

Quality Close to Home

**A Preliminary Design for an Integrated
Quality Management System**

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By
The Wisconsin Department of Health and Family Services
APS Healthcare
The Management Group, Inc.



Quality Close to Home: A Preliminary Design for an Integrated Quality Management System

for Home and Community-based Long-term Care Programs
for Adults with Disabilities and Frail Elders

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SUMMARY

In late 2003, the Department of Health and Family Services, with the help of a grant from the federal Centers for Medicare and Medicaid Services (CMS), initiated a three-year project known as “Quality Close to Home,” or QCTH. This project set out to:

design a coherent and comprehensive quality management system for home and community based long-term care programs for adults in Wisconsin, working with the skills, knowledge and insights of the stakeholders in Wisconsin’s long-term care system; the CMS Quality Framework; and federal, state, and local requirements.

The attached report, *Quality Close to Home: A Preliminary Design for an Integrated Quality Management System*, is the last of the several products of this project, which was complete September 30, 2006. The attached report:

- Defines the scope of activities considered to be ‘quality management;’
- Describes the challenges facing quality management activities in the home and community-based long-term care system;
- Identifies the federal rules and regulations that must shape the quality management activities in federally-funded long-term care programs; and
- Describes a detailed vision for the activities that could comprise the core of an effective quality-management system for home and community based long-term care and how these responsibilities might be distributed in a system that efficiently integrates state and local efforts.

Of all the management functions that must operate in any organization—budgeting, procurement, human resources, the services themselves, and quality management—it is quality management that most needs to demonstrate what it means to engage in continuous improvement. Therefore, the attached report is not—cannot—be a comprehensive or final prescription for an effective long-term care quality management system. Quality management practices will always be evolving and improving.

Many observations in the attached report about the quality-management system of the expanding managed-care system are simple statements of fact: for example, that an External Quality Review Organization will be an integral part of the quality-management system. However, the attached report is not an official or final determination by the Department Health and Family Services of the requirements for either state or local quality-management activities in the expanding managed long-term care system. The details of the quality-management system will not be known until state and local policymakers have developed all the detailed specifications that will be included in waiver applications, contracts, and state and local policy documents relating to quality-management practices.

Instead, the attached report is intended to serve as a source of guidance, a basis for communication, and a reference for all the dedicated professionals, advocates, and consumers who will be involved in developing the specifications for and implementing quality-management practices for the emerging statewide system of managed long-term care.

Acknowledgements

The Department is deeply grateful to all who participated in this project, who are too numerous to acknowledge individually. Throughout the project, consumers provided their thoughtful suggestions and comments through the Stakeholder Committee of the Wisconsin Long-Term Care Council, which was formed during the course of the QCTH project and will continue beyond its close. Other consumers, knowing that it would have no immediate personal benefit for themselves, consented to give of their time and attention to help us test the Participant Experience Survey (PES).

Long-term care providers and leaders of advocacy groups provided valuable input through meetings of the Wisconsin Council on Long-term Care Reform and its Executive Committee, and through gracious participation in individual interviews. State staff assigned to different long-term care programs across administrative units within the Department provided ongoing input and collaboration.

Two firms, APS Healthcare and The Management Group (TMG), formed a partnership to staff the QCTH project; provide extensive background research and analyze data; organize and support the work of various workgroups; conduct interviews of consumers, state staff, providers, and local staff; and to write the several reports that the project produced.

Finally, staff and managers of local long-term care agencies gave generously of their time, effort, insight, and expertise to participate in many different ways, which included:

- Scheduling interviews for the test of the PES and opening their local programs to assessment with a tool that was unfamiliar to them;
- Providing thoughtful comment and suggestions on the different ways that outcomes measurement might be helpful to them in the quality-management efforts;
- Providing extensive feedback and insight in the course of workgroups that:

- Selected and defined a set of 12 personal-experience outcomes to serve as a basis for pursuing quality results for Wisconsin’s long-term care consumers;
- Established guidelines for useful measurement of personal-experience outcomes;
- Reviewed research on the calculation and use of performance indicators relating to clinical and functional outcomes;
- Reviewed research and shared experience related to assessing and reporting consumer satisfaction with services;
- Shared practices, insights, and ambitions relating to quality control of assessments, care plans, and service plans; and
- Explored requirements and practices relating to effective response to critical incidents; and
- Provided, through extensive individual interviews, information about their current quality-management practices, their experience about practices they found valuable; and their perspective on ways the State could usefully support their quality-management programs; and
- Sorted out requirements and issues relating to the optimal distribution of quality management responsibilities between the State and local agencies.

During the course of this project, a group of staff and managers who have responsibilities for quality management in their local long-term care agencies came together in a lively, productive group known as the QCTH Local Advisory Panel. In this group, they provided valuable insight to the development of the attached report, shared best practices, and formed the core of what the Department expects will be one long-lasting legacy of the QCTH project: a statewide Quality Management Council, which is expected to provide effective guidance and set the bar for effective long-term care quality management for years to come.

Background

In 2002, the Department of Health and Family Services merged the organizational units that administered several programs of community long-term care for adults with physical or developmental disabilities and frail elders. At the time of the merger, these different programs (primarily the Community Options Program, or COP; the Community Integration Program, or CIP; Family Care; and the Wisconsin Partnership Program) had different policies and practices related to the assessment of quality, the remediation of quality issues, and quality improvement.

When federal funds became available in 2003 for systems-change efforts related to quality assurance and quality improvement, the Department applied for, and received, a CMS Systems Change grant to undertake the Quality Close to Home project. At that time, a primary objective of the project was to devise quality-management strategies (that is, policies and procedures that would discover the extent to which quality objectives were being attained, remediate any identified problems, and carry out quality improvement) that could be used across all the recently-reorganized programs (COP, CIP, Family Care, and Partnership.)

However, during the course of the project, the Governor of Wisconsin announced an ambitious initiative to expand managed long-term care beyond the few counties served by the Family Care and Partnership Programs to the entire state, eventually supplanting the fee-for-service waiver programs. At that point, the QCTH project focused its efforts solely on the quality-management system that would be needed to discover, remediate, and improve the quality of care in the new system.

