1-1-2005

Home and Community-based Services: Quality Management Roles and Responsibilities [Appendices]

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January 2005

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NATIONAL ACADEMY for STATE HEALTH POLICY

January 2005

Discussion Paper

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS)

Appendices

Home and Community Based Services: Quality Management Roles and Responsibilities

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, the Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

This document was developed under Grant No. 11-P-92015/2-01 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any part of this document in dissemination activities.

Contents

Appendix A: Wisconsin Quality Management Concept

Title: Wisconsin Quality Management Concept
Author/Organization: WI Division of Health & Family Services
Date: 2004
Contact Person: Karen McKim, mckimk@dhfs.state.wi.us

QA/QI Grantee Website Location: Wisconsin Definition & Explanation of Quality Management at *Resource Library > Browse Document by Category > Quality Management System Design > Designing QM structure*

Document Description
WI's definition of quality management includes a discussion of the four levels where quality can be assessed, as well as steps to achieving quality.

Where Quality Exists

The quality of any program or agency can be assessed at any of four levels:

1. **Processes**: What is the quality of the policies that shape the program and the methods that the agency has adopted?
2. **Inputs**: What is the quality of the resources that are committed to the agency or program?
3. **Outputs**: As the inputs and processes work in operation together, what is the quality of the products that they create?
4. **Outcomes**: the results, the intended purpose of the system, such as health, comfort, living in the setting the participants desire.

In a hierarchical system, the outputs from one level become the inputs and processes for the 'lower' level. The following table has been quickly sketched in to support discussion—there are innumerable other possible variations on the text within each cell:

	Feds/CMS	**State Waiver agency**	**County/local waiver agency management**	**Care Manager**
Input	Legislation	Federal guidance	Rules and guidance from State.	Local program policies, tools, and training
Process	Rule-making, hearings, etc.	State rule-making and program administration	Local hiring and program-creation.	Assessment and care planning
Output	Clear federal guidance that supports good waiver programs	Rules and guidance for local agencies' waiver programs.	Useful policies, tools, and training for care-management staff.	High-quality assessments, care plans, monitoring practices
Outcome	States adopt well-designed waiver programs.	Local agencies all set up well-designed waiver programs.	Care managers are well-qualified and well-trained.	Consumers are safe and happy.

Quality can be achieved or assessed within any one of the cells in the grid above. Working to achieve quality in any one of the cells is doing a high-quality job. Quality management is something different—checking to see whether quality has been achieved, correcting it if it has not, and continuously improving.

Four Steps to Achieving Quality

Quality Design

1. Quality **Processes**
   Select or create the processes, methods, and standards that will be used in the program.
   Examples: Writing policies that will govern the program, designing the work-flows; writing performance-based contracts with providers; adopting performance standards, etc.

2. Quality **Inputs**
   Obtain or create the resources that will be used in the program.
   Examples: Hiring qualified staff; effective training, supervision and technical assistance; contracting with good providers; obtaining tools (such as IT software and forms) that will be used, funding and supplies; etc.

3. Quality **Implementation** (**Outputs)**
   "Quality is everyone's job."
   Inputs and processes get to work; people strive to achieve good performance levels.

4. Quality **Management**
   Check to see whether all is working as intended and getting the intended results, and if not, correct whatever needs correcting. Get better in any way we can.
   Examples: Monitoring, measuring, giving feedback, investigating causes of problems, revising practices and policies to fix problems and improvements.

   Quality Management is carried out under three general approaches:

• Compliance	• Quality Assurance	• Quality Improvement
Discovery seeks to determine whether the processes and inputs (and outputs, to a lesser extent) meet specific requirements or expectations that are typically set outside the agency or program.	*Discovery* focuses primarily on outputs and outcomes, and seeks to determine the extent to which they meet minimum performance standards, which are not typically required but are adopted or developed by the agency itself.	*Discovery* seeks to identify the areas in which the agency can meet targets for outcomes that are higher than current performance, by improving processes, inputs, or outputs.
Remediation focuses on specific identified areas of noncompliance and works to bring those lapses up to minimum required standards.	*Remediation* focuses on bringing identified areas of weak performance up to minimum standards, by understanding and correcting the causes (inputs and processes) and on *prevention* of future similar problems.	*Remediation* is not a function in quality improvement activities.
Improvement beyond remediation is not a function of compliance activities.	*Improvement* results to the extent that remediation improves the inputs and design issues that caused or allowed weak performance.	*Improvement* is focussed on establishing and maintaining ongoing higher levels of performance.

Doing our jobs well does not constitute "Quality Management." Creating and adopting good program design (policies, practices, goals, objectives, etc.) doe not constitute QM. QM is any activity or task that has the purpose of:

1) discovering the quality or level of performance or results;
2) correcting identified problems; or
3) improving performance levels (based on evidence and data.)

QM is a system in itself to which the grid above can be applied: we need to design QM processes, commit resources to QM, implement QM activities, and check to see whether we are having the intended results.

The table above imposes three categories on quality management activities, but other divisions could be made and defended. In general, however, the idea is that quality management activities can be placed anywhere on several relevant continuums:

Focus on *past* performance or achievement	⟷	Focus on *future* performance or achievement.
Focus primarily on *processes* and *inputs*	⟷	Focus on *outcomes*, *results*.
Focus on *individual* events or cases	⟷	Focus on *system* functioning and performance.
Expectations, standards are set *outside* the agency/program	⟷	Expectations, standards, are set *by* the agency/program.
Agency/program is *accountable* to an outside entity.	⟷	Agency/program *voluntarily* strives to achieve the results.
Agency can passively *accede* to achieving the standard	⟷	Agency must deliberately focus on *adopting* the standard
Goals or objectives are *defined* and *standardized*.	⟷	Goals or objectives, and the methods of achieving them are *experimental* and *risky*.

Appendix B: Sample State HCBS Values and Principles

Title: GA Quality Improvement Policy, Procedures and Program Description
Author/Organization: GA Div. of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD)
Date: Revised Effective Date 07/01/03
Contact Person: Stephanie Frankos, sfrankos@dhr.state.ga.us

QA/QI Grantee Website Location: GA Quality Improvement Policy, Procedures and Program Description at *Resource Library > Browse Document by Category > Quality Management System Design > Designing QM structure*

Document Description
GA's written policy for Continuous Quality Improvement (CQI) organizes division QM activities and processes around the seven CMS Quality Framework domains. It was approved as effective last July and signed into policy in August 2003.

Title: TX DADS Quality Vision, Mission and Principles
Author/Organization: TX Department of Aging and Disability Services (DADS) Quality Task Workgroup
Date: 2004
Contact Person: Teresa Richard, teresa.richard@dads.state.tx.us

QA/QI Grantee Website Location: TX Quality Vision, Mission and Principles Planning Document at *Resource Library > Browse Document by Category > Quality Management System Design > Designing QM structure*

Document Description
Written in response to an organizational merger, TX's Quality Vision, Mission and Principles statement articulates the shared values and expectations of the newly formed Department of Aging and Disability Services (DADS).

Division
MHDDAD

POLICY

NO: 9.101

ORIGINAL EFFECTIVE DATE: 06/01/99

REVISED EFFECTIVE DATE: 07/01/03

SUBJECT: Continuous Quality Improvement

REFERENCE: Official Code of Georgia Annotated 37-1, 37-2, 37-3, 37-4 ~~and 37-7~~

I. POLICY STATEMENT

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to establish and maintain a Continuous Quality Improvement (CQI) Program for all mental health, developmental disabilities and addictive diseases services. The CQI Program systematically analyzes data and information collected by the Performance Measurement and Evaluation System (PERMES) and other DMHDDAD measures to improve treatment, training, support and prevention services throughout DMHDDAD.

II. APPLICABILITY

This policy is applicable to State and Regional Offices of the Division of Mental Health, Developmental Disabilities and Addictive Diseases and to all service providers who are state operated, contracted, or under letter of agreement with the DMHDDAD.

III. DEFINITIONS

A. **Consumer -** A person who is or has been a recipient of mental health, developmental disabilities or addictive diseases services.

B. **Quality** - The degree to which services for individuals and populations increase the probability of desired outcomes and are consistent with current knowledge and best practices within the field.

C. **Quality Improvement** - A systematic approach to the continuous study and improvement of the processes of providing services to meet the needs of the individuals served. The goal of quality improvement activities is to improve the overall functioning of the agency and to increase quality outcomes for consumers.

D. **Quality Elements -** The generally accepted elements of a quality program include:
   1. The development of a strong consumer focus.
   2. The continuous improvement of all processes by using a systematic improvement method.

FY04, Provider Manual, Section V, Chapter O, 38 Pages

   3. The encouragement of teams and staff involvement.
   4. The mobilization of data and teams through the utilization of QI tools and graphically displayed data.

IV. PROCEDURES

DMHDDAD will establish guidelines for a Continuous Quality Improvement (CQI) Program which systematically analyzes and uses data and information collected by the Performance and Evaluation System (PERMES) and other DMHDDAD measures to improve consumer training, treatment, support and prevention services. The CQI Program design utilizes the Home and Community-Based Services (HCBS) Quality Framework as a guideline and, when appropriate, the QI Program Description may be tailored to address issues relevant to a particular consumer population.

E. The CQI Program will address the following quality domains:
   1. Service entry and linkage;
   2. Consumer-centered service planning and delivery;
   3. Provider capacity and capability;
   4. Consumer protection;
   5. Consumer rights and responsibilities;
   6. Consumer outcomes and satisfaction; and
   7. Provider system performance.

F. The CQI Program will include mechanisms for the collection and analysis of information relative to each of the above domains.

G. The CQI Program will include mechanisms for dissemination of information and strategies for addressing identified opportunities for improvement.

H. The Quality Improvement Unit coordinates the development and implementation of the Continuous Quality Improvement Program, utilizing critical input and guidance from the DMHDDAD Quality Improvement Committee, which consists of broad representation of DMHDDAD and Regional staff. The Quality Improvement Program Description is approved by the DMHDDAD Director. At least annually, the Quality Improvement Program Description is reviewed for appropriateness and effectiveness, and revised as needed.

Attachment 1: Quality Improvement Program Description

DADS Quality Vision

A Comprehensive, Outcome Based, Quality Assurance and Improvement System

DADS Quality Mission

Continuously Improving the Quality of Supports for Older Texans and Persons with Disabilities while ensuring Accountability and Efficiency.

DADS Quality Principles

- Consumers and stakeholders are active participants in defining and evaluating quality
- Science and measures of outcomes is used to assess progress toward specific goals and objectives
- Effectiveness of services and business operations are continuously monitored and evaluated
- Accountability to internal and external stakeholders is maintained
- Identification and application of new quality initiatives is pursued aggressively
- Data is used to identify and assess system improvement and produce actionable business intelligence
- Quality is multi-dimensional and encompasses:
    - Consumer Choice/Empowerment
    - Satisfaction
    - Outcomes
    - Efficiency
    - Effectiveness
    - Accountability
    - Provider/staff competency
    - Proactive approach to improvement

DADS Quality Planning

- Each organizational unit will develop a business plan that includes two or more quality goals.
- Each quality goal will identify objectives related to both process and outcome.
- Quality goals and objectives are developed and evaluated with input from consumers and other stakeholders.
- Quality goals and objectives are measurable.
- Quality goals and objectives are communicated throughout the DADS organization and to stakeholders
- Accountability to the achievement of quality goals and objectives is reflected in employee performance appraisals.
- Accountability to the achievement of quality goals and objectives is reflected in provider contracts.
- The Centers for Policy & Innovation and Program Coordination are partners in the identification, coordination and monitoring of metrics related to DADS organizational unit's business plans.

