QUALITY IMPROVEMENT STRATEGY (QIS)

Fiscal Year 2017-2018

Presented by: Emily Kelley and Leila Norden

November 2018

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

TOPICS

Overview and History of Quality Improvement Strategy (QIS)

What's New?

Next Steps

GLOSSARY

- ANE: Abuse, Neglect, and Exploitation
  - Also MANE: Mistreatment, Abuse, Neglect, and Exploitation
- CAP: Corrective Action Plan
- CCB: Community Centered Board
- CIR: Critical Incident Report
- CMA: Case Management Agency
- CMS: Centers for Medicare and Medicaid Services
- HCPF: Department of Health Care Policy and Financing (Department)
- PM: Performance Measure
- QIS: Quality Improvement Strategy
- SEP: Single Entry Point

OVERVIEW AND HISTORY

WHAT IS QIS?

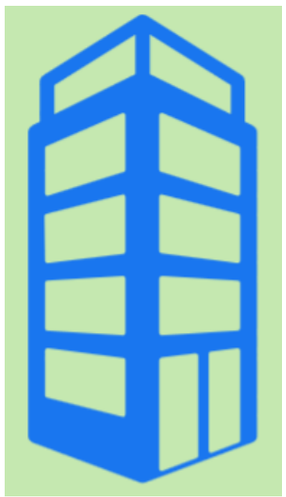
Requirement of Centers for Medicare and Medicaid Services (CMS)

- Ten Appendices for each waiver
- Six Appendices have Quality Improvement Strategy components
- Specifies Assurances and Sub-Assurances

Department of Health Care Policy and Financing

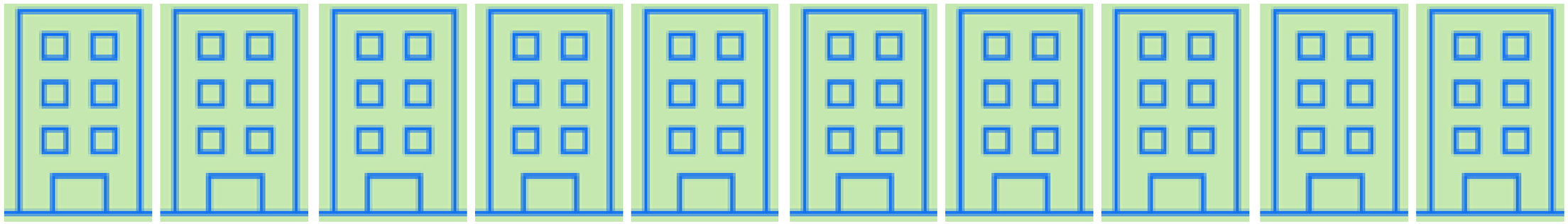
- Identifies Performance Measures (PM)
- Annually reviews a sample from each waiver
- Submits 372 Report of QIS results to CMS annually

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)



HEALTH CARE POLICY AND FINANCING (HCPF)

CASE MANAGEMENT AGENCIES (CMA)



WHAT IS QIS?

Provides multiple snapshots of effectiveness

1. Individual Case Management Agency
2. Individual Waiver
3. Statewide

Does NOT provide a snapshot of individual case manager performance

WAIVER APPENDICES

Appendix A	Waiver Administration and Operation
	Quality Improvement: Administrative Authority of the Single State Medicaid Agency
Appendix B	Participant Access and Eligibility
	Quality Improvement: Level of Care
Appendix C	Participant Services
	Quality Improvement: Qualified Providers
Appendix D	Participant-Centered Planning and Service Delivery
	Quality Improvement: Service Plan
Appendix E	Participant Direction of Services
Appendix F	Participant Rights
Appendix G	Participant Safeguards
	Quality Improvement: Health and Welfare
Appendix H	Quality Improvement Strategy
Appendix I	Financial Accountability
	Quality Improvement: Financial Accountability
Appendix J	Cost Neutrality Demonstration