The earlier QCTH reports, although completed before the announcement of the managed-care expansion initiative, remain useful. These earlier efforts informed the development of the attached report, but are not repeated within it:

- the results of a trial of a participant experience survey instrument that had recently been made available to states by CMS;
- a review of other outcomes-measurement tools being used in Wisconsin's programs that serve adult long-term care consumers;
- specifications for a system of monitoring and improving the completeness and accuracy of the functional screens that determine eligibility for the adult long-term care programs; and
- a review of various practices and methods being used by local long-term care agencies (managed-care organizations and county waiver programs) to monitor and improve the quality of their services.

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Acronyms

ADL Activities of daily living

AHRQ Agency for Healthcare Research and Quality

BCAP Best clinical and administrative practices

BLTS Bureau of Long Term Support

CBRF Community Based Residential Facilities

CHP Community Health Partnership

CIP Community Integration Program

CMS Centers for Medicare and Medicaid

COP-W Community Options Program Waiver

DCFS Division of Children and Family Services

DDES Division of Disability and Elder Services

DHFS Department of Health and Family Services

EQRO External Quality Review Organization

HCBS Home and Community based Services

HSRS Human Services Reporting System

IADL Independent activities of daily living

IDT Interdisciplinary teams

LAP Local Advisory Panel

LTC Long-term care

MCO Managed Care Organization

MMIS Medicaid Management Information System

PIP Performance Improvement Projects

QCTH Quality Close to Home

QSR Quality Service Review

TMG The Management Group

WPP Wisconsin Partnership Program

Part I. Preface

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

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

Background

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

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

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

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

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

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

Key Principles

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

PURPOSE OF QUALITY MANAGEMENT

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

INTEGRATION

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

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

EMPHASIS ON LOCAL QUALITY SYSTEMS

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

EFFICIENT USE OF RESOURCES

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

Part II. What Is Quality Management?

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

Defining Quality: Process vs. Outcomes

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

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

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

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

Therefore, a good quality management system needs to focus on the results, or outcomes, that are produced for consumers. These include measures of the consumers’ health and well-being—clinical and functional outcomes such as the incidence of health problems and levels of functional abilities. In addition, the Department has identified 12 ‘personal-experience outcomes’ as a primary basis for defining quality¹. Personal-experience outcomes are individually defined by each consumer and provide both care managers and quality reviewers with a sense of each individual’s quality of life.²

- I decide where and with whom I live.

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

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

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

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

Defining Quality Management

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

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

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

PLANNED, SYSTEMATIC APPROACH

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

CONTINUOUS MONITORING

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

ANALYSIS

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

CORRECTION

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

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

IMPROVEMENT OF PERFORMANCE

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

What Quality Management is Not

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

DOING WORK WELL

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

TECHNICAL ASSISTANCE

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

ANECDOTAL EVIDENCE

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

PROGRAM DESIGN

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

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

Discovery, Remediation and Improvement—The Heart of Quality Management

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

DISCOVERY

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

Discovery Strategies

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

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

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

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

Stages of Discovery - Primary and Secondary

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

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

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

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

REMEDIATION

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

Remediation Strategies

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

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

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

IMPROVEMENT

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

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

Improvement Strategies

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

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

CHARACTERISTICS OF A QUALITY MANAGEMENT SYSTEM

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

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

Part III. Challenges In Quality management System Design

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

THE “PRODUCT” IS A SERVICE, NOT AN OBJECT

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

LONG-TERM CARE SERVICES ARE HIGHLY INDIVIDUALIZED

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

THE SERVICE INVOLVES MANY PLAYERS

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

LONG-TERM CARE TAKES PLACE IN PRIVATE

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

THE CONSUMER OF THE SERVICE IS PART OF THE SERVICE

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

OUTCOMES OF LONG-TERM CARE ARE AMORPHOUS

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

LONG-TERM CARE IS HIGHLY REGULATED

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

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

Part IV. Federal Regulatory Framework for Quality Management

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

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

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

Level of Care:

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

Individual Plan:

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

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- Between/among waiver services and providers.

Qualified Providers:

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

Health and Welfare:

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

Administrative Authority:

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

Financial Accountability:

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

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

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

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

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

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

Subpart D requires that:

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

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

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

Part V. Design and Operation Of The Quality management System

This section outlines roles and responsibilities for the Managed Care Organization (MCO), the Department, and the External Quality Review Organization (EQRO) in the long-term care quality management system. It then introduces an overall structure for quality management activities.

Role of the Managed Care Organization

The MCO has primary responsibility for assuring the quality of care that its members receive. It is responsible for administering a comprehensive, integrated quality management system with ongoing discovery, remediation and improvement activities. The MCO is responsible for measuring member outcomes and program performance, and using the findings to inform continuous quality improvement.

Specific MCO activities include:

- Developing and submitting a quality management program description and annual quality improvement plan to the Department;⁵
- Discovering the members' achievement of personal-experience, clinical, and functional outcomes;
- Discovering the quality of the assessment and care-planning processes;
- Administering a member satisfaction survey;
- Tracking complaints and grievances;
- Responding to critical incidents;
- Maintaining an organized system for assuring that that systems issues behind problems are identified and addressed;
- Systematically pursuing continuous quality improvement; and
- Participating on a statewide Quality Management Council

The Department will likely continue its requirement that each MCO appoint a quality manager with the capability and authority to manage quality activities and to establish a broad-based quality council to oversee and support quality management efforts. The MCO will work with Department and EQRO staff to guide the overall quality management system. Although the Department will establish basic contract requirements for the MCOs' quality management systems, the MCOs will have flexibility to shape the activities to meet the needs of their members and their local environments.

Role of the Department

The Department has primary responsibility for establishing expectations and standards both for the managed long-term care programs and for their quality management systems.

⁵ More information about Quality management program Descriptions and Quality Improvement Goals is provided in Part VII – Organization of Quality Management Functions.