Quality Task Workgroup

Appendix C: Examples of State Templates for Mapping HCBS QM Activities

Title: ME Quality Assurance and Quality Improvement: Home and Community Based Programs, Quality Matrix and Discovery Methods
Author/Organization: ME Department of Health & Human Services, Bureau of Medical Services
Date: 2004
Contact Person: Julie Fralich, julief@usm.maine.edu

QA/QI Grantee Website Location: ME Mapping Worksheets: Quality Matrix and Discovery Methods at *Resource Library > Browse Document by Category > Quality Management System Design > Mapping activities against CMS Quality Framework*

Document Description
ME's mapping worksheets provide a way to conduct an inventory of quality assurance activities by mapping protocol activities identified in the CMS Interim Guidelines with Discovery Methods used to obtain data.

Title: OH's ODMR/DD Quality Framework
Author/Organization: OH Department of Mental Retardation and Developmental Disabilities
Date: Revised 9/29/04
Contact Person: Don Bashaw, Don.bashaw@dmr.state.oh.us; Suzzanne Freeze, suzzanne.freeze@dmr.state.oh.us

QA/QI Grantee Website Location: OH's ODMR/DD Quality Framework at *Resource Library > Browse Document by Category > Quality Management System Design > Mapping activities against State Framework*

Document Description
Ohio's Quality Framework includes Domains, Value Statements, Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

Title: MN HCBS Waiver Quality Assurance Design and Discovery Planning Tool
Author/Organization: MN Department of Human Services' Continuing Care Administration
Date: 2004
Contact Person: Jolene Kohn, Jolene.Kohn@state.mn.us

QA/QI Grantee Website Location: MN Focus Area Planning/Strategy Tables at *Resource Library > Browse Document by Category > Quality Management System Design > Mapping activities against CMS Quality Framework*
MN Waiver Quality Assurance Plan Comparison Chart at *Resource Library > Browse Document by Category > Quality Management System Design > Mapping activities against CMS Protocol*

Document Description
MN's QM mapping worksheets were designed for analyzing activities by CMS Quality Framework Domains and Waiver Quality Assurances.

Maine Quality Assurance and Quality Improvement
Home and Community Based Programs
Quality Matrix and Discovery Methods

Instructions

The following worksheets provide a way to conduct an inventory of quality assurance activities. These worksheets are designed to provide a way to map the protocol activities identified in the CMS Interim Guidelines with the Discovery Methods that are used.

Worksheet 1: This worksheet provides a way to identify whether the protocol related activity is being reviewed or monitored as part of existing quality assurance processes. For example, if level of care evaluations are conducted as part of desk reviews of state quality assurance staff, this would be checked on worksheet 1. Similarly if level of care evaluations are also monitored as part of in-home visits by a substate entity, then this would also be checked.

Worksheet 2: This worksheet provides a way to identify whether the discovery method can produce reports or evidence, how reliable, timely or easily aggregated such data is, and whether there is a process for acting on the data. This worksheet will help to identify areas where there may need to be standardized data collection tools, or more formalized methods of reporting.

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
PARTICIPANT ACCESS												
Level of Care (LOC) Determination/ Monitoring: • Individual LOC evaluations are conducted.												
• Enrolled participants are reevaluated at least annually or as specified.												
• The process and instruments described in waiver are applied to determine LOC.												
• State submits evidence that it has reviewed applicant files to verify that individual LOC evals and reevaluations are conducted, using instrument described in waiver.												
PERSON CENTERED PLANNING AND DELIVERY												
Plan of Care (POC) Monitoring: • POCs updated/revised when warranted by participant's needs												

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
• POCs address participant's needs, personal goals, either by waiver or through other means. Services delivered in accordance w/ POC.												
• State monitors POC development in accordance w/ policies/procedures, takes action when inadequacies identified in POC development.												
PERSON CENTERED PLANNING AND DELIVERY												
• Participants offered choice btw waiver services and institutional care and between/among waiver services and providers.												
• State demonstrates POCs reviewed to assure needs being addressed.												
• State submits evidence that corrective action taken when POC not developed according to policies/proced.												
• State submits evidence												

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
of monitoring process for POC updates/ reviews.												
• State submits evidence of interviews with participants to assure choice was offered.												
PROVIDER CAPACITY AND CAPABILITIES												
Qualified Providers: • State verifies that providers meet required licensing/cert standards.												
• State monitors non-licensed providers to assure adherence to waiver requirements.												
• State identifies/rectifies when providers do not meet requirements.												
• State implements policies for verifying that training is provided.												
• State provides documentation of periodic review by licensing entity, monitoring of non licensed; doc of corrective actions taken when needed;											√	

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
documentation of monitoring of training												
PARTICIPANT SAFEGUARDS												
Health and Welfare: • On an ongoing basis, the state demonstrates that it identifies addresses and seeks to prevent instances of abuse, neglect, exploitation.												
• State demonstrates that appropriate actions are taken when health or welfare of a participant has not been safeguarded.												
• State submits results of analysis of abuse, neglect, exploitation trends and strategies implemented for prevention.												
SYSTEM PERFORMANCE												
Administrative Authority: • State engages in routine, ongoing oversight of waiver program.												
• State submits evidence												

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
of its monitoring in accordance with MoU and actions it has taken when problems in operation of waiver program identified. ?												
Financial Accountability: • State financial oversight exists to assure that claims are coded and paid for in accordance with reimbursement methodology specified in approved waiver.												
System Performance												
• State submits results of its financial monitoring process for verifying maintenance of appropriate financial records												
• State submits results of its review of waiver claims. State demonstrates that interviews with state staff and interviews /site visits with providers are conducted periodically												

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

	Waiver Agency				Contractor/Regional Office				DHS/BMS			
Protocol Reviewed	Desk Reviews	In-home visits	Consumer Survey	Complaints	Appeals	Record Reviews	Complaints	Cons. Survey	HCFA 372s	Claims	Licensure	SURS
to verify that they maintain financial records according to provider contracts and any financial irregularities are addressed.												

Worksheet 1: Inventory of Protocol Processes and Discovery Methods

Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

Discovery Method (QA Function)	Is data collected on all partici-pants or a sample? (All/ Sample)	If data is collected as part of a larger effort, is it possible to identify waiver partici-pants separately? (y/n)	If a sample is used, what is the sample method? (random, targeted, other)	Number of records in a year for which data is collected.	Location of Original Data	Is there a standard-ized format/ data collection tool for data collection? Y/N)	Is it possible to aggregate the results of the data collection?	Is the data collected and maintained in an electronic format? (y/n)	Are reports routinely generated? y/n and how often	Who reviews them?	Has the data been used to identify any quality improve-ment activities.
Waiver Agency											
Desk Review											
In-home Visit											
Consumer Survey											
Complaints											
Appeals											
Provider/ Contractor/ Regional Office											
Record Audits											
Case Management Calls											

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Instructions: For each protocol area (column 1), indicate with a check mark in the appropriate discovery method column, whether this activity is evaluated or monitored as part of a discovery method (e.g. desk reviews, in-home visits, etc). For example, if individual level of care evaluations are reviewed as part of the desk reviews and in-home visits, put check marks in those boxes.

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In-Home Visits											
Complaints											
Consumer Survey											
DHS/BMS											
HCFA 372s											
Claims											
Licensure											
SURS											

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **PHYSICAL HEALTH AND PREVENTION**			**Defining Value:** Access to resources and supports to acquire and maintain healthy body
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD Data Sources and Data Customers**
Individuals access routine and preventative healthcare and are supported in having the best possible health		IV. Participant Safeguards	
		IV. Participant Safeguards	
Individuals feel safe in their homes and in their communities.		IV. Participants Safeguards: Critical Incident Management	
Individuals feel safe in their homes and in their communities.		IV. Participant Safeguards: Medication	
		IV. Participant Safeguards: Medication	
		IV. Participant Safeguards: Medication	
Individuals feel safe in their homes and in their communities.		IV. Participant Safeguards: Behavior Interventions	
		IV. Participant Safeguards: Housing and Environment	

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DOMAIN: **PHYSICAL HEALTH AND PREVENTION**			**Defining Value:** Access to resources and supports to acquire and maintain healthy body
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD Data Sources and Data Customers**
		II. Participant Centered Service Planning	

Ohio's ODMR/DD Quality Framework

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DOMAIN: **PERSONAL& EMOTIONAL WELL-BEING**			**Defining Value:** Access to resources and supports that empowers the individual to exert control over one's life
OUTCOMES	**ODMRDD CORE INDICATORS**	**CMS FOCUS AREAS**	**ODMRDD DETAIL INDICATORS**
Individuals experience financial well-being and security		IV. Participant Safeguards	
		IV. Participant Safeguards	
		IV. Participant Safeguards	
Individuals are provided opportunities and necessary supports to make choices, to make decisions and to experience the dignity of risk		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	
Individuals are provided opportunities and necessary supports to make choices, to make decisions and to experience the dignity of risk		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	

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OUTCOMES	**ODMRDD CORE INDICATORS**	**CMS FOCUS AREAS**	**ODMRDD DETAIL INDICATORS**
Individuals have opportunities for personal relationships		II. Participant Centered Service Planning	
Individuals have opportunities for personal relationships		II. Participant Centered Service Planning	
Individuals have control over their lives.		II. Participant Centered Service Planning and Delivery: Responsiveness to changing needs	
		IV. Participant Safeguards	
Individuals have control over their lives.		II. Participant Centered Service Planning and Delivery	
		V. Participant Rights and Responsibilities: Civic and Human Rights	

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DOMAIN: **PERSONAL& EMOTIONAL WELL-BEING**			**Defining Value:** Access to resources and supports that empowers the individual to exert control over one's life
OUTCOMES	**ODMRDD CORE INDICATORS**	**CMS FOCUS AREAS**	**ODMRDD DETAIL INDICATORS**
Individuals gain skills that will enable them to live as independently as possible, regardless of the residential setting		II. Participant Centered Service Planning and Delivery: Service Plan	
Individuals gain skills that will enable them to live as independently as possible, regardless of the residential setting		II. Participant Centered Service Planning and Delivery: Assessment	
		II. Participant Centered Service Planning and Delivery: Assessment	
Individuals continue to improve their self-esteem and self-image		II. Participant Centered Service Planning and Delivery	
Individuals are satisfied with the services and		VI. Participant Outcomes and Satisfaction	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **PERSONAL& EMOTIONAL WELL-BEING**			**Defining Value:** Access to resources and supports that empowers the individual to exert control over one's life
OUTCOMES	**ODMRDD CORE INDICATORS**	**CMS FOCUS AREAS**	**ODMRDD DETAIL INDICATORS**
supports that are provided to them		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **COMMUNITY**			**Defining Value:** Opportunities are available for individuals to fully utilize the broad range of community resources to support complete membership and participation
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
Individuals participate in their communities		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	
Individuals have control over their living arrangement		II. Participant Centered Service Planning and Delivery	
Individuals have control over their living arrangement		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	

