

## Appendix H: Quality Improvement Strategy (1 of 3)

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

ODP selects for review a proportionate, representative, random sample of waiver participants, using a confidence level of 90% and margin of error of 10%. The results obtained reflect how the AAW system is performing and if it is responsive to the needs of the participants served. ODP trends, prioritizes and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained across each of the waiver assurance areas.

ODP leads quarterly Quality Management meetings attended by the supervisors of each BSASP Regional Office. These meetings focus on reviewing aggregated provider and participant monitoring data, designing improvement projects to respond to identified needs, and tracking progress on completion and effectiveness of these projects.

Specific to assuring health and safety, ODP staff meet quarterly regarding risk management. The meetings include a representative from the BSASP Central Office, each BSASP Regional Office, and the BSASP clinical team. Before each meeting, ODP reviews monthly incident report data and the results of monitoring of Supports Coordinator notes for participants who have exhibited “very serious” or “extremely serious” challenging behaviors, or who have experienced a crisis event in the past quarter. ODP staff analyze the data from that quarter and previous quarters to identify statewide and regional trends by incident type, by participant, and by provider. During the meeting, staff discuss identified trends, identify possible causes, and specify next steps for reducing participants’ risk of abuse, neglect, or exploitation.

ODP assigns staff to implement quality improvements based on the scope of the design change and the expertise required. ODP involves additional stakeholders including Administrative Entities, providers, Supports Coordination Organizations, participants served and their families, and other State agencies based on the design change involved and specific input needed.

Information used for trending and prioritizing opportunities for system improvements is also obtained through Independent Monitoring for Quality (IM4Q), a statewide method the State has adopted to independently review quality of life issues for people who receive services from ODP that includes a sample of waiver participants. IM4Q monitors satisfaction and outcomes of participants receiving services through indicators organized into areas of satisfaction, dignity and respect, choice and control, inclusion, and physical setting. IM4Q also monitors satisfaction with supports coordination services. Aggregate IM4Q data is used for continuous quality improvement purposes by ODP.

Recommendations for action are also identified by ODP’s Information Sharing and Advisory Committee (ISAC). The ISAC serves as ODP’s stakeholder quality council. ODP prioritizes opportunities for system improvements in conjunction with the ISAC, then disseminates these priorities to the field. Stakeholders representing their constituencies on the ISAC are expected to collaborate with ODP in the implementation, monitoring and evaluation of changes designed to achieve system improvements using a data-based approach.

## ii. System Improvement Activities

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify: <div></div>	<b>Other</b> Specify: <div></div>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

ODP uses a Plan-Do-Check-Act (PDCA) Model of continuous quality improvement. The steps in this model involve planning and implementing system design changes followed by monitoring of data results to check the effectiveness of the selected strategies. Using the analysis of performance data collected to identify next steps, the cycle is repeated. Depending on the area of focus, specific units within ODP are assigned responsibility for designing, initiating, monitoring and analyzing the effectiveness of system design changes. ODP monitors these system design changes during quarterly Quality Management and risk management meetings and on an annual basis.

ODP produces an Annual Quality Assurance Report with a summary of findings and corrective action from its review of performance across each of the waiver assurance areas from a sample of waiver participants. The primary audience for this report is the public, including people with ASD, advocacy groups, and providers. The report is posted on the DHS website.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

On an annual basis, considering input from Quality Management meetings and the ISAC, ODP's Executive Staff assesses program and operational performance as well as ODP's Quality Management Strategy (QMS). Results of this review may demonstrate a need to revise ODP's QMS, including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):