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Specific Department responsibilities should include:

- Reviewing and approving MCO quality management program descriptions;
- Reviewing quality management plans submitted annually by MCOs;
- Establishing statewide requirements for quality-improvement activities, which could include methods of measuring outcomes and performance and basic requirements for a quality management system, such as quality indicators, response to critical incidents, and member-satisfaction surveys;
- Defining performance standards, and providing leadership in defining benchmarks in areas such as personal experience, clinical, and functional outcomes, care plans and assessments;
- Monitoring the execution and results of the MCOs' quality management efforts through direct monitoring and performance review;
- Assuring compliance with CMS quality management requirements for 1915 (b) and (c) waivers; and
- Convening and supporting the Quality Management Council

The contract between the Department and the MCO will be the primary vehicle through which Department expectations will be communicated and enforced. As a contractual requirement, MCOs will likely be required to submit an annual quality plan.

The role of the Department could best be described as a careful purchaser of results from MCOs. Careful purchasers provide good, clear specifications for the things they want to purchase and then follow through by checking to make sure they are getting what they intended to buy. If they don't, they collaborate with the supplier (in this case the MCO) in identifying and diagnosing the problem, but it remains the supplier's responsibility to make it happen. The Department's role is then to follow up again to make sure that they are now getting what it is they want to purchase.

The Department will retain the services of an EQRO, which is a qualified independent organization working in compliance with federal regulations. The Department will work with the EQRO to carry out much, but not all, of its quality management discovery and quality-improvement responsibilities. Activities relating to assuring the MCOs' compliance with contract requirements and to remediation will need to remain direct responsibilities of the Department and its staff. The Department will likely perform periodic site visits as part of the certification process for the contracted MCOs.

A number of approaches could be considered to ensure that these site visits provide strong quality management value. A promising model for the Department's site visits is the Quality Service Review (QSR) currently used by the DHFS Division of Children and Family Services (DCFS) for reviews of county-administered child welfare programs. The QSR involves in-depth review of a limited number of families involved with the child welfare system, to determine whether desired outcomes are being achieved, and to provide insight on how the system is or is not working to support families in achieving their outcomes. In addition to dedicated reviewers, it utilizes a network of "peer reviews," including county staff and other human services professionals to conduct

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reviews, thereby expanding the number of people who understand and can evaluate child welfare practices. The child welfare QSR approach potentially could be adapted to long-term care. If the Department is to directly carry out site visits, it would be important to assure that there is an adequate number of trained staff available to conduct the visits and to oversee the peer review system.

Role of the EQRO

CMS managed-care regulations⁶ outline mandatory and optional responsibilities for the EQRO.

Federally required responsibilities of the EQRO include:

- Validating of performance improvement projects carried out by the MCO;
- Validating of performance measures carried out by the MCO; and
- Monitoring the MCOs' compliance with certain federal regulations.

The Department determines whether the EQRO also carries out the following optional activities:

- Validating encounter data;
- Administering or validating consumer or provider surveys;
- Calculating of performance measures;
- Conducting performance improvement projects in addition to those carried out by the MCO;
- Conducting studies focusing on the quality of particular aspects of clinical or non-clinical services;
- Providing technical assistance relating to quality management to the MCOs; and
- Participating in the Quality Council.

Role of the Quality Management Council

A Quality Management Council, comprised of Department, EQRO and MCO staff could provide guidance to both the Department and MCOs on quality management policy, practices and benchmarks. A detailed description of the Quality Management Council can be found in Part VIII of this report.

Overall Structure of the Quality Management System

Figure 1 represents the recommended approach to quality management in Wisconsin. The figure illustrates what the quality management system would look like at the MCO level. This is consistent with the central responsibility for quality being vested in the MCO, with the Department and the EQRO being responsible for determining whether or not the MCO is effectively administering the quality management system.

⁶ 42 CFR 438, Subpart E

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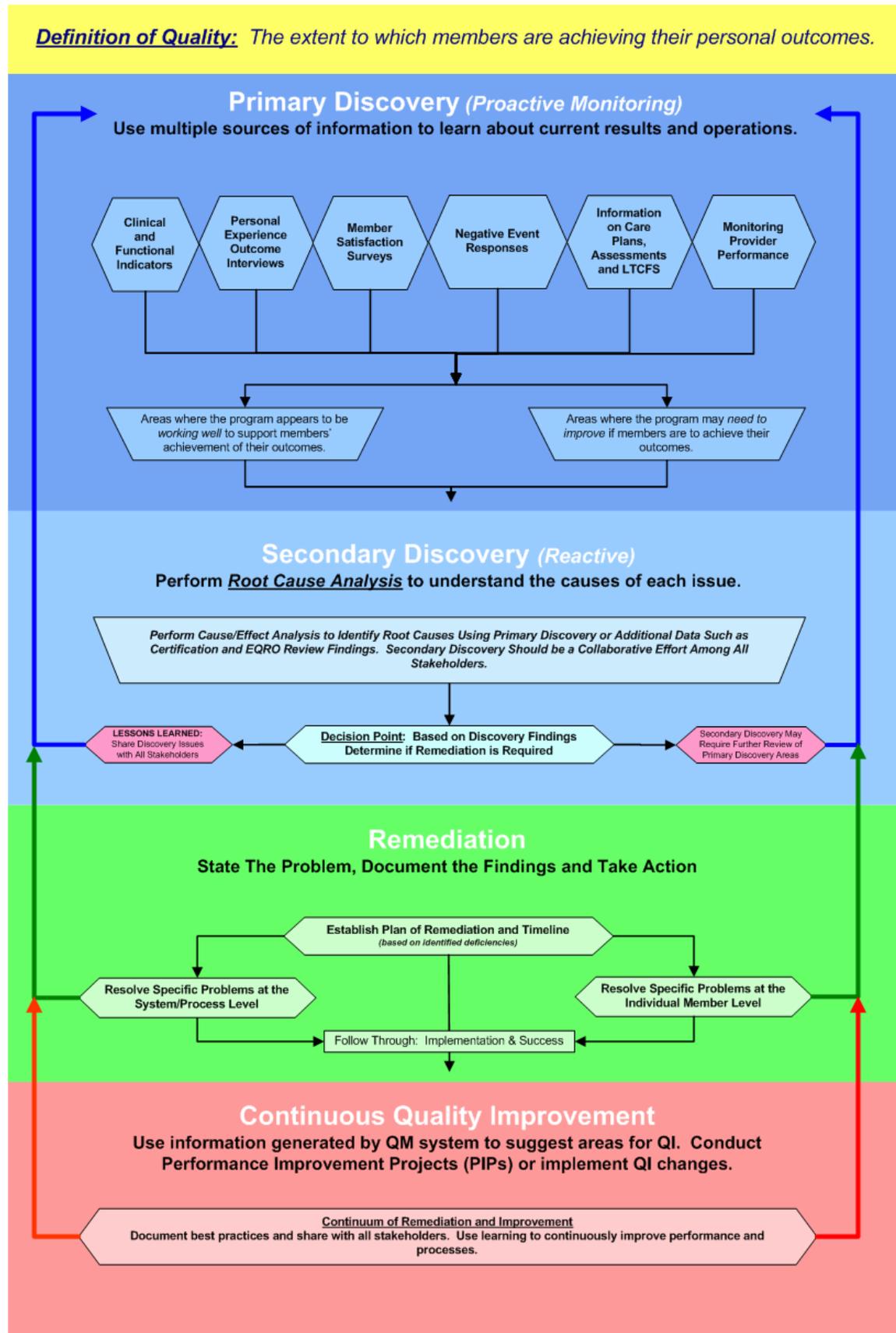
The diagram identifies six methods of ongoing primary discovery. These methods are:

1. Clinical and functional indicators;
2. Personal-experience outcome interviews;
3. Member satisfaction surveys;
4. Analysis of negative events affecting members;
5. Review of assessments, care plans and service delivery; and
6. Monitoring of providers.

These *primary discovery* methods systematically review performance to provide assurance that the program is operating as intended and achieving the desired results, or to identify preliminary indicators of problems. Potential problems identified through primary discovery are followed by *secondary discovery* to identify the root causes of problems. Once the root cause of problems is known, *remediation* strategies can be developed and implemented. Regardless of whether the MCO has discovered any problems, it continuously carries out *quality improvement* projects to improve the overall level of systems performance.

Part 5 defines each of the primary discovery methods and discusses how they would be carried out. Part 6 addresses how findings from primary discovery can be used to provide insight about whether or not quality is being achieved, how secondary discovery takes place, and how remediation and improvement is carried out.

Figure 1 Home and Community Based Services (HCBS) Quality Management System



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

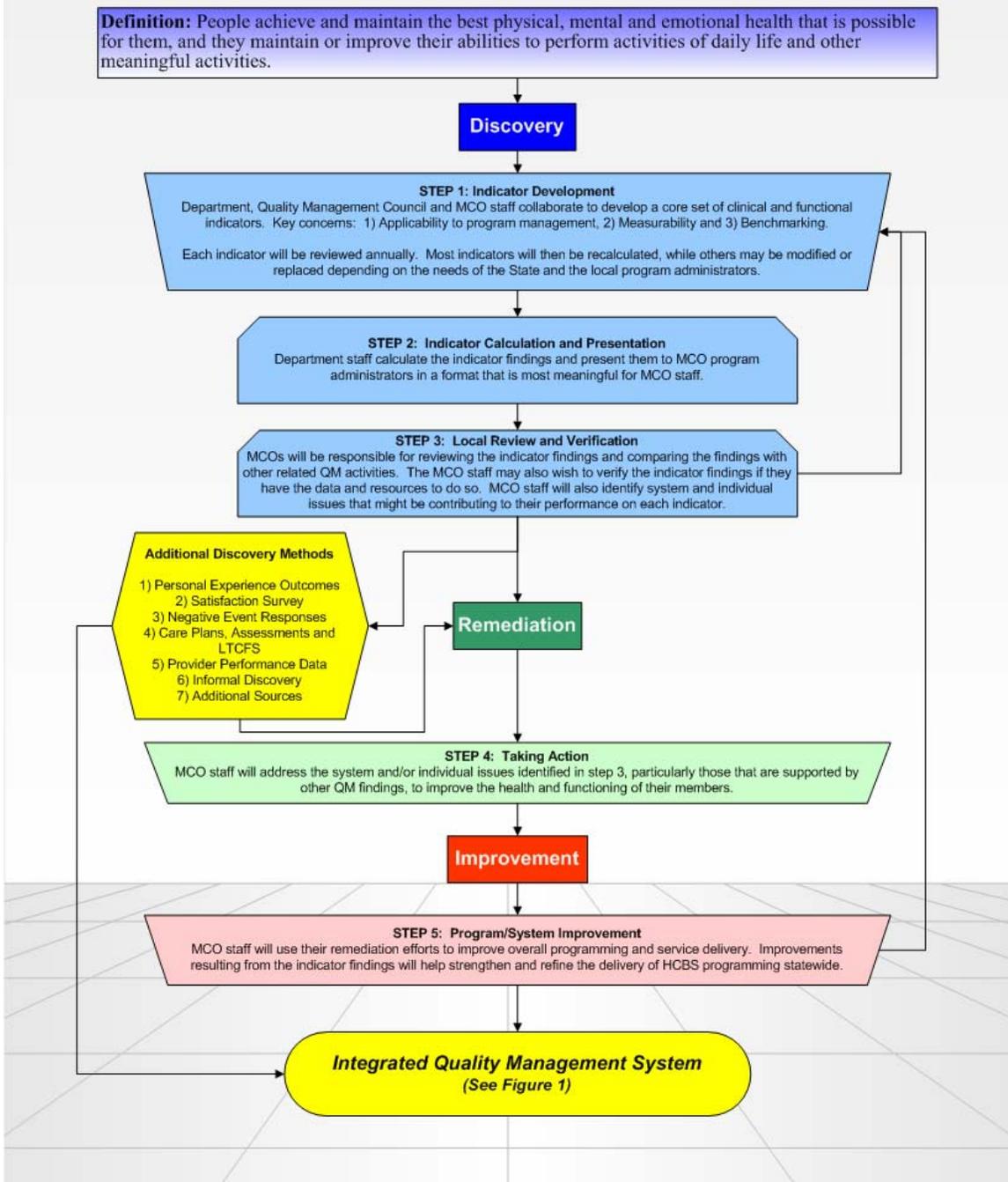
Currently, there is no consistent approach to development and use of clinical and functional indicators among Wisconsin's long-term care programs. For example, the Family Care staff produce routine reports of changes in the program's members' limited activities of daily living (ADLs) and instrumental 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.