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DOMAIN: **COMMUNITY**			**Defining Value:** Opportunities are available for individuals to fully utilize the broad range of community resources to support complete membership and participation
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
Individuals move freely about in their community		II. Participant Centered Service Planning and Delivery	
		II. Participant Centered Service Planning and Delivery	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **EMPLOYMENT AND BUSINESS**			**Defining Value:** Opportunities for individuals to have choices in acquiring meaningful employment and business options and to have income to support their chosen lifestyle
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
Individuals who express a desire to work will receive appropriate job development services.		II. Participant Centered Service Planning & Delivery	
Individuals are offered jobs that reflect their interests/ employment goals, requested number of hours worked per week, fair compensation for hours worked, and employment benefits.		II. Participant Centered Service Planning & Delivery	
Individuals are offered jobs that reflect their interests/ employment goals, requested number of hours worked per week, fair compensation for hours worked, and		*VI. Participant Outcomes and Satisfaction*	
		VI. Participant Outcomes and Satisfaction	
		VI. Participant Outcomes and Satisfaction	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **EMPLOYMENT AND BUSINESS**			**Defining Value:** Opportunities for individuals to have choices in acquiring meaningful employment and business options and to have income to support their chosen lifestyle
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
employment benefits.		VI. Participant Outcomes and Satisfaction	
Individuals receive relevant employment training and assistance in learning the job and understanding the expectations of the employer.		VII. System Performance	
Individuals are provided with opportunity for community-based employment.		V. Participant Rights and Responsibilities	
Individuals are satisfied with their current employment situation.		VI. Participant Outcomes and Satisfaction	
Individuals have opportunities for career advancement.		VI. Participant Outcomes and Satisfaction	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **LEADERSHIP AND ORGANIZATION MANAGEMENT**			**Defining Value:** The degree to which organizations and their leadership are managed effectively and efficiently in support of their constituency.
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
The organization maintains stability, efficiency and effectiveness		VII. System Performance	
		VII. System Performance	
		VII. System Performance	
The organization maintains stability, efficiency and effectiveness		VII. System Performance	
The organization is in compliance with federal, State, and local rules, regulations, and contractual agreements.		I. Participant Access	
The organization is in compliance with federal, State, and local rules, regulations, and contractual agreements.		I. Participant Access	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **LEADERSHIP AND ORGANIZATION MANAGEMENT**			**Defining Value:** The degree to which organizations and their leadership are managed effectively and efficiently in support of their constituency.
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
The organization is in compliance with federal, State, and local rules, regulations, and contractual agreements.		IV. Participant Safeguards	
A stable and knowledgeable work force manages and delivers services and supports.		III. Provider Capacity and Capabilities	
Effective employment, retention, and recruitment of staff are fostered throughout the organization.		III. Provider Capacity and Capabilities	
Effective employment, retention, and recruitment of staff are fostered throughout the		III. Provider Capacity and Capabilities	
		III. Provider Capacity and Capabilities	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **LEADERSHIP AND ORGANIZATION MANAGEMENT**			**Defining Value:** The degree to which organizations and their leadership are managed effectively and efficiently in support of their constituency.
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
organization.		III. Provider Capacity and Capabilities	
Through executive leadership a culture/environment exits within which employees, contractors and individuals deliver and receive supports that effectively result in an improved quality of life.		VII. System Performance	
		VII. System Performance	
Individuals and the public are knowledgeable about the direction, purpose and opportunities of the organization.		VII. System Performance	
		VII. System Performance	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **LEADERSHIP AND ORGANIZATION MANAGEMENT**			**Defining Value:** The degree to which organizations and their leadership are managed effectively and efficiently in support of their constituency.
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
Individuals control the type and frequency of supports through the organization's use of self-determination and person centered planning.		VII. System Performance	
Resources are sufficient to develop and provide services at the highest degree of efficiency and effectiveness.		VII. System Performance	
		VII. System Performance	
Resources are sufficient to develop and provide services at the highest degree of efficiency and effectiveness.		I. Participant Access	
Prompt and effective access to services and supports required		I. Participant Access	
		VII. System Performance	

Ohio's ODMR/DD Quality Framework

Ohio's Quality Framework includes Domains, Value Statements (to explain the domains), Outcomes and Core Indicators, as well as a column where Ohio Outcomes and Indicators are cross-walked to CMS Quality Framework Domains.

DOMAIN: **LEADERSHIP AND ORGANIZATION MANAGEMENT**			**Defining Value:** The degree to which organizations and their leadership are managed effectively and efficiently in support of their constituency.
OUTCOMES	ODMRDD CORE INDICATORS	CMS FOCUS AREAS	**ODMRDD DETAIL INDICATORS**
by individuals are available to those identified individuals/families.		I. Participant Access	
Prompt and effective access to services and supports required by individuals are available to those identified individuals/families.		III. Provider Capacity and Capabilities	
		I. Participant Access	
The organization ensures that basic human and constitutional rights and privileges extend to individuals.		V. Participant Rights and Responsibilities	

Focus I: Participant Access

(Level of Care (LOC) Determination)

CMS Outcome:	**Individuals have access to home and community-based services and supports in their communities.**
QDC Recommendation:	**Individuals have ready access to the information, supports, services, and accommodations that they need to fully participate in their communities.**

Framework Outcomes:	**Data Avail Now**	**Rule/Law HCBS Design Features**	**Priority** Hi Med Low	**Source of Evidence/ Discovery Activity**	**Indicator**	**Benchmark/ Performance Standard**	**Remediation Plan, Resources Needed**
1. Information and Referral: Individuals and families can readily obtain information concerning the availability of Home and Community Based Services, how to apply and, if desired, offered a referral.							
2. Intake and Eligibility: User-Friendly Processes: Intake and eligibility determination processes are understandable and user-friendly to individuals and families. **2a.** There is assistance available in applying for HCBS.							
3. Referral to Community Resources: Individuals who need services but are not eligible for HCBS are linked to other community resources.							
4. Individual Choice of HCBS: Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.							
5. Prompt Initiation: Services are initiated promptly when the individual is determined eligible and selects HCBS.							
6. Other State Goals Related to Access - Reductions in disparity, eg - Waiting lists if any							

Web-based Resources to Support Access	Other DHS Activities Related to Access	▪ Quality Improvement Plans for Participant Access:
	Review County Policies : County submission of QA Plans include indications that the county LTCC unit: __ Provides information and referral about long term care options? __ Provides early intervention activities? __ Complete nursing facility level of care determination? __ Provide face-to-face assessment to all citizens requesting such assistance? __ Complete assessments within 10 working days of referral? __ Develop community support plans for all citizens requesting such assistance?	

Focus II: Participant-Centered Service Planning and Delivery

(Plan of Care)

CMS Outcome:	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.
QDC Recommendation:	*Participants are active in designing their services and supports, which are effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*

Framework Outcomes * *Indicates a difference in wording based on QDC feedback.* Text that is different from the CMS framework is provided in *italics*.	Data?	Required? (MN Rule/Statute)	Priority?
1. *Assessments: Assessments contain comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports. *The participant is active in developing a personalized service plan based on the comprehensive assessment.*			
2. Participant Decision Making: Information and support is available to help participants make informed selections among service options.			
3. *Free Choice of Providers: Information and support is available to assist participants to freely choose among qualified providers. *There should be a sufficient number of providers for participants to make choices.*			
4. *Service Plan: *The participant is active in developing* a personal service plan that comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.			
5. Participant Direction: Participants have the authority and are supported to direct and manage their own services to the extent they wish.			
6. Service Delivery – Ongoing Service and Support Coordination: Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.			
7. Service Provision: Services are furnished in accordance with the participant's plan.			
8. Ongoing Monitoring: Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.			
9. Responsiveness to Changing Needs: Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan.			

Web-based Resources:
Other Resources:

Focus III: Provider Capacity and Capabilities

(Qualified Providers)

CMS Outcome:	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
QDC Recommendation:	*There are sufficient HCBS providers to provide consumers with a choice of services, and the system is flexible in allowing providers and consumers creativity in meeting individual needs. These providers will possess and demonstrate the capability to effectively serve participants, and support individual choices and responsibilities*

Framework Outcomes	Data?	Required? (MN Rule/Statute)	Priority?
1. **Provider Networks and Availability:** There are sufficient qualified agency and individual providers to meet the needs of participants in their communities.			
2. **Provider Qualifications:** All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively.			
3. **Provider Performance:** All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan.			

Web-Based Resources:
Other Resources:

Focus IV: Participant Safeguards

(Health and Welfare)

CMS Outcome:	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
QDC Recommendation:	*Participants are safe and secure in their homes and communities. This takes into account their informed and expressed choices, as well a their tolerance for risk and personal responsibility.*

Framework Outcomes * *Indicates a difference in wording based on QDC feedback.* Text that is different from the CMS framework is provided in *italics*.	Data?	Required? (MN Rule/Statute)	Priority?
1. Risk and Safety Planning: Participant health risk and safety considerations are identified and potential interventions identified that promote health, independence and safety with the informed involvement of the participant.			
***2. Critical Incident Management:** There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations *and to inform participants about the potential risks for the informed choices they have made*			
3. Housing and Environment: The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.			
4. Behavior Interventions: Behavior interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight			
5. Medication Management: Medications are managed effectively and appropriately.			
6. Natural Disasters and Other Public Emergencies: There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.			
***7. Formal and informal networks**: *Both formal and informal networks to support individuals are identified, and informal networks are supported as part of the individual's plan of care*			

Web-based Resources:

Focus V: Rights and Responsibilities

(no prior CMS equivalent)

CMS Outcome:	Participants receive support to exercise their rights and in accepting personal responsibilities.
QDC Recommendation:	*Participants receive support to understand and exercise their rights and to carry out the responsibilities they have chosen to take on*

Framework Outcomes * *Indicates a difference in wording based on QDC feedback.* Text that is different from the CMS framework is provided in *italics*. ** This outcome does not appear in the final CMS framework, but was approved by the Quality Design Commission	Data?	Required? (MN Rule/Statute)	Priority?
1. Civic and Human Rights*:* Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.			
2. Participant Decision Making Authority: Participants receive training and support to exercise and maintain their own decision-making authority			
3. Grievances: Participants are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.			
4. Due Process: Participants are informed of and supported to freely exercise their Medicaid due process rights.			
5. **Alternate Decision Making: *Decisions to seek guardianship, surrogates or other mechanisms that take authority away from participants are considered only after a determination is made that no less intrusive measures are or could be available to meet the participant's needs.*			

Resources:

Tables Under Development

Focus VI:	Participant Outcomes and Satisfaction
CMS Outcome:	Participants are satisfied with their services and achieve desired outcomes.
QDC Recommendation:	*Participants are satisfied and achieve outcomes that they have identified for themselves in the quality of services that they receive and in their quality of life.*

Service Outcomes:
Outcomes:

1. *Participant Satisfaction:* Participants and family members, as appropriate, express satisfaction with their services and supports.
*2. *Participant Outcomes:* Services and supports lead to positive outcomes *that are identified as important* for each participant.

