PASSPORT Quality Assurance and Quality Management

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May 31, 2007

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INTRODUCTION

While quality assurance and quality management were included among the list of specific questions to be addressed in the PASSPORT evaluation, the entire evaluation speaks to the quality of the program. As noted in the summary report[1], the evaluation found that PASSPORT is a cost-neutral, appropriately targeted, quality-oriented, thoroughly monitored, consumer-responsive home care program**.** These conclusions reflect the quality that has been designed into program processes and structures, and that quality monitoring and improvement procedures are effectively implemented.

Each of the other topical reports that are part of the PASSPORT evaluation might have been subsumed under an overarching quality report, since each aspect of the evaluation is related to a required waiver assurance and/or a dimension of the Centers for Medicare and Medicaid Services (CMS) quality framework. CMS assesses compliance with six statutory requirements for home and community-based waiver programs. These requirements are given in the appendix, and discussed briefly below. The waiver assurances overlap considerably with the focus areas in the CMS Quality Framework, but the framework is strongly participant-centered and places greater emphasis on a quality management approach with explicit processes for discovery, remediation, and improvement in seven areas of quality. A description of the CMS Quality Framework is in the appendix. Adoption of the CMS Quality Framework in not mandated, but Ohio has elected to develop such a model for its PASSPORT program, in the interest of comprehensive quality management and ongoing improvement of the program. The dimensions of quality assurance and management that are not specifically addressed in other reports are

[1] For information about the summary report and topical reports, see reference page.

addressed herein. The chart below clarifies how the detailed topical reports speak to each of the quality assurances and quality framework dimensions.

Topical report	Quality assurances/Quality framework dimensions
Consumer Eligibility	Appropriate level of care determination
Cost Neutrality	Compliance with approved waiver
Assessment and Care Planning	Plan of care responsive to participant needs/ Participant Access; Participant-centered service planning and delivery
Providers	Qualified providers serve participants/ Provider capacity and capabilities
Fiscal Accountability	Fiscal accountability for waiver/System performance
Quality Assurance and Quality Management	Health and welfare of participants assured/ Participant rights; Participant safeguards; Participant outcomes and satisfaction; System performance

Thus, the PASSPORT evaluation speaks to all of the major issues encompassed in the HCBS waiver assurances, and in the CMS Quality Framework. This report focuses on two questions specified in the PASSPORT evaluation scope of work: *Does PASSPORT have quality assurance processes in place and working to safeguard the health and welfare of participants? How congruent are the existing PASSPORT quality assurance processes with the new Centers for Medicare & Medicaid Services' (CMS) "Quality Framework" that Ohio will be required to fully implement by 2008?*

METHODS

ODA Interviews

Staff at the Ohio Department of Aging (ODA) were interviewed on several occasions, sometimes individually, and sometimes as part of a group. Senior management and several staff

members from the Community Long Term Care Division participated in discussions about quality assurance and quality management. These interviews took place at the ODA offices, when ODA staff visited Scripps for a meeting, and by telephone. To a person, ODA staff were open, cooperative and generous with their time and expertise. They shared data, documents, history and invaluable insights about how the PASSPORT program is designed and implemented.

PAA Interviews

Some PASSPORT Administrative Agency (PAA) staff involved in quality assurance were interviewed in person, and other information about quality assurance/quality management issues were addressed in a discussion group with site directors or their designees. Tape-recorded interviews from other researchers' site visits were also used to inform quality assurance questions, since many of the discussions cut across several areas of the PASSPORT evaluation. PAA staff were very helpful, generous with their time, and open in their assessments of the PASSPORT program, PASSPORT providers, and PASSPORT consumers.

ODA monitoring data from consumer interviews

As part of their biannual monitoring of PAAs, ODA conducts surveys with a sample of consumers from each of the PAAs. ODA provided data from the consumer Participant Experience Survey (PES; developed by CMS) conducted in 2005 (N=126), and paper copies of the completed interview schedules (a substantially modified version of the PES) that were gathered during 2006 PAA monitoring visits (N=78). We entered the data from the 2006 survey, and analyzed data from both years as part of the evaluation of PASSPORT's quality assurance and improvement processes.