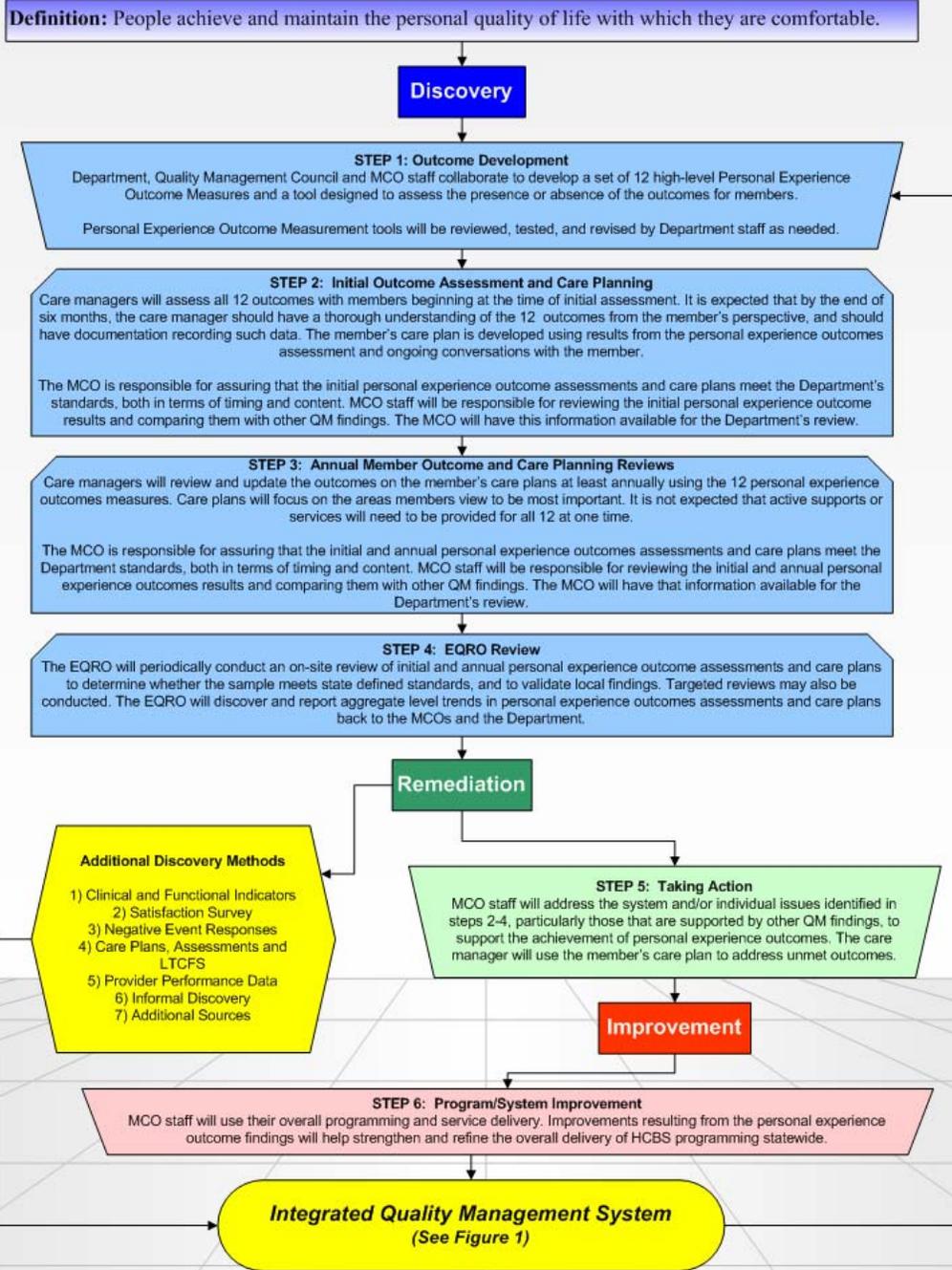
An MCO could use several different strings of data it already possesses to deal with complaints, safety concerns, or other potentially serious report individually and systemically. For instance, a young MCO member with a developmental disability might report during an annual outcome interview that she 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