Resources:

Tables Under Development

Administrative Authority / Financial Accountability	
Focus VII:	System Performance
CMS Outcome:	The system supports participants efficiently and effectively and constantly strives to improve quality.
QDC Recommendation:	*Participants are supported by efficient and effective systems that constantly strive to improve quality throughout the HCBS delivery system.*

Service Outcomes:

*1. *System Performance Appraisal:* The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact *on quality of life.*
2. *Quality Improvement:* There is a systemic approach to the continuous improvement of quality in the provision of HCBS.
3. *Cultural Competency:* The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds.
4. *Participant and Stakeholder Involvement:* Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.
5. *Financial Integrity:* Desired Outcome: Payments are made promptly in accordance with program requirements.

Resources:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
I. Health & Welfare	The State has in place policies, shows evidence that it implements and reviews policies and gathers participant input to improve the system. Policies must address: 1. Use of participant feedback in development of policies and procedures 2. Participant access to services 3. Ways to ID discrepancies between services in the plan of care and services received 4. Types of data that is collected to measure outcomes 5. Complaint procedure 6. Consumer and family support knowledge of reporting abuse, neglect and exploitation. 7. Contingency plan for emergencies where lack of care would pose a serious threat. 8. Dissemination of information to providers 9. Methods for verifying provider quality assurance and procedures for addressing non-compliance.	The State has in place policies, shows evidence that it implements and reviews policies and gathers participant input to improve the system. Current policies and procedures include:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
II. **Plans of Care**	The State has in place and shows evidence of implementation of policies that address developing, approving and monitoring POCS. Policies and procedures must address: 1. Description of development process 2. Staff responsible for development process. 3. Methods for assessing participant/caregiver input. 4. Freedom of choice between waiver/institutional settings and among providers 5. Description of approval process. 6. Frequency of state approval process. 7. Sampling methods. 8. Persons responsible for conducting POC approval and qualifications. 9. Methods for assessing whether POC address all of participants' assessed needs/how those needs are addressed through waiver and other means. 10. Methods for assessing whether POC changes when needs change.	The state has in place policies and shows evidence of implementation of policies that address developing, approving and monitoring POCS. Current activities include:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
III. Provider Qualifications	The State has in place and demonstrates implementation of policies and procedures to verify that all waiver services are provided by qualified providers. Policies and procedures must address: 1. Licensing standards 2. Process for enrolling and monitoring unlicensed providers 3. Monitoring activities to assure providers meet standards, including frequency 4. Methods to identify and rectify situations where providers are determined not to meet requirements. 5. Verification that provider training is conducted in accordance with approved waiver.	The State has in place and demonstrates implementation of policies and procedures to verify that all waiver services are provided by qualified providers. Current policies and procedures address:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
IV. Level of Care Determination	The state must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating and applicant's/waiver participants level of care need in the following ways: 1. Provides an individual evaluation for LOC for each eligible applicant. 2. Uses the processes and instruments described in its waiver for determining LOC. 3. Provides LOC evaluation and re-evaluation. 4. Monitors LOC decisions to assure need for institutional LOC. 5. Takes action to address inappropriate LOC decisions. 6. Maintains documentation pertaining to evaluations and re-evaluations.	The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating and applicant's/waiver participants level of care need in the following ways:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
V. Oversight	The State must demonstrate that it retains administrative authority of the waiver program consistent with its approved waiver application in the following ways: 1. There is an interagency agreement between the state Medicaid agency and the operating agency 2. The state agency assumes responsibility for all policy decisions regarding the waiver and monitors implementation. 3. Both the administrating and operating agencies provide the information and data needed to carry out the interagency agreement. 4. The State agency monitors the agreement to assure the provisions specified are executed.	The State demonstrates that it retains administrative authority of the waiver program consistent with its approved waiver application in the following ways:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
VI. Division Financial Accountability	The State has in place and implements an adequate system for assuring financial accountability. Policies and procedures must include: 1. How financial records are maintained by the state and by providers 2. The nature and frequency of reviews /audits it conducts 3. Actions the state takes if problems are identified 4. The nature and frequency of reviews/audits of operating agencies (counties). 5. Staff who conduct the reviews/audits. 6. Procedures for assuring appropriate financial oversight if the review of claims is delegated to counties.	The State has in place and implements a system for assuring financial accountability. Policies and procedures include:

MN Waiver Quality Assurance Plan
Comparison Chart

	CMS	Aging & Adult Services Division
VII. Consumer Rights	The state must demonstrate the it: 1. Provides due process in handling requests for waiver services including informing applicants of their right to request a fair hearing if their request for services is denied 2. Observes due process in the operation of the waiver including providing written notice when a decision is made to reduce suspend or terminate services	

Appendix D: Sample State HCBS Performance Indicators

Title: KY Performance Measures for MH and MR
Author/Organization: KY Cabinet for Health Services, Department for Mental Health and Mental Retardation
Date: accessed 11/8/04
Link: http://mhmr.ky.gov/afm/Plan%20and%20Budget/Performance/Brief%20Performance%20indicators%20FY%2005.doc

QA/QI Grantee Website Location: KY Performance Measures for MH and MR at *Resource Library > Browse Document by Category > Performance Measurement > Performance Indicators*

Document Description
KY's performance measures for mental health and mental retardation are part of the department's effort to work towards a performance-based system of contracting for services supported with state and federal funds.

BRIEF PERFORMANCE INDICATORS
UPDATED WITH DEPARTMENTAL INDICATOR FY '05

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
ACCESS	**People should have access to needed services**	**MR**	• Proportion of people who report having adequate transportation to/from services. • Proportion of people who report that "needed" services are not available. • Proportion of families reporting that consumers have access to needed services. • Proportion of people receiving services from blended funding sources. • Average number of hours worked per month during the previous year. • Proportion of people earning at or above minimum wage. • Proportion of people currently working who have been continuously employed for 3 months or longer. • Proportion of students who transitioned from school to supported employment.. • Proportion of people who transitioned from Community Habilitation programs to supported employment. • Crude separation rate defined as the proportion of direct contact staff separated in the past year. • Average length of service for currently employed direct contact staff. • Proportion of staff meeting training requirements. • Proportion of staff reporting that they receive on going training pertinent to job responsibilities. • Vacancy rate defined as the proportion of direct contact positions vacant as of a specified date.

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE

	Out-of-pocket costs to clients do not discourage the use of necessary mental health services. (1.1)	**MH**	• Percent of responses on survey/interviews that report that cost is not a barrier to service. (1.1.1)
			• Services to victims of abuse and to clients of their immediate family at no cost to victim or family if: (1.1.2)
			  • DCBS waived, and
			  • Inability to pay
			  • Agreement between agencies, and
			  • Joint treatment plan

	Entry into mental health services is quick, easy and convenient. (1.2)	**D** **B** **D**	• Number & percentage of the population (1.2.1) • Percent of initial clinical contacts commenced within specified time frames for emergent, urgent, and routine. (1.2.2) • Percent of adults with SMI, percent of children with SED, etc. (by prevalence) who receive a service. (1.2.3) (Reg Pop Sum) • Percent of adult clients with SMI who are homeless. (1.2.4) (Reg Pop Sum) • Percent of estimated adults with SMI and percent of estimated children with SED in rural counties receiving a mental health service. (1.2.5) (Reg Pop Sum) • Proportion of referrals from the justice system of adults with SMI and children with SED. (1.2.6) (Reg Pop Sum) • Proportion of referrals from Public Health for adults and children. (1.2.7) (Reg Pop Sum) • Twenty-four (24) hours per day, seven (7) days per week Emergency services is accessible via a toll free telephone number TTY capability. (1.2.8) • Proportion of referrals from DCBS(1.2.9) (Reg Pop Sum) • Proportion of referrals from State Guardianship(1.2.10) • The percentage of clients who receive psychotropic medication (1.2.11) • Of these clients, the average length of time between admission/initial appointment to psychiatric evaluation(1.2.11)

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, culture, age and disability. (1.3)	**D**	• Percent of responses on survey/interviews report that providers are culturally sensitive. (1.3.1) • Percent of specified provider groups. (1.3.2) • Percent of staff who received training. (1.3.3) • Percent of facilities with TTY capability and access to interpreters (1.3.4) • Percent of high-volume facilities accessible to persons with disabilities. (1.3.5)

	A full range of mental health services options is available. (1.4)	**D**
		D
		
		D
		
		D
			• Percent of responses on survey/interviews that report clients received the services they needed (1.4.1)
			• Percent of home service encounters (1.4.2)
			• Provider Availability – Utilization by type of service (1.4.3) (Spec Rpt)
			• Provider Accessibility – Percent of services utilized in county of residence. (1.4.4) (Spec Rpt)
			• Percent of evaluations that result in no follow-up services. (1.4.5)
			• Service units per resident. (1.4.6)
			• Service units per consumer. (1.4.7)
			• Percent of clients seen for follow-up after evaluation, and for clients seen, average time from evaluation to follow-up service, by type of evaluation. (1.4.8)
			• Number of self-help groups per 1000 clients. (1.4.9)
			• Percent of CSU days for all out-of-home emergent days including inpatient. (1.4.10) (Reg Pop Sum)
			• A full range of MH services options is available
			  • KRS 210.410 (1.4.11)
			  a) Inpatient services,
			  b) Outpatient services,
			  c) PHP or Rehab.
			  d) Emergency
			  e) Consultation & Ed
			  f) MR services

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	The needs of priority populations are being served.	**SA**	• Percent of substance abuse services provided to the general population estimated to need services. • Percent of substance abuse services provided to the pregnant women estimated to need services. (Reg Pop Sum) • Percent of substance abuse services provided to women with dependent children estimated to need services. (Reg Pop Sum) • Percent of substance abuse services provided to adolescents estimated to need services. (Reg Pop Sum) • Percent of substance abuse services provided to clients referred by CPS who are estimated to need services. (Reg Pop Sum) • Percent of substance abuse services provided to clients referred by TANF who are estimated to need services. (Reg Pop Sum)
COST	**Efficient use of department funds optimizes improvements in health status of citizens/population groups.**	**MR** **D**	• Total number of people receiving each service (taken from client event data): • 20-Psychological testing • 25-Miscellaneous Purchases • 31/32-Respite (hourly) (Reg Pop Sum) • 62-Support Coordination (Reg Pop Sum) • 78-MR Prevocational Services • 79-Community Living Supports • 81-Community Habilitation (Reg Pop Sum) • 84-Behavior Support (Reg Pop Sum) • 85-Supported Employment (Reg Pop Sum) • 87-Occupational Therapy • 88-Physical Therapy • 89-Speech Therapy • 90-PASRR Specialized Services (Reg Pop Sum) • 91-Crisis and Prevention (Reg Pop Sum) • 92-MR Individual Supports (Reg Pop Sum) • 93/33/40/82-Residential (Reg Pop Sum) Total number of people on waiting list for each service.

