

Part VII. The Fully Integrated Quality management System

Background

Part 5 of this report outlines a number of discovery approaches that are used in a quality management system, including:

- Member outcomes interviews;
- Quality indicators;
- Analysis of negative events affecting members;
- Satisfaction surveys;
- Review of assessments and care plans; and
- Monitoring provider performance.

Both the MCOs and the Department have unique but complementary roles to play in carrying out each of these discovery methods (see Appendix F). These approaches can be individually useful in identifying potential problems for further review. They also can work together to provide a deeper perspective on how the program is achieving results for its members. For example, satisfaction surveys may indicate that many members are not satisfied with their home care providers. Is this dissatisfaction also evidenced in member outcome interviews? In negative event monitoring? In monitoring of provider performance? What does this information, in total, tell us about why members are unhappy, or whether people who are dissatisfied meet particular criteria (homebound, non-elderly, etc.) or are served by a particular agency? Are assessments and care plans adequately capturing and addressing the members' preferences with respect to home care?

Relationship Between the Various Discovery Methods

Appendix G is a QM System Reference Guide illustrating the relationship between the various discovery methods and the personal outcomes that are used to define quality. For each outcome, the guide outlines practices that MCOs could be expected to adopt to support achievement of that outcome. It then shows which specific discovery activities support learning about achievement of the outcome.

To illustrate how the reference guide operates, consider the outcome "I am free from abuse and neglect:"

The MCO would likely carry out practices designed to reduce the chance that members would suffer from abuse and neglect. For example, care managers would be expected to ask members specific questions related to abuse and neglect on a regular basis. The MCO would have policies concerning discovery, reporting and remediation of critical incidents involving abuse and neglect. It might track clinical indicators (such as specific mental health diagnoses or emergency room visits for particular injuries or conditions) that could be associated with abuse and neglect, and follow-up with individual members as appropriate.

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Information from several discovery methods could provide perspective on whether MCO members are free from abuse and neglect. They might serve as “red flags” indicating a potential problem needing further follow-up. Alternatively, they might be helpful in secondary discovery, helping with a deeper investigation when an initial problem has been found. For example:

Outcome interviews. Members would be asked about abuse and neglect during outcome interviews, and follow-up outcome interviews with care managers would indicate whether supports are in place to guard against abuse and neglect. Findings of high or increasing percentages of members for whom abuse and neglect is an issue would prompt further investigation of abuse and neglect issues, leading to remediation and improvement activities. Similarly, if care manager follow-ups indicated that supports were frequently lacking in this area, it would be grounds for further investigation followed by remediation actions.

Review of assessments. One discovery technique is ongoing review of assessments to make sure they are complete, addressing the strengths, goals, and needs of the consumer and noting any health or safety risks to which the person may be exposed. If the assessment review indicates that assessors are not routinely asking about abuse and neglect, this could prompt follow-up to assure that assessors know how to ask about abuse and neglect, and to reassess members for potential abuse and neglect issues.

Clinical indicators. Certain clinical indicators could be useful for identifying early signs of abuse and neglect issues. For example, increases in emergency room visits for certain injuries or other conditions associated with abuse and neglect—may indicate the need for further exploration of whether there is abuse and neglect in the system.

Negative event reports. A negative event involving abuse and neglect is an emergency that would be responded to at once. However, a negative event report may trigger secondary discovery efforts to learn whether the event was isolated or whether it was indicative of a more pervasive systems issue.

Taken together, these discovery methods have the potential to provide significant insight about, in this case, abuse and neglect of MCO members. For the other outcomes as well, these various discovery methods, along with other potential approaches, work together to help identify and understand problems that may arise.

SECONDARY DISCOVERY

Secondary discovery begins when information obtained through monitoring indicates the possibility of a problem. Through various forms of investigation, secondary discovery determines whether there is, in fact, a quality issue and if so, determines the source of the problem.

Secondary discovery can take a number of forms. It could involve deeper analysis of existing data, development and analysis of new data, interviews, focus groups, observations or other approaches. The most important requirement for secondary

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discovery is that it “keep asking why”—digging deeper and deeper into the causes of problems until the root cause(s) of the problem is identified with certainty. In investigating the cause of a problem, it is important not to jump to conclusions as to causation—this can lead to “solving” a problem that does not exist and failing to address the real problem.

MCO could use the following framework outlined in *The Team Handbook* by Joiner Associates to identify the root causes of quality issues:¹⁴

1. Identify potential causes;
2. Verify causes with data;
3. Check your conclusions; and
4. Take action

Identify Potential Causes. When primary discovery indicates that there may be a potential problem, start by brainstorming potential reasons that the problem may be occurring. Invite a variety of people to participate in this discussion, to assure that diverse perspectives are represented. For example, suppose that in outcomes interviews a high percentage of members indicate that they don't get out in the community as much as they would like. Ask next, why are members unable to participate in the community as much as they would like?

