REGULATION OF PROVIDERS

Many categories of long-term care providers are subject to significant regulation at the state and federal levels. Fee-for-service (c) waiver regulations include a number of requirements for provider regulation, including:

- States must adopt adequate standards for providers of service under the waiver. It must verify on a periodic basis that providers meet these standards, and rectify situations where providers do not meet standards;
- The state must monitor non-licensed or non-certified providers to assure that they are adhering to waiver requirements, and must identify and rectify situations where providers are not meeting these requirements; and
- The state must have policies and procedures for assuring that providers receive training in accordance with state requirements and the approved waiver.

Managed care (b) waiver regulations require MCOs to ensure that:

- Providers meet state standards for timely access to care and services;
- Providers offer hours of operations for MCO members that are comparable to those available to non-MCO members; and
- Services are available 24 hours a day, 7 days a week when medically necessary.
- Providers comply with practice guidelines, which must be adopted by the MCO.

MCOs are primarily responsible for monitoring providers' compliance, and for establishing mechanisms to ensure compliance.

The EQRO conducts periodic reviews to ensure the MCO:

- Maintains and monitors a provider network sufficient to offer adequate services to its members.
- Has a process in place to credential and re-credential providers in its network.
- Oversees the functions and responsibilities it delegates to its subcontractors.
- Evaluates the provider's performance on an ongoing basis.
- Identifies deficiencies or areas for improvement, and takes corrective action with providers.

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The Bureau of Quality Assurance (BQA) has major responsibility for setting provider standards and ensuring compliance with those standards. The BQA Office of Caregiver Quality (OCQ) has primary responsibility for:

- Administration of the Caregiver Program that requires background checks of caregivers, facility owners, board members and non-client residents in Department-regulated facilities;
- Receiving, screening and investigating allegations of caregiver misconduct, and maintaining the Caregiver Misconduct Registry;
- Administration of the federal and state requirements for nurse aide training, the competency evaluation program and the federal nurse aide registry; and
- Oversight of the Federal Background Check Pilot Program which establishes a fingerprint-based background check process and provides abuse-prevention and training in 4 pilot counties.

The BQA Provider Regulation and Quality Improvement Section (PRQI):

- Determines if health care providers regulated by BQA meet state licensure and federal certification standards;
- Recommends and implements state enforcement actions, when appropriate;
- Works with the Department's Office of Legal Counsel on cases in litigation
- Serves as the main state liaison to CMS for federal certification, enforcement and audit activities;
- Coordinates standards and administrative rule development and promulgation activities;
- Interprets codes and policies;
- Conducts industry and new BQA employee training;
- Provides specialized consultation;
- Develops and carries out quality improvement and assurance efforts; and
- Maintains the Home Health Hotline.

While important and valuable, BQA oversight of providers does not diminish the MCO's obligation to discover the quality of provided services and to identify and remediate problems. Discovering the quality of provided services can be challenging, since MCO representatives typically are not present when the services are being delivered to members. However, through a combination of the following approaches, MCOs can discover whether providers are providing high quality services to members:

- Reviews and site visits, both scheduled and unannounced;
- Event reporting;
- Direct feedback from members; and
- Requirements in provider contracts.

Each of these approaches is discussed below.

REVIEWS AND SITE VISITS

Observations made by alert care managers and MCO staff visiting with members are a primary source of information for quality management, if these observations are reported and acted upon. In addition, contracts with providers should specify that the MCO retains the right to make unannounced site visits at any time to observe the quality of services. They would stipulate that the MCO may require changes as a result of quality issues found during the visit. The MCO could schedule these visits on a periodic basis, particularly targeting visits to providers about which there are concerns.

Staff conducting site visits would be provided with specific criteria to monitor. This would help ensure that visits are thorough, and that providers are reviewed in a consistent manner. An example of this approach is the “Model Quality and Performance Measures” for CBRFs, developed by BLTS in conjunction with a Northeastern region workgroup.¹² The BLTS tool provides a model care management checklist for the evaluation of quality in CBRFs, with specific evaluation criteria in the following broad areas: Resident and staff relationships; service delivery; administration and staffing; and facility characteristics. Similar tools would be developed for other categories of care provider.

Findings of site visits may be used in several ways. First, any immediate health and safety concerns will need to be brought to the provider’s attention and resolved right away. Other concerns would be noted and discussed with the provider. Depending on the issue, the provider may be asked to develop and implement a plan for correcting the concern.

Findings from site reviews would be analyzed across providers and over time to identify possible patterns. For example: Are there particular types of problems common to most providers of a particular type? Do some providers not have that problem? How do those providers avoid that problem? This type of information could be helpful in working with the provider community to address persistent problems. Similarly, it may be found that more problems are associated with workers for a particular supportive home care agency, or for a particular transportation provider. Analysis of site review data would assist in identifying and addressing these trends.

EVENT REPORTS

Discovery of negative events affecting members is described earlier in this report.¹³ Through their daily work, MCO staff visit members in a variety of settings. In so doing, they have the opportunity to observe and learn about events that impact members. Systematically gathering and analyzing this information could provide valuable insight about the quality of services and the incidence and patterns of problems.

Community Health Partnership (CHP), a Wisconsin Partnership Program site, maintains a comprehensive incident reporting system. Staff who learn of out-of-the-ordinary events enter that information into a database. Quality staff review the database entries and determine the type and urgency of remediation and the monitoring needed to assure that

¹² *Model Quality Performance Standards & Measures* DHFS Division of Supportive Living, September 2002

¹³ See Discovery Method 4: Analysis of Negative Events Affecting Members, page ____

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remediation takes place. The database also supports data analysis to identify problem trends. An “event report” is used to record information about events involving falls, infections, acute care episodes, and complaints. A “medication event report” is used to record errors involving incorrect drugs, incorrect doses, adverse or allergic reactions, and other drug-related problems. The resulting databases are searchable. For example, quality staff can identify patterns for different types of events including falls or medication errors, by provider, age of member, or other criteria. The ability to conduct analysis at this level helps quality staff to identify the systems issues that lead to occurring events.

DIRECT FEEDBACK FROM MEMBERS

An important way to learn about provider performance is to learn directly from members. There are several potential ways of learning directly from members about their experience with providers:

- Contractually required annual satisfaction surveys administered by the MCO can ask about satisfaction with providers;
- Member outcomes interviews may also offer perspective on member’s perceptions of the support they are receiving from providers in achieving their outcomes;
- During conversations with members, care managers would routinely ask members about their experiences with providers;
- Formal complaints are an opportunity to learn about provider problems; and
- The MCO contracts with providers would require that providers conduct an annual satisfaction survey and make the results available to the MCO.

REQUIREMENTS IN PROVIDER CONTRACTS

Contracts between the MCO and providers should require providers to implement their own quality management systems. Requirements could vary depending on the size of the provider and the number of members it serves. A small provider serving a limited number of clients might just be required to administer an annual client satisfaction survey and report the results to the MCO. Alternatively, a major provider organization could be required by contract to administer its own quality management system. For all of the above discovery approaches, it is mechanisms are needed to assure that findings are:

- Promptly recorded in a consistent format;
- Immediately reviewed and assigned priority for remediation. If remediation is needed, responsibility and timelines would be developed;
- Discussed with providers as appropriate; and
- Analyzed to identify patterns and trends, to support efforts to address systems issues that are barriers to high quality provider performance.

SYSTEM DESIGN – MONITORING OF PROVIDERS

Figure 7 below outlines how the monitoring of provider performance would operate within the quality management system.

Figure 7

Provider Quality Management System

Definition: MCOs ensure that contract providers provide high quality services through evidence-based practices and reporting.