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	Funds are handled responsibly. (2.1)	**MH**	• Costs per unit of service. (2.1.1) • Percent of community service costs. (2.1.2) • Per capita spending. (2.1.3) • Per capita child spending. (2.1.4) • Per capita special populations spending. (2.1.5)
EFFECTIVE-NESS	**People are satisfied with the services and supports they receive.**	**MR**	• **Proportion of families with an adult family member living in the home that report satisfaction** • Proportion of people who report satisfaction with where they live. • Proportion of people who report that satisfaction with their job or day program. • Proportion of people who report satisfaction with the number of hours they work.
	Service Clients experience increased independent functioning. (3.1)	**MH** **D** **D** **B**	• The average change in Functional Assessment Scale score for adult clients and, for children, the CAFAS score. (3.1.1) • Percent of adult clients and SMI adult clients who are employed (3.1.2) (Reg Pop Sum) • Percent of adult clients and SMI adult clients who are living independently. (3.1.3) (Reg Pop Sum) • Percent of IMPACT children with SED who attend school regularly. (3.1.4)
	People with mental illnesses should experience reduced involvement in the criminal justice system. (3.2)		• Percent of adult Clients with a referral from a criminal justice source. (3.2.1) (Reg Pop Sum) • There is collaboration between jails and centers. (3.2.2) • Percent of child Clients with SED who have contact with the justice system (3.2.3) (Reg Pop Sum)
	Service Clients experience an increased sense of personhood. (3.3)		• Percent of responses on survey/interviews report improved self-esteem. (3.3.1)
	Service results in positive		• Percent of responses on survey/interviews that report improved

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	changes in problems as defined by Clients. (3.4)		functioning as a result of services. (3.4.1)
	Clients experience minimal interference with productive activity, such as work, school or volunteer activities, as a result of alcohol, drug and/or mental disorders. (3.5)	**B**	• Percent of responses on survey/interviews that report minimal interference with productive activity. (3.5.1) • Placement Stability - Percent of IMPACT children with SED where a stable home environment is reported. (3.5.2)
	The level of psychological distress from symptoms is minimized. (3.6)		• Average percent symptom change as a result of outpatient treatment. (3.6.1) • Average percent symptom change as a result of crisis intervention treatment. (3.6.2)
	Clients experiencing an episode of acute psychiatric illness receive care that reduces the likelihood of a recurrence within a short period of time. (3.7)	**D**	• Percent of psychiatric hospital readmissions within 30 days of discharge (3.7.1) (FIS Rpt - 10/30 day readmissions) • Percent of clients having psychiatric hospital admissions (3.7.2)
	Clients take an active role in managing their own illnesses. (3.8)		• Percent of responses on survey/interviews that report improved ability to manage their illnesses (3.8.1)
	Clients function in community settings with optimal independence from formal services systems. (3.9)		• Percent of responses on survey/interviews that report participation in self-help groups (3.9.1)
	For Clients receiving medications, the average		• Clinical instrument mean (3.10.1)

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	level of functional impairment resulting from the effects of prescription medication is minimized. (3.10) **Service Clients experience increased natural supports and social integration (3.11)** **Clients experience minimal impairment from the use of substances. (3.12)**	**D**	• Percent of responses on survey/interviews that report less interference from illness with social activities (3.11.1) • Percent of responses on survey/interviews as a result form services, report less substance abuse (3.12.1) • Percent of responses on clinical instrument that report that clients with mental illness are less impaired by substance abuse (3.12.2) • Percent of Clients with multiple diagnosis who receive MH/MR, MR/SA, MH/SA or MH/MR/SA services. (3.12.3) (CMHC-I7)
	Clients are achieving reductions in harmful behaviors related to substance use/abuse.	**SA**	• Percentage of substance abuse clients reporting a reduction in alcohol use 12 months after treatment. • Percentage of substance abuse clients reporting a reduction in drug use 12 months after treatment. • Percentage of clients reporting fewer arrests 12 months after treatment. • Percentage of clients reporting fewer DUI arrests 12 months after treatment. • Percentage of clients reporting increased employment 12 months after treatment. • Percentage of clients reporting increased stability in living arrangements 12 months after treatment. • Percentage of clients reporting reductions in hospitalizations and emergency room episodes 12 months after treatment. • Percentage of increase in retention of substance abuse clients in treatment.
PREVENTION	**System ensures that people**	**MR**	• Incidence of serious injuries reported among people with MR/DD in

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	are safe and remain in the best possible health.		the course of service provision. • Proportion of people who report that they feel safe in their home and neighborhood • Proportion of people who have had a physical exam within a year • Proportion of people who have had a dental exam within 6 months • Proportion of women who have had a GYN exam within a year • Proportion of people receiving Psychotropic medications • Proportion of people receiving Psychotropic medications who have an appropriate Axis I diagnosis. • Proportion of people receiving Psychotropic medications without an Axis I diagnosis that have a drug reduction plan in place.
	Clients are provided information that helps lower their risk of developing mental and/or substance use disorders. (4.1) **Individuals at risk are provided specific programs that enable them to reduce their risk of developing mental disorders. (4.2)**	**MH** **D** **D**	• Suicide rate per 1000 residents (4.1.1.) (Monitoring M-6H) • Suicide rate per 1000 clients (4.1.2) (Monitoring M-6I) No indicator(s) at this time.
QUALITY: DEPARTMEN-TAL INDICATOR, CONTRACT 1.5.3	**COMPLETE AND ACCURATE DATA IS COLLECTED AND SUBMITTED TIMELY FOR ANALYSIS.**	**MR** **MH** **SA** **AFM**	• DATA REPORTED BY DUE DATE • DATA REPORTED IS COMPLETE AND ACCURATE
QUALITY	**People make life choices and participate actively in planning their services and supports.**	**MR**	• Proportion of people who report that they have access to their spending money • Proportion of people who report that they choose how to spend their

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
			money. • Proportion of people who report that they participated in the development of their individual plan • Proportion of people who report that their plan includes things of importance to them. • Proportion of people who make choices about important life decisions including housing, roommates, and daily routine, job, support staff or providers of services, and social activities. • Proportion of people who participate in integrated activities in the community including sports, using public services, religious events, arts and entertainment and dining out. • Proportion of people who report having friends and caring relationships with people other than support staff. • Proportion of people who report having a close friend, someone they can talk to about private matters. • Proportion of people who are able to visit with family and friends when they want. • Proportion of families of an adult not living in the home that report satisfaction with services. • Proportion of people who report having an advocate or someone who speaks on their behalf. • Proportion of people who report that their basic rights are respected • Proportion of people who report that they have participated in self advocacy activities • Proportion of people who report satisfaction with the amount of privacy they have. • Proportion of people who report that support staff treat them with respect
	Services are delivered, where possible, in accordance with known and accepted best-practice guidelines. (5.1)	**MH**	• Anti-psychotic medication mean dosage compared to clinical benchmark. (5.1.1) • Mean compliance score on clinical instrument that clients are taking medication as prescribed and/or percent of responses on survey/interviews that report taking medication as prescribed. (5.1.2) • Mean number of medications compared to clinical benchmark. (5.1.3)

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
			• Percent of Clients with depression who receive treatment consistent within medical standards for depression. (5.1.4) • Percent of Clients with schizophrenia who receive treatment consistent within medical standards for schizophrenia. (5.1.5) • Percent of sample of provider personnel files meeting credentialing process and qualification requirements. (5.1.6) • Percent of sample of provider personnel files meeting continued education program. (5.1.7) • Percent of sample of provider personnel files meeting supervision process. (5.1.8) • QI program uses external databases for best practice comparisons. (5.1.9) • Physical facilities are appropriate for their uses. (5.1.10) • Quarterly reports on monitoring of subcontractors including any findings, investigative actions of reported abuse and neglect, incident reports, corrective actions (5.1.11)
	People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance and service delivery (5.2)		• Percent of responses on survey/interviews that report clients are free to express concerns about their treatment. (5.2.1) • Percent of treatment plans with documentation of client involvement (or non-involvement if inappropriate). (5.2.2) • Percent of treatment plans with appropriate family/ significant other participation. (5.2.3) • Percent of treatment plans with parent/ guardian participation. (5.2.4) • Percent of clients, family members, and parents participate on the governing board. (5.2.5) • Percent of records with signed Consent to Treat and Release of Information (ROI) forms (5.2.6)
	The mental health provider or system maximizes continuity of care (5.3)	**B**	• Percent of psychiatric hospital discharges seen for clinical outpatient services within 7, 14, and 30 days of discharge(5.3.1)(Monitoring M-4) • Percent of psychiatric discharges recommended for case management who receive a case management service within 7, 14, and 30 days of discharge. (5.3.2)

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
		B/D	• Percents of adult clients with SMI and child clients with SED who receive targeted case management services AND Percents of estimated adult residents with SMI and estimated child residents with SED in the region who receive targeted case management services. (5.3.3) (Reg Pop Sum) • Percent of sample of treatment records where interagency collaboration is evident. (5.3.4) • Percent of clients discharged from psychiatric hospitals with prescription change within one month of discharge. (5.3.5) • Number of Boarding Home Discharges and percent that are meeting the client's needs (based on the Boarding Home Assessment Form). (5.3.6)
	Mental health clients have equal access to effective physical healthcare. (5.4)		• Percent of clients who receive a physical examination directly or by CMHC documented referral and follow-up. (5.4.1) • Rate of mortality of clients compared to Kentucky age cohort. (5.4.2)
	Clients receive services in a manner that satisfies their needs. (5.5)		• Percent of responses on survey/interviews that report clients would recommend their provider to a friend or family member. (5.5.1) • Formal complaints per 1000 clients. (5.5.2)
	Clients receive information that enables them to make informed choices about services. (5.6)		• Percent of responses on survey/interviews report a choice of Services. (5.6.1) • Percent of responses on survey/interviews report that clients were informed about their illness and medications. (5.6.2)
	The mental health provider or system offers services that promote the process of recovery. (5.7)		• Percent of Clients with SED or SMI who receive a rehabilitation service. (5.7.1)
	Clients function in community settings with optimal independence from formal service systems. (5.8)		• Average length of stay for acute inpatient or psychiatric care (5.8.1) • Average length of stay for site-based rehabilitation programs (5.8.2)

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized. (5.9) **Data integrity is maintained. (5.10)**	**D** **D**	• Percent of high-volume outpatient facilities posting comprehensive rights policies. (5.9.1) • Percent of medical records containing a signed statement documenting that a Client is informed of his or her rights and processes to assert them. (5.9.2) • Complaints/100 Clients (5.9.3) • Percent of data accuracy. (5.10.1) • Percent of data (including reports) that is complete and timely. (5.10.2) • Percent of medical records of persons matching the priority population profile whom are marked accordingly. (5.10.3) • Percent of medical records of coded services that meet requirements. (5.10.4)
	Complete and accurate data is collected and submitted for analysis.	**SA**	• Percent of new substance abuse clients on whom baseline data was collected. • Percentage of accuracy in baseline data collected on new substance abuse clients. • Percentage of accuracy in follow-up locator information on new substance abuse clients who give informed consent to the follow-up. • Percent of valid consents obtained from new substance abuse clients. • Percent of clients with complete event data across all modalities of care and programs.
	To analyze treatment event data for the treatment retention, drop-outs and overall lengths of stay associated with treatment outcomes.	**SA**	• **Rate of retention, drop-outs and lengths of stay for unduplicated number of clients served.**
COST	**Assets are used or available for generating income**	**A&FM**	• Working capital: **Current assets minus current liabilities, divided by total assets**
	Ability to meet short term		• Current ratio: **Curent assets divided by current liabilities**