Brainstorming answers to this question might yield the following ideas:

- There aren't enough transportation providers
- Members aren't asked about their preferences for being in the community during the assessment and care planning process
- Many people have severe disabilities that make it extremely difficult for them to leave their homes.
- There aren't enough activities in the community for people to participate in.
- Care managers want to help people with this problem, but don't know how to do it.

Depending on which of these ideas is actually the root cause of the problem, very different remediation strategies would be selected.

Verify causes with data. Identify what data or other objective information would be useful in determining whether the potential root causes identified in brainstorming are indeed the root causes. Some of this data may already exist, while other information may need to be generated. Whenever possible, use graphs, charts and other means to visually display data.

In the above example, the following types of data could be useful:

¹⁴ Joiner Associates *The Team Handbook*, Second Edition 1996

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- Reviewing care plans to determine how many people get out into the community, where they are going, and how they are getting there;
- Reviewing provider network to determine its capacity for transporting and supporting people in the community;
- Reviewing transportation expenditures over the last several years; and
- Reviewing assessments to see if they address people’s preferences for community participation.

Check your conclusions. The data analysis may help rule out some of the potential root causes identified in step 1, while supporting the role of other root causes. For instance, data might show that assessments are recording people’s preferences for getting out into the community, but that the transportation network for getting them there is inadequate for the demand. Thorough data analysis will point to the root causes of the problem.

Take action. This is *remediation*.

Remediation involves correcting the problem, both for any individuals who might be involved, and addressing the systems problems that created or allowed the problem in the first place.

In the example above, it might mean working with transportation providers to expand network capacity. It might mean working with care managers on strategies for utilizing informal supports (families, neighbors, etc.) to help people access the community.

In planning remediation, it is particularly important to assure that the remediation strategy: a) fits with the identified root cause, and b) is practical to accomplish, both in terms of time and expense.

It is also important to develop a concrete plan for implementing the remediation action. The plan would detail:

- What exactly will be done;
- Over what time period it will be done—when it will start and when it will be completed;
- Who is responsible for carrying out what specific tasks; and
- Who has overall responsibility for assuring that the remediation is complete.

Workplans can be useful tools for displaying the above information and monitoring progress. The MCO’s quality coordinator would be closely involved in monitoring all remediation activities, to make sure that they are completed on a timely basis and to address any problems that may arise.

Finally, the MCO will need to test whether the remediation succeeded in correcting the problem. In the example above, did expanding transportation provider capacity result in more people going into the community? Were more people engaged in the community with the help of informal supports? A timeframe for measuring success

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would be set (recognizing that major changes take time to accomplish.) Specific measures of success would be established in advance. In addition to providing assurance that the remediation effort successfully addressed the problem, quantified, documented evidence of successful remediation efforts is valuable in maintaining staff morale and providing motivation for additional quality management efforts.

It is important to note that not all problems identified through discovery end up being remediated. Staff resources to work on remediation are finite, and priorities need to be set. Clearly, problems that negatively affect large numbers of members, or which jeopardize members' health and safety, need to be corrected before lesser problems. Some local long-term care programs have adopted formal approaches for assessing the risk of particular problems and prioritizing problems for remediation.

Improvement compared to Remediation

The primary distinction between “remediation” and “improvement” involves different meanings for the terms:

- Remediation is targeted at fixing problems and bringing operations at least to an *acceptable* level.
- Improvement is targeted at raising the threshold of performance to new, *higher* levels.

In addition, improvement has special meaning in federal managed-care regulations. Federal regulations for quality in managed care (42CFR Part 438, Subpart D) require that MCOs have an ongoing program of performance improvement projects (PIPs) focusing on clinical and non-clinical areas. The PIPs involve measurement of performance, using objective quality indicators, and they are designed to achieve improvement of quality. Interventions resulting from the PIPs must be evaluated, and there would be ongoing activities to increase or sustain improvement. PIPs are best designed to provide measurable improvement within a reasonably short timeframe, and to allow for prompt mid-course corrections.

MCOs report the status and results of their PIPs to the Department. With the assistance of the EQRO, the Department reviews, at least annually, the impact and effectiveness of each MCO's performance improvement program.

Successful PIPs are frequently targeted on issues identified by the quality management system. A common weakness of PIPs is insufficient assessment of the problem to be addressed, a weakness that is less likely if PIPs are designed to focus on issues that have already been examined by other quality management efforts.

Teams representing the range of stakeholders associated with the issue could be involved in planning, carrying out, or evaluating PIPs. Members, care managers, providers, administrators and other appropriate persons could be included. Successful PIPs have a team leader and a structured process. The PIP process focuses on the use

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of data and information to identify the root causes of problems, identify and plan interventions, and measure the effectiveness of interventions.