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

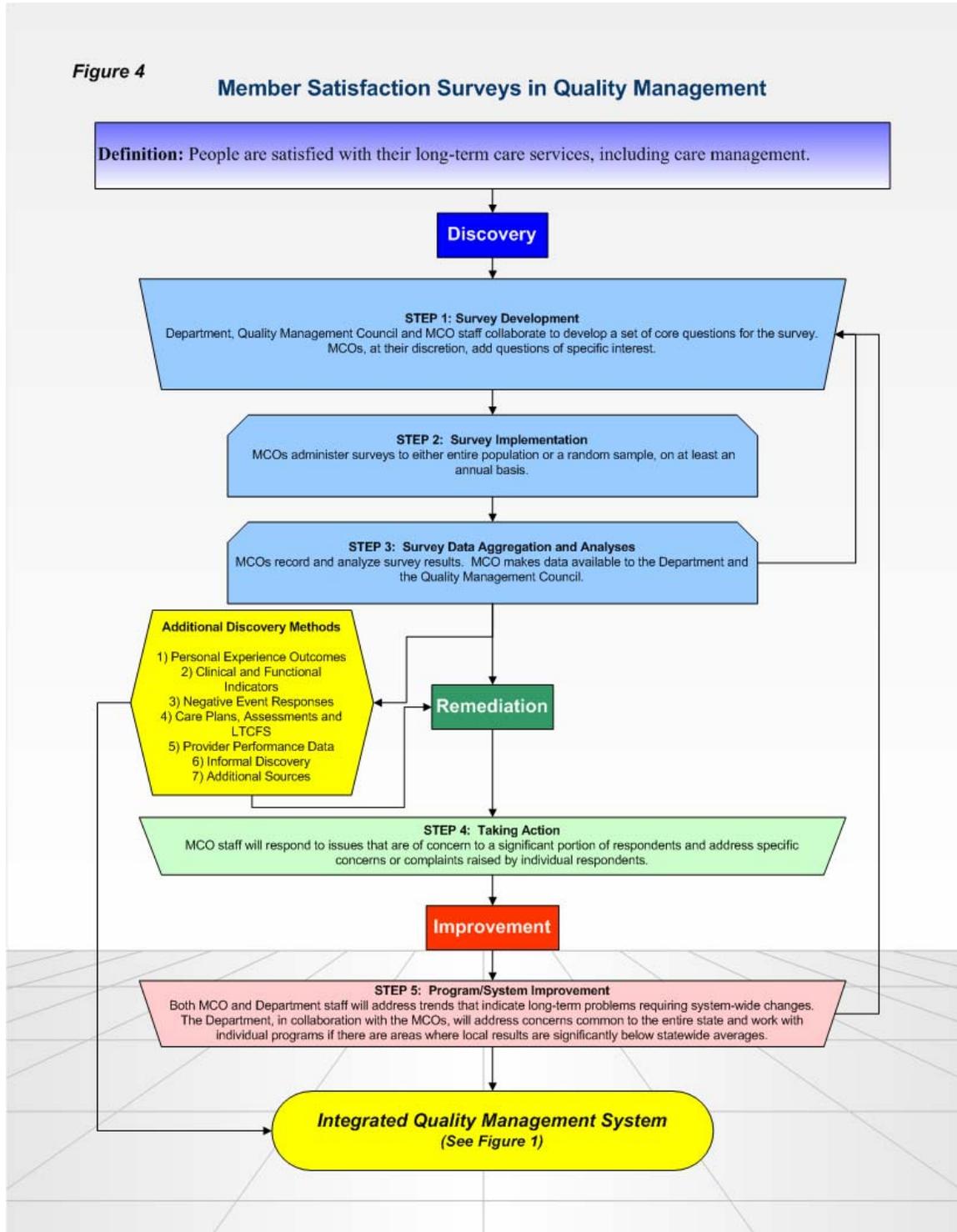
The results of satisfaction surveys, favorable or unfavorable, need to be considered in conjunction with results from other discovery methods. Much information will be anecdotal, coming from only one member, but will need further inquiry regardless. Even when aggregate satisfaction-survey data indicate 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.

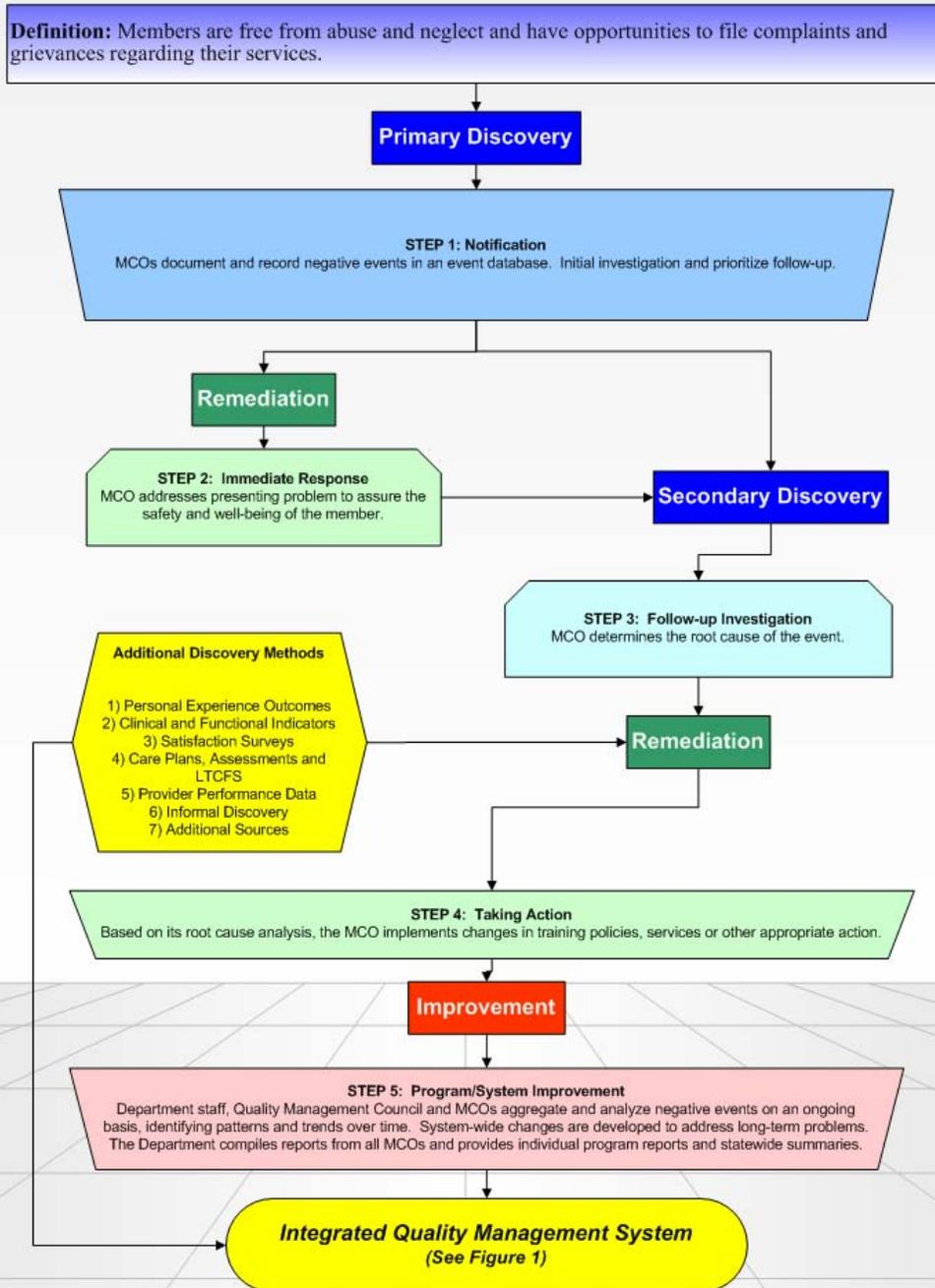
The information gathered through negative event investigations could usefully be supplemented with evidence from other discovery methods. For example, a negative-event investigation might find that several members residing at a particular CBRF have complained about problems with staff, ranging from rude 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.