DOMAIN	RATIONALE/CONCERN	DIVISION	MEASURE
	operating needs		
	Ability to pay bills and keep operating		• Quick Ratio: **Cash plus current receivables divided by current liabilities**
	No. of days an organization can operate with the cash on hand		• Cash interval: **Cash divided by ave. daily operating cost (excluding depreciation**
	Growth of fund balance		• Growth Ratio: **Net income divided by beginning fund balance**
	Profit compared to cost		• Operating margin: **Total revenue and support divided by operating expense before depreciation, minus 1**
	Amount earned for the funds invested		• Return on equity: **Excess of revenue over expenses before depreciation, divided by the fund balance**
	Earnings in return for use of assets		• Return on assets: **Excess of revenue over expenses before depreciation, divided by total assets**
	Efficiency (Center)	**B**	• Per capita MHMRC expenses: **Total reported CMHMRC expenses divided by number of residents of the region**
	Efficiency (Dept.)	**B**	• Per capite Dept. expenses: **Total DMHMRS funds paid or due divided by the number of residents of the region.**

B = Department's Plan & Budget Instructions for the SFY 2002 identified 9 Baseline performance indicators
D = Department's Plan & Budget Instructions for the SFY 2002 identified 21 Developmental performance indicators

Some Measures may be found on the Regional Population Summary reports (Reg Pop Sum), some on reports currently available on the Web (FIS Rpt - 10/30 ReAdmissions), (CMHC_I7), and (Monitoring reports M-4, M-6H, M-6I), some on Special Reports attached to the Regional Population Summary reports

Appendix E: Oregon HCBS Contract Reporting Requirements

Title: OR HCBS Contract Reporting Requirements, Excerpt from Chapter 411, Division 320, Community Developmental Disability Program, Section 9, p. 33-38
Author/Organization: OR Department of Human Services, Seniors and People with Disabilities
Date: Effective 8/3/2004
Link: http://www.dhs.state.or.us/policy/spd/rules/411_320.pdf

QA/QI Grantee Website Location: OR HCBS Contract Reporting Requirements at *Resource Library > RFPs/Contracts > Contracts*.

Document Description
This document specifies OR's contractual requirements for record maintenance and reporting for its Community Developmental Disability Programs (CDDPs)

(9) Local quality assurance program. Each CDDP must implement and maintain a local quality assurance system in accordance with these rules.

(a) QA system purpose and scope. The local quality assurance system will:

(A) Ensure the development and implementation of a quality assurance system by:

(i) Providing direct support to DHS in implementation of its quality assurance (QA) plan; and

(ii) Generally improving the quality of services by evaluating service delivery and outcomes and adjusting local planning and performance where needed.

(B) Include all Department funded developmental disability services provided within the county, including services that are operated or subcontracted by the CDDP, state operated community programs for developmental disabilities; and those developmental disability services operating under a direct contract with the Department; and

(C) Include, at a minimum, the quality indicators and all activities that are to be carried out at the local level according to the most recent edition of the Department's Quality Assurance Plan for Developmental Disability Services (Department's QA Plan).

(b) Quality assurance activities. The CDDP will perform quality assurance activities that include, but are not limited to, the following: 33

(A) Develop and maintain a local QA plan that describes the major activities to be performed by the CDDP, including the timelines for each of those activities.

(i) These activities must include all activities that are to be carried out at the local level according to the most current edition of the Department's QA plan.

(ii) The local QA plan must be updated whenever changes are made, but at least annually.

(B) Develop CDDP policies and procedures needed to implement the local QA plan.

(C) Implement the activities defined in the local QA plan, including the timely delivery of data and information to the Department as required in the Department's QA plan.

(D) Maintain data and information that has been gathered through implementation of the local QA plan.

(E) Maintain a record of conclusions and recommendations that have been drawn from analysis of the information gathered.

(F) Take management actions as needed to improve service quality or to correct deficiencies; and

(G) Maintain records that document:

(i) The CDDP's performance of the activities described in the local QA plan.

(ii) The CDDP's performance measured against statewide performance requirements as specified in the Department's QA Plan.

(iii) The CDDP's findings, corrective actions and the impact of its corrective actions that have been reviewed at a policy level within the CDDP's department structure within the County; and 34

(iv) The timely submission of information to the Department, as required in the Department's QA Plan.

(c) Performance requirements. The CDDP will meet or exceed the minimum performance requirements established for all CDDP's in the Department's QA Plan.

(A) The CDDP will collect and analyze information concerning performance of the activities represented in OAR 411-0320-0040(9)(a)(A), in the manner specified in the Department's QA Plan.

(B) Data concerning the CDDP's performance will be sent to the Department in the format and within the timelines established by the Department.

(C) The CDDP must cooperate in all reviews, by the Department or its designee, of CDDP performance in accordance with these rules.

(D) Records that document the CDDP's performance will be maintained and be made available to the Department or its designee, for audit purposes, upon request.

(d) Corrective actions. The CDDP will act to correct deficiencies and poor performance through management actions.

(A) Deficiencies and substandard performance found in services that are operated or subcontracted by the county will be resolved through direct action by the CDDP.

(B) Deficiencies and substandard performance found in services that are operated by the state or through direct state contracts will be resolved through collaboration with the Department.

(C) Deficiencies and substandard performance found in services provided through a Region will be resolved 35

through collaboration between the regional management entity and the affected CDDPs.

(e) Local quality assurance committee. The CDDP will utilize a committee of stakeholders to assist in the development and review of local quality assurance plans and activities.

(A) Committee membership will include persons representing self-advocates, service providers, advocates, family members of individuals with developmental disabilities and Services Coordinators.

(B) Activities of the committee will include:

(i) Providing review and comment on CDDP plans for local QA plan activities;

(ii) Providing review and comment on data gathering instruments and methods; and

(iii) Providing review and comment on the results of information gathered by the CDDP and the effectiveness of corrective actions.

(f) Quality assurance resources. The CDDP must allocate resources to implement the local QA plan.

(A) Individuals employed to carry out implementation activities will have the training and education, as well as the rank or classification within the organization that is appropriate for the tasks assigned.

(B) One position within the CDDP will be designated as the QA Coordinator. The minimum requirements must include:

(i) The QA Coordinator must be a full time CDDP employee, unless prior approval of an alternative plan has been obtained from the Department;

(ii) At a minimum the position must meet the qualifications for a Services Coordinator for 36 individual with developmental disabilities as described in OAR 411-320-0030(3)(b)(A)(i-iv);

(iii) The purpose of the QA Coordinator is to facilitate the CDDP's quality assurance process through activities such as the following:

(I) Participate in Department sponsored activities such as planning and training that are intended to assist in development and implementation of Department's QA plan requirements, compliance monitoring procedures, corrective action plans and other similar activities.

(II) Draft local quality assurance plans and procedures that both meet QA requirements established by the Department and consider the unique organizational structure, policies and procedures of the CDDP.

(III) Keep CDDP administrative staff informed concerning new or changing requirements being considered by the Department.

(IV) Coordinate activities within the CDDP such as preparation of materials and training of county staff as needed to implement the local QA plan.

(V) Monitor the implementation of the local QA plan to determine the level of county compliance with Department requirements. Keep CDDP administrative staff informed about compliance issues and need for corrective actions.

(VI) Coordinate delivery of information requested by the Department, such as the Serious Event Review Team (SERT). 37

(VII) Assure record systems to store information and document activities are established and maintained.

(VIII) Perform abuse investigations, if approved by the Department as part of the CDDP's QA plan.

Appendix F: Georgia Performance Profile Statewide Summary

Title: PERMES - Georgia's Performance Measurement and Evaluation System: FY2003 Performance Profile MHDDAD Statewide Summary, Section III Key Findings, p. 16-20

Author/Organization: Evaluation Unit, Decision Support Section, Division of MHDDAD and The Center for Mental Health Policy & Services Research University of Pennsylvania

Date: December, 2003

Contact: Stephanie Frankos, sfrankos@dhr.state.ga.us

QA/QI Grantee Website Location: GA System Performance Profile Report at *Resource Library > Browse Document by Category > Performance Measurement > Performance Indicators*

Document Description

The Georgia Performance Measurement and Evaluation System (PERMES) is a comprehensive outcome evaluation and performance management system designed to improve both accountability and the performance of the state's public mental health, developmental disabilities and addictive diseases (MHDDAD) system.

Section III: Key Findings

This year's report reflects the continuous growth of PERMES and numerous positive and encouraging findings about the service system. The collection of data presented, particularly those obtained through the consumer and family surveys and the expanded outcome assessments, should be considered a major accomplishment. Findings indicate mostly positive consumer views and system performance but also indicate areas for further improvement. Results are summarized below by overall domain areas, as well as by each consumer group.

Access Domain

- Utilization rates per 1,000 persons show a dramatic increase since FY2001 for community mental health services. Utilization rates have remained relatively stable for community developmental disabilities and addictive disease services. Like other states, it is likely that DMHDDAD services are reaching only a small percentage of those who need and desire public services. Extremely low rates of utilization among Hispanics and non-African American minorities suggest significant barriers to accessing services.
- Hospital utilization rates are well above national norms. Last year's mental health hospital utilization rate of nearly 2 per 1,000 state population was more than twice the national median reported for FY2000. The hospital utilization rate for adult mental health (including forensics) has slowly increased over the last three years. The hospital utilization rate for consumers with developmental disabilities has decreased over the same time span.
- Consumer ratings of the time and place of services are very good to excellent. Overall, 87% of consumers agreed that services were easily accessible. At the same time, large numbers (almost 40 percent) of family members of children and adolescents with SED and consumers with developmental disabilities, find it difficult to arrange needed services. It is unclear why such a large discrepancy exists between consumers and family members' views of service accessibility.

Quality/Appropriateness Domain

- The percent of consumers satisfied with services is just slightly below performance expectations of 80% (78.2%). Generally, consumers served in the community expressed significantly higher levels of satisfaction than consumers served in hospital settings. Though levels of satisfaction expressed by family members of consumers with DD are similar to the responses from consumers themselves, satisfaction levels expressed by parents of children and adolescents receiving mental health services (65%) fell well short of performance expectations .
- Though consistent with national trends, participation in service planning by consumers and family members leave some room for improvement.
- Support for parents or guardians of consumers living at home fell slightly below performance expectations. Seventy percent (70%) of families of children and adolescents with SED and 78% of families of consumers with DD were satisfied with the level of family support provided by DMHDDAD. Such support is critical for keeping consumers in home settings.
- Both consumers and family members give high marks to the competence and professionalism exhibited by provider staff, especially in community settings.
- Eighty percent (80%) of consumers surveyed reported at least one non-emergency room visit to see a doctor in the past year. At the same time, large numbers of consumers of adult mental

health services rated their physical health as fair or poor. It is well recognized that physical health problems often interfere with recovery.