APPENDICES DETAIL

All waivers have the same Assurances

Sub-Assurances and Performance Measures are closely aligned across all waivers

Some Performance Measures are waiver-specific

- Examples:
  - HCBS-CMHS: Mental health provider contacted every 180 days
  - HCBS-DD: Annual physical exam

Department is normalizing Performance Measures

THE MATRIX

Compilation of all Assurances, Sub-Assurances and Performance Measures for which CMAs are responsible

It also accounts for data source and methodology for our calculation

Each CMA will receive a copy of the Matrix in their SharePoint site

EXAMPLE: APPENDIX G

ASSURANCE:

The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare

EXAMPLE: APPENDIX G

SUB-ASSURANCE:

The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death

EXAMPLE: APPENDIX G

PERFORMANCE MEASURE *(non-IDD waivers)*:

Number and percent of abuse, neglect, or exploitation (ANE) critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver

EXAMPLE: APPENDIX G

PERFORMANCE MEASURE *(non-IDD waivers)*:

Numerator = Number of ANE critical incidents reported by the CMA timely

Denominator = Total number of ANE critical incidents

EXAMPLE: APPENDIX G

PERFORMANCE MEASURE *(IDD waivers)*:

Number and percent of all critical incidents in the representative sample reported within the required timeframe

EXAMPLE: APPENDIX G

PERFORMANCE MEASURE *(IDD waivers)*:

Numerator = Number of critical incidents in the sample reported within the required timeframe

Denominator = Total number of critical incidents reported in the sample

PERFORMANCE MEASURE	SUB-ASSURANCE	ASSURANCE
Number and percent of all critical incidents in the representative sample reported within the required timeframe	The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death	The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare

WHAT'S NEW?

WHAT'S NEW?

BEFORE:

- Case Management Agencies completed review

NOW:

- Reviews completed by outside vendor

WHAT'S NEW?

Review completed by vendor selected by HCPF

Case Management Agencies receive results on November 19, 2018 in SharePoint sites

Two reports for each Case Management Agency

1. CMA and Statewide data on applicable Performance Measures
   - *QIS Results Report*

2. Identifies areas requiring improvement by CMA
   - *QIS Corrective Action Plan FY 2017-18*

WHAT'S NEW?

BEFORE:

- Individual remediation completed

NOW:

- Corrective Action Plan (CAP) required

WHAT'S NEW?

Corrective Action Plan (CAP) required for each result at 85% or below

EXCEPT for Critical Incident Reports of MANE where appropriate follow-up was not taken

- Requires 100% individual compliance

Case Management Agencies develop their CAP

COLORADO
Department of Health Care Policy & Financing

Case Management Agency Name

QIS Corrective Action Plan FY 2017-18

The following illustrates the results of the Fiscal Year 2017-2018 Quality Improvement Strategy (QIS) program review for all waivers. You are required to submit a Corrective Action Plan (CAP) to remediate issues when the threshold of compliance with a measure is at or below 85%, except in substantiated instances of mistreatment, abuse, neglect, or exploitation (MANE), where the threshold is 100% compliance. Please complete the following tables, upload to your SharePoint site, and notify the Department of completion, **no later than December 7, 2018.**

- Performance Measure and Compliance Percentage by Waiver has been populated.
- **Actions to be Taken:** You must choose an Action to be Taken, but may choose multiple options. The options are as follows;
    - **Training:** When choosing this option, the following documentation must be provided to the Department, after the action takes place.
        - Training Agenda that includes the date, time, and topic covered.
        - Training materials, unless using Department training.
        - List of training attendees
        - These items must be reported to the Department on a quarterly basis, as needed.
    - **Monitoring:** When choosing this option, the following documentation must be provided to the Department, after the action takes place.
        - Provide a brief description of the monitoring process.
        - Anticipated results of monitoring.
        - Observed results of monitoring.
        - Further action, if anticipated results did not occur.
        - These items must be reported to the Department on a quarterly basis, as needed.
    - **Other:** When choosing this option, the following documentation must be provided to the Department, after the action takes place.
        - Provide a detailed explanation of steps to be taken.
        - These items must be reported to the Department on a quarterly basis, as needed.
- **Action Details:** Please provide a narrative of the Actions to be Taken, as chosen above.
- **Employee(s) Responsible for Implementing Actions:** Who will ensure that the Actions to be Taken will be implemented?