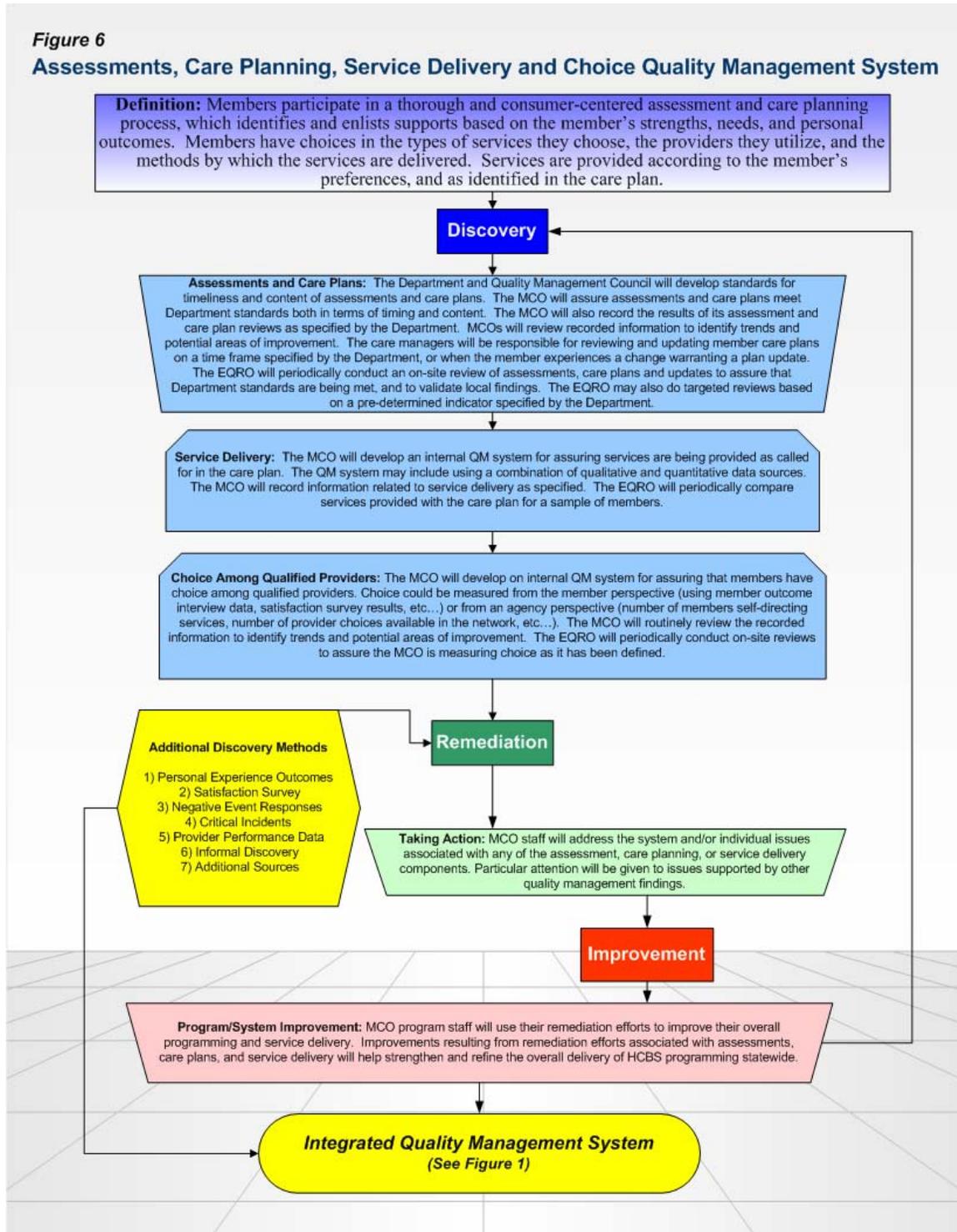
ROLES OF THE DEPARTMENT AND EQRO

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.