- The use of evidence-based practices for the seriously mentally ill is an area of needed improvement. Large numbers (nearly 90 percent) of hospital consumers with schizophrenia utilize new generation (atypical) antipsychotics. In community services, however, only a third of consumers with a primary diagnosis of schizophrenia received a new generation agent in FY2003.[1] The national median for consumers with schizophrenia served in community settings is almost twice this rate. In addition, very few consumers (1%) are enrolled in Assertive Community Treatment (ACT), a leading evidence-based practice for persons who are seriously mentally ill.
- The percentage of CAMH consumers placed in an out-of-home 24-hour residential setting is higher than the previous two fiscal years. In addition, most of these stays are long-term given that the average number of days during the fiscal year spent in an out-of home placement was 200 days (out of 365). On a more positive note, almost 25 percent of these placements have been in therapeutic foster care, the least restrictive form of out-of-home placement for children with serious emotional disorders and a leading evidence-based practice.
- The readmission rate among discharged mental health hospital consumers is significantly higher than national averages for state-operated psychiatric hospitals. Both the 30 and 180-day readmission rate has remained fairly consistent over the past two fiscal years.
- The use of seclusion and restraint among consumers served in inpatient settings is well below national averages.
- The number of medication errors reported in state-operated psychiatric hospitals is slightly below national averages.
- The injury rate in state hospitals is slightly higher than national norms. Most of these injuries were accidental (rather than self-inflicted injuries or assaults) and 95% required no medical intervention or emergency room medical care.
- The elopement rate from state hospitals is lower than the national average.

Outcomes Domain

- Seventy-nine percent (79%) of consumers surveyed report positive change occurring in their lives as a result of services. Results were higher for consumers receiving services in the community as compared to the hospital. Less than half of parents of children and adolescents with SED, however, saw any positive change in their children's lives.
- Based upon the result of outcome assessment instruments, the overwhelming majority (95%) of consumers with mental illness and addictive diseases maintained or improved on their ability to function in daily life while in services.
- Over half of consumers receiving child and adolescent mental health services with severe impairment in school functioning upon enrollment in services improved. For these consumers, time in services coincided with attending (or returning to) school, passing most classes, and meeting minimum requirements for behavior in the classroom.

[1] This figure reflects the percent of consumers served by DMHDDAD who receive a new generation antipsychotic through the DMHDDAD service delivery system. Currently, the Division does not track consumers who may receive antipsychotic medication (new generation and otherwise) from other service delivery systems (the Veteran's Administration, Medicaid providers not under contract with DMHDDAD, etc.). This may partially account for the relatively low number reported.

- The quality of life of consumers enrolled in community DD services exceeded national norms, as measured by the QOL-Q.
- Unemployment -- particularly among adult consumers receiving mental health service-- is high. A majority of unemployed consumers want to work and need the support of the service delivery system in finding and holding paid jobs.
- On a composite measure of choice/satisfaction with housing, approximately 80% of adult consumers responded positively.
- Self-reported community integration and self-determination among consumers enrolled in DD services is very good.

Adult Mental Health Results

- The adult mental health community services utilization rate of 15.7 consumers per 1,000 adult population represents a 12% increase in just two years. Utilization of public services among Hispanics, however, is below 4 per 1,000 Hispanic adult population.
- Hospital utilization rates have increased since FY2001.
- Almost four out of every five consumers expressed satisfaction with services.
- Treatment participation was up slightly from last year, but at 74% still suggests the need for promotion of consumers' involvement in their own services.
- Eighty-one percent (81%) of consumers report having at least one non-emergency room visit to a doctor in the past year.
- 40% of consumers report their health as poor to fair.
- Availability or utilization of evidence based practices in community settings remains extremely low.
- Thirteen percent (13%) of admissions (non-forensic) to state hospitals are consumers who have been discharged within the previous 30 days. Almost 30% are consumers who have been discharged in the previous six months. These rates are well-above national averages for state-operated psychiatric hospitals.
- Almost 4% of consumers in forensic units were restrained at least once in FY2003. By contrast, only 1.3 percent of consumers in non-forensic units were restrained over the same time period.
- Almost 80% of consumers report positive changes occurring as a result of services in the consumer survey. With a median of 161 days between assessments, 18% of consumers show significant improvement and 78% demonstrate maintenance in functioning.
- The unemployment rate, at almost 70%, is higher than the prior two years. A majority of unemployed consumers report they are able and want to work.

Child and Adolescent Mental Health Results

- Utilization rates (17.6 consumers per 1,000 population) of community child and adolescent mental health services have increased 17% since FY2001. Rates remain extremely low for Hispanics.
- Nearly 40% of family members report fair to poor accessibility of services.
- Levels of satisfaction among children and their families leave substantial room for improvement.
- Three-quarters of families report participation in planning their child's services.
- Seventy percent (70%) of families report satisfaction with the level of support designed to strengthen their

ability to provide care to their child at home.
- Both children and their families give high marks to the provider staff providing care.
- The rate of out-of-home placement has increased over the previous two fiscal years. Almost 25% of these placements are in therapeutic foster care, considered the least restrictive and most efficacious service for children with serious emotional disorders.
- Though the overall rate of seclusion is low, CAMH has the highest rate (1.7%) of all consumer groups in the percent of hospital consumers secluded in the past year.
- Though three-quarters of community consumers view services as positively impacting their lives, less than half of parents report positive changes in their child while enrolled in services. Though low, parental responses are consistent with national norms.
- Only 62% of consumers receiving services in the hospital viewed services as positively impacting their lives.
- Nearly 20% of consumers exhibited significant improvement in functioning as measured by the CAFAS. For those with severe impairment in school/work, over half showed improvement over a short period of time.

Developmental Disabilities Results

- Hospital utilization rates have decreased in FY2001.
- Nearly 40% of family members or guardians report difficulties in accessing services.
- Satisfaction with services -- among both consumers and family members -- was extremely high.
- The level of consumer and family involvement in service planning was 70%, which was lower than service expectations. The result, however, continues a trend of improvement from FY2000 to the present.
- Nearly 80% of family members of a consumer with DD living at home, report satisfaction with the level of support they have received. Eight-four percent (84%) indicated that this support had made a difference in keeping their family member at home.
- Both linkage to physical health services and self-reported health status were relatively good.
- Nearly 4% of consumers served in state-operated DD units in hospitals were restrained at least once during the fiscal year.
- The quality of life among consumers with DD served in community settings is well above national norms.
- Sixty percent (60%) of consumers reported being employed. Three quarters of these consumers are employed at a workshop rather than an integrated setting. Almost 60% of unemployed consumers report wanting to work.
- Eighty percent (80%) of surveyed consumers exercised some independent choice in their current living arrangement.
- Large numbers of community consumers (86%) report a high degree of self-determination, including the ability to participate in community activities and engage in activities of one's choice.
- The injury rate at state hospitals is typically higher for consumers receiving developmental disability services.

Addictive Diseases Results

- Utilization of services has remained fairly consistent over the past three

years. Rates are noticeably low among children and adolescents, Hispanics and non-African American minorities.

- Though meeting performance expectations, accessibility of services was lowest among consumers with addictive diseases.
- Though only 75% of consumers reported that they actively participated in decisions regarding their services, the rate was the highest among all consumer groups.
- Almost 30% of consumers characterized their physical health as fair to poor.
- Eighty-one percent (81%) of consumers viewed services as improving their lives, the highest number among all consumer groups.
- Ninety-six percent (96%) of consumers experienced improved or maintained functioning while enrolled in services.
- Almost 60% of consumers with addictive diseases surveyed, reported that they were unemployed. An overwhelming majority of those unemployed view themselves as physically and mentally able to work.

Appendix G. Sample Job Descriptions

Title: OH Description of Services from QA Consultant Contract
Author/Organization: OH Department of Mental Retardation and Developmental Disabilities
Date: 2004
Contact: Don Bashaw, Don.bashaw@dmr.state.oh.us; Suzzanne Freeze, suzzanne.freeze@dmr.state.oh.us

QA/QI Grantee Website Location: OH Description of Services from QA Consultant Contract at *Resource Library > RFPs/Contracts > Contracts*

Document Description
Consultant job description.

Title: PA Position Description: Long Term Care Improvement Operations Administrator
Author/Organization: PA Governor's Office of Health Care Reform
Date: 2004
Contact: Gregory Howe; ghowe@state.pa.us

QA/QI Grantee Website Location: PA Quality Administrator Job Description at *Resource Library > RFPs/Contracts > Job Descriptions*

Document Description
Position description.

Description of Services from Ohio's QA Consultant Contract

The Contractor will provide identified support, analysis, development, information-gathering/application over the three- year period noted in this contract. These functions to be performed by the contractor include:

- Maintaining a national perspective on self-determination in the field of developmental disabilities, knowledge of the CMS Independence Plus Waiver, familiarity with CMS Quality Initiatives and in general HCBS waiver services, experience in managing a regional or statewide project over an extended period of time, knowledge and understanding of the foundations of Ohio's system change efforts, demonstration of knowledge and ability to utilize data and data synthesis into broad scope information systems, and use of data as a basis for the operation and management of a statewide quality assurance system. The primary focus of the project is the acquisition of capacity to generate reporting mechanisms using data translation.

- Developing and maintaining a systems strategy of working with the ODMRDD and county boards in research, design and implementation (demonstration county boards only) of a "quality framework" using data sources as the foundation on which a statewide system of integrated quality management is based. The contractor agrees to support the approach that available data collected as a result of a number of ODMRDD activities can in fact be utilized to identify activities by the "system" to improve efficiency and effectiveness of service/support delivery. The contractor agrees to demonstrate a commitment and understanding of the necessity for the construction of a quality framework for Ohio.

- Coordinating collaborative work of ODMRDD, the five (5) demonstration county boards, and the project advisory committee. The contractor will be utilized to establish the elements of Ohio's quality framework, including the identification of personal and systems measures. These outcome measures must identify the specific expectations for both the system (state and local) and for people in an aligned relationship. The contractor will be integrally involved in the research and development of a Quality Framework for Ohio using the four CMS elements of design, discovery, remediation and improvement.

- Coordinating work with the ODMRDD project staff including developing and maintaining identified strategies, materials, and schedules necessary to complete the deliverables with the approval of ODMRDD. The contractor will have available ODMRDD resources and necessary contacts with stakeholders in order to achieve a successful demonstrations phase. The contractor will work with the ODMRDD project staff in a cooperative manner with both the research and demonstration phases of the project. The contractor will assist in the evaluation and development of a state quality management system. The contractor will assist project staff in the identification of other states involved in a similar stage of systems-change to maximize time efficiency during the project's research phase. The contractor will

provide periodic objective and independent evaluation of progress toward the project's identified objectives.

- Providing the results of evaluations in an electronic format to be developed in coordination with the ODMRDD. The contractor will periodically report progress on the work to ODMRDD through meetings with the project manager and others, as determined appropriate by ODMR/DD. The contractor will submit the supporting documentation in ODMRDD-approved formats. The contractor shall, at a minimum, meet with ODMRDD representatives or communicate through a mutually agreed upon method (meetings, phone calls, e-mail,), on an every other week basis, to provide status updates, complete training and technical assistance materials, develop identified work/business plans, and to coordinate schedules and general administrative and evaluation activities of the project. The Project Director shall determine the frequency and necessity for the consultant to perform the duties of the contract in Columbus, Ohio.