- **Implementation Time Frame:** The CAP implementation will begin on December 7, 2018 and will commence once all the Actions to be Taken have been completed, reported to the Department, and approved by the Department. All CAP actions must be completed by June 30, 2019.
- **Root Cause Analysis:** What do you attribute to the deficiency? What systemic issues do you see as obstacle(s) that contribute to the deficiency?

Appendix D – Service Plan

Performance Measure	Number and percent of waiver participants in a representative sample whose Service Plans (SPs) address the needs identified in the ULTC assessment, through waiver and other non-waiver services. **Numerator** = Number of waiver participants in the sample whose SPs address the needs identified in the ULTC 100.2 assessment, through waiver and other non-waiver services. **Denominator** = Total number of waiver participants in the sample.		
Compliance % by Waiver			
Actions to be Taken	☐ **Training**	☐ **Monitoring**	☐ **Other**
Action Details			
Employee(s) Responsible for Implementing Actions			
Implementation Time Frame			
Root Cause Analysis			

Performance Measure	Number and percent of waiver participants in a representative sample whose SPs address identified health and safety risks through a contingency plan. **Numerator** = Number of waiver participants in the sample whose SPs address health and safety risks through a contingency plan. **Denominator** = Total number of waiver participants in the sample.		
Compliance % by Waiver			
Actions to be Taken	☐ **Training**	☐ **Monitoring**	☐ **Other**
Action Details			

Performance Measure	**Numerator** = Number of waiver participants in the sample whose SPs address the needs identified in the ULTC 100.2 assessment, through waiver and other non-waiver services. **Denominator** = Total number of waiver participants in the sample.		
Compliance % by Waiver			
Actions to be Taken	☐ **Training**	☐ **Monitoring**	☐ **Other**
Action Details			
Employee(s) Responsible for Implementing Actions			
Implementation Time Frame			
Root Cause Analysis			

Please provide a narrative of the Actions to be Taken, as chosen above.

NEXT STEPS

INDIVIDUAL REMEDIATION DEADLINES

Complete individual remediation by December 7, 2018

No deadline extensions will be granted

Update spreadsheet on SharePoint site

Specify follow-up is completed and the date of completion in the BUS

CORRECTIVE ACTION PLAN DEADLINES

Submit to the Department by December 7, 2018, via SharePoint Site

No deadline extensions will be granted

All CAP actions must be completed by June 30, 2019

- Updates to be reported quarterly to the Department, to start March 2019

CORRECTIVE ACTION PLANS

1. Action to be taken
2. Details of Action
3. Employee(s) responsible for implementation
4. Planned date(s) of Action
   - CAP deadline date: June 30, 2019
5. Root cause analysis
   - What is the deficiency attributed to?
   - Possible systemic obstacles contributing to deficiency

ACTION TO BE TAKEN

Training

- Agenda with date, time, and topic of training
- Training materials (unless using Department training)
- List of training attendees

Monitoring

- Brief description of monitoring
- Anticipated results of monitoring
- Observed results
  - Updates to be provided to Department quarterly
- Further action, if anticipated results did not occur

Other

- Detailed explanation of steps to be taken

THINGS TO CONSIDER

When developing the implementation timeframe, consider that earlier implementation dates:

- May identify positive results in future QIS
- May prevent future CAP requirement for that Performance Measure
- Will lead to quality case management practices sooner

CORRECTIVE ACTION PLANS

Performance Measure	(Performance Measure details) **Numerator =** **Denominator =**		
Compliance % by Waiver			
Actions to be Taken	☐ Training	☐ Monitoring	☐ Other
Action Details			
Employee(s) Responsible for Implementing Actions			
Implementation Time Frame			
Root Cause Analysis			