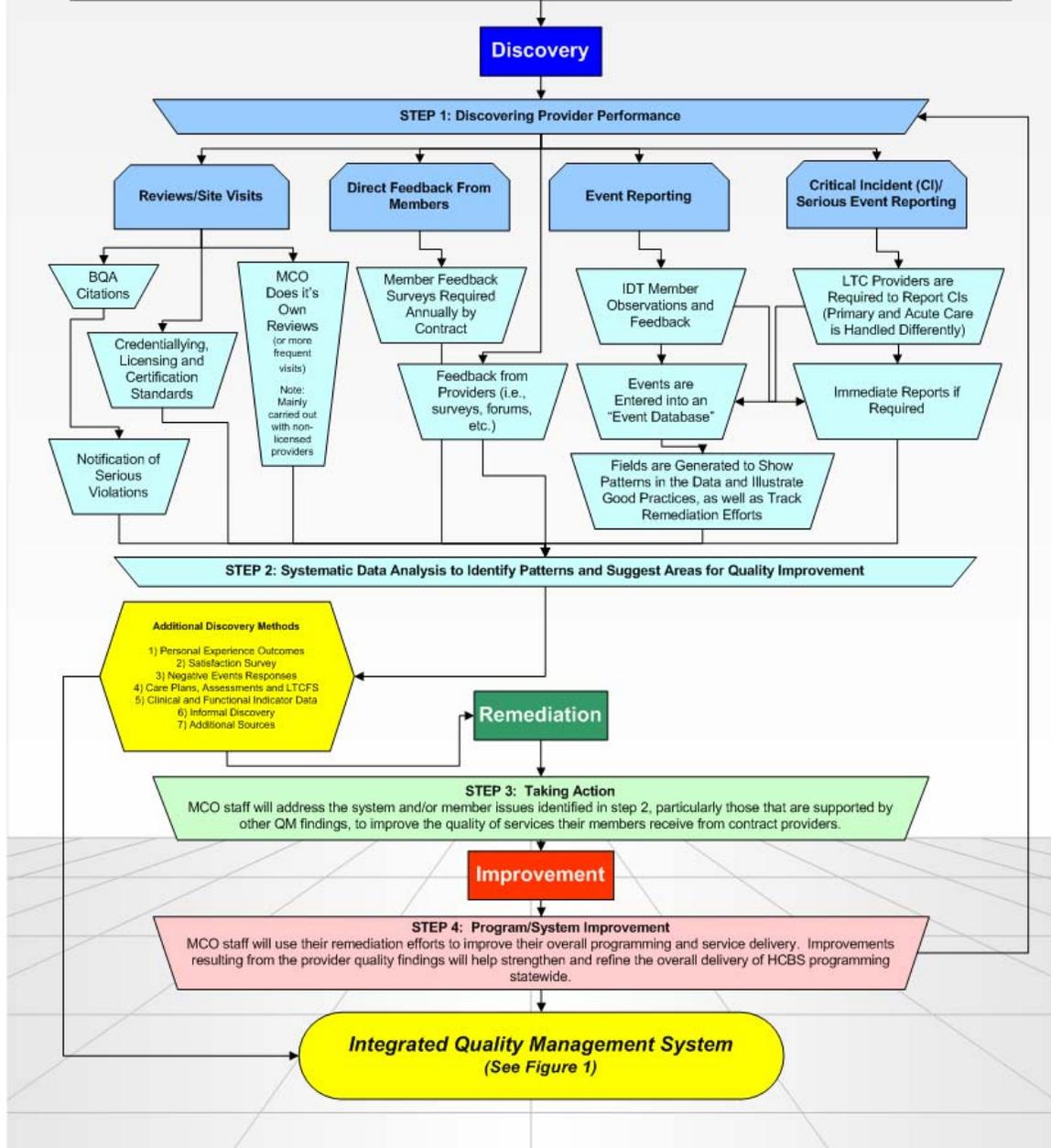
SYSTEM DESIGN – MONITORING OF PROVIDERS

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.



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.

Appendices

Appendix A: Personal-experience outcomes

PERSONAL-EXPERIENCE OUTCOMES IN LONG-TERM CARE

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

Choice

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

I decide where and with whom I live.

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

I make decisions regarding my supports and services.

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

I decide how I spend my day.

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

Personal Experience

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

I have relationships with family and friends I care about.

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

I do things that are important to me.

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

I am involved in my community.

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

My life is stable.

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

I am respected and treated fairly.

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

I have privacy.

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

Health and Safety

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

I have the best possible health.

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

I feel safe.

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

I am free from abuse and neglect.

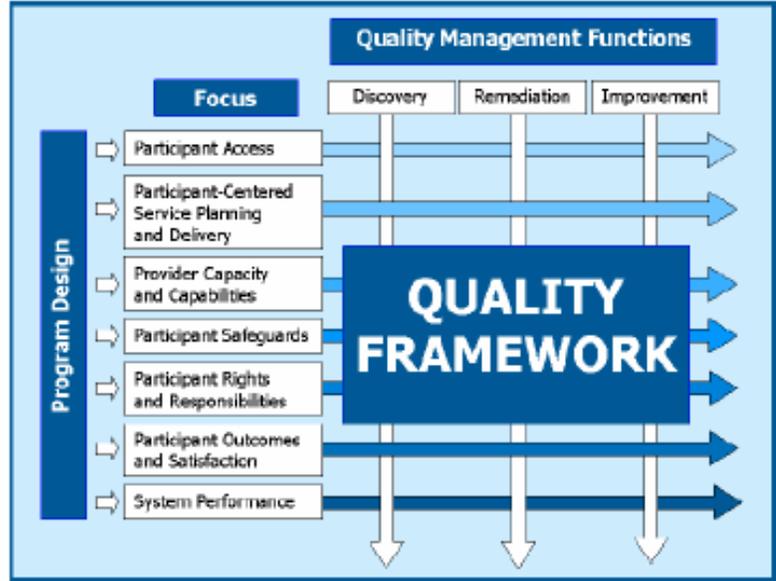
I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.

Appendix B: CMS HCBS Quality Framework

HCBS QUALITY FRAMEWORK

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

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



Quality management encompasses three functions:

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

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

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

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

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

Appendix C: Respect Outcomes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Findings

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

Functional Indicators

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

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

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

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

Clinical Indicator (not calculated)

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

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

Appendix E: Draft Consumer Satisfaction Survey

Draft Consumer Satisfaction Survey and field-testing results

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

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

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

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

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

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

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



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

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



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

3. I would recommend this program to a friend.



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

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



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

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



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

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



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

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



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

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



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

9. I am happy with the services I get.



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

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

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

Appendix F: Roles in Discovery

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

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

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

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

Appendix G: Quality Management System Reference Guide

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix H: Glossary

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

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

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

Complaints: Same as grievances (below)

Consumer: A recipient of long-term care services

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

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

Department: The Department of Health and Family Services

Discovery: The systematic gathering of evidence

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

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

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

Member: A recipient of services from a Managed Care Organization

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

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

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

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

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

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

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

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

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