The specifications of deliverables are components of an overall strategy of the construction of a statewide quality framework that focuses on the utilization of both current and projected collection of data. It is intended that the use of data will be focused on the development of a fully integrated quality management system that will support improved effectiveness and efficiency of the service/support system in Ohio. The research, design, content and procedures for demonstration strategy is subject to approval by ODMRDD. The contracted services shall include, but not be limited to, the following areas:

1. Analysis of current ODMRDD quality assurance activities and determination of potential utilization of current data yield in the QIMS project.

2. Analysis of related ODMRDD activities that currently have no data yield, but potential for transition into a data system mode.

3. Provide technical assistance and support to project staff and to the stakeholder advisory committee on the achievement of the grant objectives.

4. Provide technical assistance to project staff in the integration of current "program" quality assurance information and the data input/output phase of the project.

5. Research and provide relevant information from other states' activities similar to Ohio's QIMS project.

6. Establish necessary work/business plan, using MS Project, to support the effective implementation of the demonstration phase of the project, including timelines for completion and persons responsible.

7. Assist in the development of the training curricula for both the technical and operations aspects of the project for both internal (ODMRDD) and external (local stakeholders).

8. Communicate with representatives from ODMRDD on an every other week basis, unless otherwise mutually agreed to by the contractor and ODMRDD, to coordinate the next two weeks' activities, to provide a status update on the project (MS Project), and to provide suggestions and feedback for the future concerning the outcomes of the ODMRDD project. Provide written reports on the status of the project once per month during the term of the contract (MS Project), once at the completion of the research/design phase (by March 31, 2005), and once at the conclusion of the demonstration phase (by October 31, 2006).

9. Provide technical assistance and additional training to any of the identified participants that is needed to fulfill the scope of deliverables defined in this RFP.

10. Provide follow-up consultation with ODMRDD personnel as necessary.

11. Based on the successful implementation of the demonstration phase, provide a business plan for full implementation statewide.

12. Assist project staff in the development of a sustainability plan that will ensure continuation and expansion of the QA/QI Grant goals and objectives.

Position Description
Long Term Care Quality Improvement Operations Administrator

Position Purpose: Develop and coordinate the long-term care quality improvement and assurance activities of the departments of Aging, Health and Public Welfare through the Office of Health Care Reform and is responsible for activities under the CMS Quality Assurance and Quality Improvement grant.

Requirements:

- Certification in continuous quality improvement.
- At least five years experience in managing continuous quality improvement, preferably in the area of publicly funded home and community based services for persons receiving services in the community.
- Significant administrative experience, with a proven record of effective management.
- Preferably experience with consumer-directed, agency-directed and consumer-centered long-term care services and supports.
- Excellent facilitation skills and ability to work closely with consumers, providers and other stakeholders.
- Significant data management skills and knowledge of and ability to use essential information systems.
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- Excellent speaking and writing skills.
- Experience with grant management.
- Knowledge of and sensitivity to issues facing older and younger persons with disabilities that require personal care services.
- Ability to immediately begin activities under the CMS Quality Assurance and Improvement grant and to implement the policy changes impacting the quality of publicly funded long-term care services in Pennsylvania.
- Ability to work collaboratively with the Long Term Care Operations Administrator.

Description of Duties:

1. Work collaboratively with senior policy staff in the Office of Health Care Reform and the Departments of Welfare, Aging and Health and reports to the three Secretaries from these departments through the Office of Health Care Reform.

2. Provide executive staff support for designing quality systems with stakeholder participation, implementing long term care quality improvement policy decisions through out Commonwealth agencies.
3. Administer the CMS Quality Assurance Quality Improvement grant, including ensuring completion of grant deliverables, filing reports, etc.
4. Establish quality assurance and improvement systems across a wide range of home and community based services, including instruments to gather information about consumer preferences and goals and use this information to develop a consumer-centered service plan, design and plan the administration of consumer satisfaction instruments, develop consumer education materials, develop a backup system requirements for service breakdowns, develop an incident management system, etc.
5. Ensure that various constituencies, consumers, organizations and persons associated with long term care in Pennsylvania have an opportunity to share their viewpoints and that their concerns are properly represented in all appropriate forums.
6. Interact with the various constituencies, consumers, associations, organizations and persons with an interest in quality issues for long term care in Pennsylvania and nationwide.
7. Work with staff of the departments of Aging, Health and Public Welfare and local agency staff to ensure the availability of quality, consumer-centered long term care services and supports for lower income Pennsylvanians who qualify for those services.
8. Work with deputy secretaries, policy and legislative staff and others to implement the long-term care quality improvement and assurance reform activities of the Office of Health Care Reform and the departments of Aging, Health and Public Welfare and oversee the day-to-day administration of these reforms.

9. Work to educate and inform consumers, associations, legislators and Commonwealth staff on new long term care procedures.
10. Convene and staff work groups to determine how to operationalize new long-term care quality policies.
11. Direct and supervise activities under the CMS quality grant and the overall operation of long-term care services delivered and funded by the departments of Aging, Health and Welfare.
12. Represent the Commonwealth on task forces, work groups, committees and advisory groups.
13. Perform related work as required.

Appendix H: Texas Health and Human Services Commission

Title: TX Transformation Roles of Centers for Policy, Program Coordination and Consumer Affairs
Author/Organization: TX Department of Health & Human Services
Date: Effective March 31, 2004
Contact: http://www.hhs.state.tx.us/consolidation/index.shtml

QA/QI Grantee Website Location: TX Roles of Centers for Policy, Program Coordination and Consumer Affairs at *Resource Library > Documents by Category > QM System Design > Development/Organization of QM Staff.*

Document Description

This document specifies the roles and responsibilities of the three offices responsible for developing policies, coordinating programs and facilitating consumer and stakeholder involvement with the departments.

HHS Transformation
Roles of Centers for Policy, Program Coordination and Consumer Affairs

effective date: March 31, 2004

Each of the four departments under the oversight of the Texas Health and Human Services Commission includes three offices that report to the deputy commissioner. These offices are responsible for developing policies, coordinating programs and facilitating consumer and stakeholder involvement with the departments.

Center for Policy and Innovation

- Develops uniform and consistent program policy for merged agencies based on a review of legacy agency program policy.
- Provides oversight, direction and technical assistance regarding program policies, procedures, standards, rules, regulations and plans.
- Ensures that program policy and administrative policy do not conflict.
- Coordinates compliance training.
- Develops general department program policy consistent with HHSC standards to guide specific program policy that will ensure that a coordinated approach to program policy development.
- Ensures that program specialist input is included in program policy development.
- Coordinates department program policies with HHSC program policy standards.
- Coordinates department program policies with agencies outside of the health and human services system.
- Develops and promulgates best clinical practices.
- Identifies best practices associated with research and grant development.
- Benchmarks program policy innovations of other states.
- Designs, monitors and evaluates program delivery improvement pilots and demonstrations.
- Coordinates with the Center for Consumer and External Affairs to ensure stakeholders involvement in program policy development.

Center for Program Coordination

- Identifies and resolves policy conflicts and ambiguity that may result from the merger of legacy agencies into new agencies.
- Facilitates continuous program delivery improvement.
- Establishes and evaluates program operation and service delivery benchmarks.
- Ensures that departmental programs and business processes use consistent standards and practices.
- Continuously assesses program operations for opportunities to improve services or reduce costs.
- Identifies program operational redundancies.
- Coordinates department program operations and processes internally, with HHSC, with other state agencies, and throughout the health and human services system.
- Ensures integrated approaches to program service delivery.
- Coordinates and facilitates the optimization of agency program functions.
- Facilitates the development, evaluation and update of compliance materials in coordination with the appropriate program office.

Center for Consumer and External Affairs

- Provides centralized support to the Department Council.
- Maintains productive stakeholder relations and provides a central location for public and stakeholder input to and information from the department.
- Evaluates and analyzes consumer input and makes recommendations to management to improve customer satisfaction.
- Coordinates the referral of inquiries to the appropriate division within the department and among departments and HHSC.
- Serves as the liaison for governmental affairs and federal oversight entities.
- Tracks and coordinates analysis of legislation and final fiscal note approval.
- Receives and processes consumer complaints (ombudsman).
- Provides guidelines for the support of federally required advisory committees.
- Establishes standards and guidelines to ensure accurate communication of department program policy and goals.
- Coordinates public information releases with HHSC.

- Coordinates responses to media inquiries with HHSC.
- Coordinates content and graphic layout of Internet and intranet websites with HHSC.
- Provides external program communication materials for executive staff.
- Coordinates translation/interpretation services.
- Reviews the development of program publications for consistency with department and HHSC communication strategies.
- Performs the customer service functions as required in the Texas Government Code, Chapter 2114.
- Coordinates and develops program public awareness activities in partnership with appropriate departmental offices and staff.
- Coordinates consumer and external affairs activities with related HHSC offices.

HHS Transformation Home Page

Appendix I: South Carolina First Health Services Partnership

Title: SC's Contract with First Health Services - Overview
Author/Organization: SC Department of Disability and Special Needs
Date: 2004
Contact: Joan Hummel, Contract Officer, Dept. of Disability and Special Needs

QA/QI Grantee Website Location: SC Contract with First Health Services – Overview at *Resource Library > Document by Category > QM System Design > Use of QIOs in State Waiver QM*

Document Description
This document provides an overview of SC's contract with First Health services, in which the state QIO has a significant role in conducting QM activities.

Overview of South Carolina's Contract with First Health Services, Corp.

Contact:
Joan Hummel, Contract Officer for First Health Services, Corp.
Department of Disability and Special Needs
South Carolina

Background:
The department has two waivers: one for individuals with MR/RD and one for individuals with head and spinal cord injuries. DDSN contracts with local county disabilities and special needs boards and other providers to deliver services. Prior to July 2002, DDSN was responsible for contractual compliance reviews. This was problematic for several reasons. First, there was no consistency in how the reviews were conducted. Second, the staff performing the reviews were also providing technical assistance to the providers they were reviewing.

The department decided to outsource this activity to expert reviewers. After issuing a RFP, they established a contract with First Health for a 5 year period. SC is now completing the third year of the contract. A sample of approximately five percent is used: primarily random but covering all service groups.

Components of QIO Review:

1. Three Types of On-site Record Review

    - Administrative: includes organizational structures, policies, procedures, etc.
    - General Agency: includes a complete review of all records for each individual in the sample
    - Early Intervention: includes a review parallel to the General Agency but specific to this service group age birth to six.

2. Consumer Interviews – person-to-person interviews with consumers in the sample and/or family members, as appropriate and available

3. Consumer Satisfaction Mail Survey – sent to approximately 1500 to 3000 consumers/families per year

Process for QIO Review:

- First Health is responsible for reviewing each of the 39 county disabilities and special needs boards annually as well as some qualified providers
- Reviews occur on-site, usually involve a team of 7 members, 4 of which work on-site, and last between 4 to 5 days.
- Thirty days after the provider's review has been completed a copy of the final report is due. It is submitted to both the provider and DDSN. Anything cited as deficient requires remediation, and the provider must complete a plan of correction. First Health then conducts a follow up review to ensure the POC has been implemented.
- Informal processes are in place for communicating First Health findings with Licensing and Internal Audit.