SAMPLE:
CORRECTIVE ACTION PLAN

Performance Measure	Number and percent of cases in a representative sample in which the ULTC 100.2 tool was applied appropriately. **Numerator** = Number of cases in a representative sample in which the ULTC 100.2 tool was applied appropriately. **Denominator** = Total number of clients reviewed in sample.		
Compliance % by Waiver	EBD = 82%, CMHS = 85%, CLLI=80%		
Actions to be Taken	☐ Training	☐ Monitoring	☐ Other
Action Details			
Employee(s) Responsible for Implementing Actions			
Implementation Time Frame			
Root Cause Analysis			

SAMPLE:
CORRECTIVE ACTION PLAN

Performance Measure	Number and percent of cases in a representative sample in which the ULTC 100.2 tool was applied appropriately. **Numerator** = Number of cases in a representative sample in which the ULTC 100.2 tool was applied appropriately. **Denominator** = Total number of clients reviewed in sample.		
Compliance % by Waiver	EBD = 82%, CMHS = 85%, CLLI=80%		
Actions to be Taken	☐ Training	☑ Monitoring	☐ Other
Action Details	1st Quarter (Jan, Feb, and March) all ULTC 100.2 assessments for these three waivers will be reviewed by CM Supervisors once verified on the BUS. After review, if 100.2 tool is applied appropriately, case manager will finalize the assessment. After 1st quarter, if trends are identified, review may be modified to only address continued areas of need to ensure appropriate utilization of ULTC 100.2 tool.		
Employee(s) Responsible for Implementing Actions	Supervisors: Cinderella, Goldilocks, and Rapunzel		
Implementation Time Frame	Jan – Mar 2019: Universal Review of all waivers / case managers Apr – Jun 2019: Possible modification of review sample		
Root Cause Analysis	Inconsistent understanding of ULTC 100.2 tool amongst case managers across multiple waivers.		

SAMPLE:
CORRECTIVE ACTION PLAN

Performance Measure	Number and percent of waiver participants in a representative sample whose SPs adequately address the waiver participant's desired goals as identified in the Personal Goals. Numerator = Number of waiver participants in the sample whose SPs adequately address the waiver participant's personal goals Denominator = Total number of waiver participants in the sample		
Compliance % by Waiver	DD = 78%, CES = 75%, SLS=83%		
Actions to be Taken	☑ Training	☐ Monitoring	☐ Other
Action Details	Newly hired case managers will all be required to view Department training on Person Centered Service Planning within 90 days of hire. Supervision of new case managers will focus on Personal Goal development. Ongoing case managers will attend CMA developed training focused specifically on Personal Goal Development to be provided by case management training staff (see attached agenda and training materials). Participant list to be provided once training is held.		
Employee(s) Responsible for Implementing Actions	Trainers: Prince Charming and Shrek		
Implementation Time Frame	New hire training: Ongoing / As Needed Personal Goal Development training: January 15, 2019 and March 15, 2019		
Root Cause Analysis	Case managers struggle with skills to develop individualized Personal Goals for all waiver recipients		

SUMMARY

SUMMARY

IMPORTANT DATES:

December 7, 2018:

- All Corrective Action Plans due to the Department via CMA SharePoint sites
- CMAs to email Emily Kelley once CAP is uploaded to SharePoint site
- All individual remediation is due

June 30, 2019:

- All CAP actions must be completed

SUMMARY

REPORTS:

QIS Results Report:

- Informational report – no action required

QIS Corrective Action Plan FY 2017-18:

- Requires development of CAP by CMA

SUMMARY

CMA SHAREPOINT:

Reports and CAPs available on CMA's SharePoint sites

CMAs to upload:

- Corrective Action Plans (CAP)
- Additional documentation
- Quarterly updates on CAPs (supporting documentation)

QUESTIONS?

CONTACT INFORMATION

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THANK YOU!