A number of methodologies have been developed for carrying out PIPs. For example, the Family Care and Partnership Programs have used the ‘Best Clinical and Administrative Practices’ (BCAP) typology. However, while details and terminology for the various approaches vary, most approaches include something similar to the following seven steps:¹⁵

1. Define the project’s purpose and scope, resulting in a clear Department of the intended improvement and how it is going to be measured;
2. Describe the current situation. Gather more information, if necessary, to assure a complete understanding of the current situation;
3. Identify and confirm root causes with objective evidence;
4. Plan and implement solutions that address the root causes;
5. Measure results, using data to evaluate both the solutions and the plans used to carry them out;
6. Standardize solutions. If the solutions that were tested appear to have improved performance, make formal changes in procedures, policies or other areas to make sure that they continue; and
7. Make plans for future improvement. Identify areas for future improvement and plan for those improvements.

¹⁵ Joiner Associates *The Team Handbook*, Second Edition 1996

Part VIII. Organization of Quality management Functions

Proper organization and staffing are crucial to the effectiveness of a quality management program. For quality management programs to be effective, program staff must have both the capacity to implement the program and the authority to drive changes to remediate problems and improve quality. Moreover, in organizations with effective quality management systems quality becomes a central component of the organization's operations, not just an afterthought or an add-on. This section describes how the MCO and the Department could organize to support a strong and effective quality management system.

Quality Management within the Managed Care Organization

Quality management at the MCO level may require a culture shift among staff, supervisors and program administrators, so that they come to understand and accept the importance of the practices needed to manage quality. Quality management staff have not traditionally been a part of the overall home and community-based care program staff, and do not have a well-understood role like that of a care manager or nurse. As a result, it may take time before each new MCO fully realizes the value of providing organizational support and authority to their quality managers and staff.

The experience of Family Care illustrates some challenges in developing the quality management role in a home community-based services program. As the Family Care CMOs started operation, they hired quality managers. However, the linkage between the quality managers and program operations was not always clear, and the quality managers often did not feel justified making recommendations or initiating quality-related activities involving other staff. Several CMOs in Family Care did not provide their quality leads with significant organizational weight until after quality issues developed.

Family Care CMOs also were disadvantaged by an early lack of accurate, timely and objective performance data, and of the capacity to produce that data. Over time, quality staff came to include persons with data management, fiscal and information technology skills to help generate and manipulate various types of performance data. These skills will be important for the overall success of quality management statewide.

Finally, the leadership of each MCO needs to accept local responsibility for quality management. In the COP and CIP programs, quality management relies heavily on Department actions. In managed care, the MCOs will have primary responsibility for quality management. Taking primary responsibility for quality management will require taking the organizational initiative to discover and monitor quality versus reactively responding to quality issues identified by the Department or by consumers. Quality management systems that rely primarily on anecdotal and subjective problem identification and assurances of quality are not sufficient for managed-care quality requirements. The quality management system of the expanded managed-care system will need to rely on data to identify quality issues and will need to produce objective evidence of the success of remediation and improvement efforts. MCOs will need to develop quality management practices that provide transparent quality assurance.

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It is recommended that the Department continue to require each MCO's quality management system to include the following key components:

- The MCO Board of Directors;
- A quality management committee;
- A quality management director; and
- A quality management program description and action plan that describes quality management support functions and assures consumer participation.

MCO Board of Directors

Each MCO's board of directors is responsible for fostering a culture of quality management, maintaining quality management as an MCO priority, and directing the necessary MCO resources to best meet the needs of the members.

Each board of directors receives reports from the MCO director, the quality management director and the quality management committee. The board of directors is responsible for setting annual quality management priorities and approving the MCO's annual quality management plan. The board of directors also continuously monitors the quality of services provided to the MCO members.

The MCO director and quality staff need to provide the board of directors with a detailed introduction to quality management principles and techniques, and to the board's quality management responsibilities. The MCO director will need to reinforce the importance of quality management and emphasize the quality management resources available to the MCO, particularly the designated quality management staff.

Quality Management Committee

The MCO's quality management committee is responsible for designing, building and maintaining the necessary quality management infrastructure to achieve successful quality management. The quality management committee is directly responsible for organizing and carrying out the quality management system described in this document. It is responsible for assuring that each component of the quality management system is fully developed and provided the necessary resources to be successful.

The quality management committee needs to draw staff from all levels of the MCO, including client-contact staff, fiscal staff, and other administrative staff. It is important that managers from all program areas — fiscal, human resources, network development, care management, information systems, etc. — be represented on the committee. The quality management committee needs to develop approaches for assuring that consumers and providers are represented in quality management activities. This could involve having consumer and provider representatives serve directly on the quality management committee. Alternatively, the quality management committee may want to establish an advisory group of consumers and providers, with which it would consult regularly.

Quality management Director

The quality management director is to be the point of contact for all quality management efforts within the MCO. The director develops and oversees the MCO's quality management plan, staffs the quality management committee and the quality management governing board, and directs day-to-day quality management activities. The quality management director would also represent the MCO when meeting with the Department to discuss quality management and quality improvement.

The quality management director should have a strong background in quality management and quality improvement principles and practices in a managed-care environment. The quality lead should also have experience working with care managers and other client-contact staff. Familiarity with financial and administrative data would also be helpful. Most importantly, the quality management lead should have the authority to allocate or access the necessary resources to ensure the success of the quality management system.

Quality management Program Description and Annual Goals

As currently required in the Family Care and Partnership programs, each MCO would develop a quality management program description, which would be reviewed and approved by the Department. The program description should describe the key components of the MCO's quality management system, including:

- Quality management system organization and staffing;
- Linkages between the quality management system and MCO operations;
- Budget and resources for quality management;
- Quality objectives and priorities;
- Description of discovery activities and reporting;
- Description of approach to remediation;
- Description of approach to improvement; and
- Approaches for assuring consumer and provider voice in the quality management system.

Additionally, the MCO will be responsible for submitting an annual quality plan, which provides the Department and the EQRO with an understanding of what quality improvement efforts each MCO plans to undertake that year. The plan serves as a workplan for stakeholder groups and federal reviews, and fosters a sense of unity and purpose within the MCO.

Organization at the Department Level

Just as the local role in quality is different in managed care than in fee-for-service programs, so is the Department's role. Under the COP-W and CIP programs, the Department carries out a large amount of direct discovery to assess the quality of local programs. Under managed care, direct discovery by the Department will be more limited. Instead, the Department contracts for quality with MCOs and monitors MCO quality management performance under those contracts.

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The importance of the quality management function would be reflected in the organization of the Department. This importance can be reflected organizationally in the following ways:

- A high-level Joint Steering Committee would oversee the development and implementation of the statewide quality management system. The Joint Steering Committee should include senior managers from within DDES, who have authority and responsibility over key program functions, and could seek consumer input.
- A quality manager would provide focus and direction for the quality management program. He or she would supervise staff assigned to the quality management program, and would work closely with program managers to inform them of quality management system findings and to assist them with designing and implementing remediation and improvement strategies.
- Two types of staff should be assigned to support quality management activities:
 - Staff with strong programmatic background who understand long-term care and managed-care operations; and
 - Staff with strong data analysis skills.

If the Department intends to conduct direct site reviews of MCOs (rather than relying solely on the EQRO for this function), it needs to assure that it has an adequate number of trained staff available to carry out this activity.

Department quality management staff could perform a number of key functions, primarily related to reviewing discovery results generated by MCOs and following up with MCOs when significant problems or concerns are recognized. For example, Department staff could review appeals and grievances, and work with MCOs on particularly significant issues. They could review quality indicators and follow up if an MCO's performance appears to significantly deviate from previous results or expected benchmarks.

The Department will need effective systems for storing, retrieving, and sharing information about MCO quality. It will be important that these systems require Department staff, regardless of specialization, to communicate effectively with one another and with the MCOs about the identification and resolution of problems, as well as the use of best practices and successful approaches.

- The Quality Management Council could provide guidance to both the Department and MCOs on quality management policy, practices, and benchmarks. Other duties could include but would not be limited to:
 - Sharing best practices in quality management
 - Sharing quality management findings
 - Providing collaborative guidance to the Department and EQRO quality management activities and methods
 - Participating in developing useful, performance indicators

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- Reviewing the results of performance indicator analysis and other Department and EQRO findings to provide guidance on statewide quality management priorities
- Providing input and guidance on program policy development as it relates to quality management

Membership would consist of quality managers from each MCO, state staff with quality management responsibilities, and EQRO representatives. Consumer and provider representatives may be consulted to advise the Department on quality-related issues, but it is not foreseen that they would attend every meeting. The Quality Management Council would maintain ongoing web-based collaboration, and would conduct quarterly in-person meetings.

The quality manager and other Department representatives should staff the Quality Management Council. That person or persons would be responsible for:

- Maintaining the calendar, facilitating communications, documenting minutes, and arranging meetings;
- Ensuring that the Quality Management Council meetings correspond with required work deadlines, and that the members of the Council have all necessary documents and materials;
- Creating and distributing reports and memos reflecting the Quality Management Council's recommendations; and
- Performing research and analysis into quality management at the Council's request.