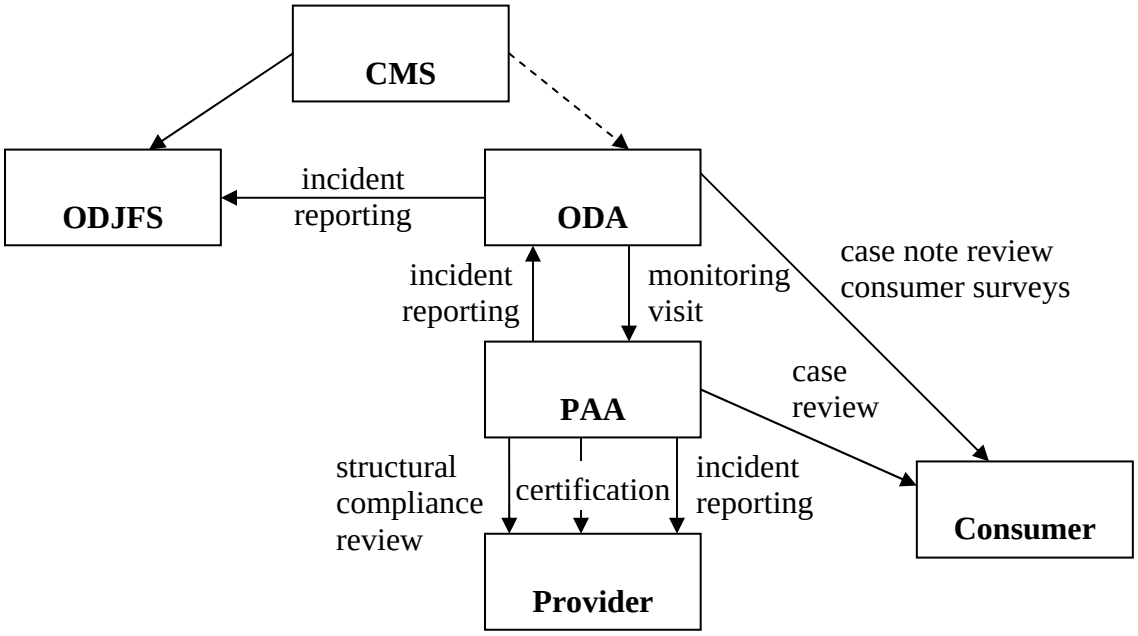
FINDINGS

Does PASSPORT have quality assurance processes in place and working to safeguard the health and welfare of participants?

PASSPORT quality monitoring retains some of its roots in, but has evolved considerably from, the early days of the program when the singular emphasis in quality assurance was on provider compliance. Structural compliance, monitoring of providers, and program adherence to waiver requirements remain important to the quality assurance processes, but there is increasing importance placed on the experience of consumers in the program. ODA and the PAAs have numerous quality assurance processes in place and effectively working to safeguard the health and welfare of PASSPORT participants. Such processes include annual structural compliance reviews of providers by the PAAs, monitoring of the PAAs by ODA, incident reporting, interviews with a sample of consumers during ODA monitoring, an annual statewide consumer satisfaction survey, and PAA-specific quality assurance/quality management committees.

Figure 1 outlines the hierarchy involved in quality monitoring activities and the relationships among the various organizations involved in quality assurance. CMS regularly monitors the PASSPORT program at the state and PAA levels, including 10 to 15 interviews with consumers and/or providers once every five years (usually prior to waiver renewal). ODJFS reviews about 400 consumers and related providers every two years. ODA reviews each PAA once every two years, and can initiate a review of a PAA at anytime if there are significant issues raised by a number of sources.

Figure 1. Quality Monitoring for PASSPORT



Ongoing monitoring includes consumer experiences, assuring health and safety, assuring compliance with waiver requirements, and overall program quality. Clearly, providers are essential to the quality of this program. With oversight provided by ODA, the PAAs have a great deal of responsibility for assuring quality of providers. Issues related to provider monitoring and provider quality are thoroughly discussed in the topical report on PASSPORT Providers. In addition, the extensive fiscal monitoring procedures are documented in the Fiscal Accountability topical report.

ODA Monitoring of PAAs

ODA conducts program monitoring visits of each PAA every two years as of 2004 (prior to 2004, monitoring was done yearly). Half of the PAAs are reviewed one year, and the other half are reviewed in the next year. The biannual monitoring includes record reviews, consumer experience surveys, and an in-depth look at consumer experiences, including a “walk through” of

several clients, following them through each step of the PASSPORT system. If the monitoring review reveals any negative findings, ODA assists the PAA in creating a directed plan of correction. The monitoring visits are also used as an opportunity to provide technical assistance and information about best practices. For example, if the monitoring visit reveals a tendency toward "cookie-cutter" care plans, ODA staff will work with the PAA to move toward more individually- focused care planning. ODA is also required to report on the following matters related to monitoring of PAAs: incident reporting or incident management issues and plans of correction that arise during a monitoring visit; ODA's review schedule for PAAs; and ODA's technical assistance and training plan with PAAs. In addition, ODA is responsible for reporting on incident trends statewide and by PAA, and a Plan of Action response to incident trends data. These latter quality management procedures related to incident reporting are discussed further in the following section.

Grievance/Complaint Processes

Any PASSPORT consumer can file a complaint or formal grievance if they have a problem with their services that have not been resolved through other channels. Most of the complaints are handled by the PAA's and they do not occur in large numbers. This is an important quality assurance mechanism at the PAA level and at the program level. Every PAA has clear procedures and timelines in place for handling grievances. ODA also handles complaints that may come from consumers or family members, legislative offices, Medicaid hotline, Director's office, Governor's office, or the long-term care ombudsman program. While the complaint numbers are not high, this is an important protection for consumers and can take significant PAA and/or ODA staff time. Complaints are viewed as an opportunity for education, advocacy, and remediation.

Incident Reporting

The incident reporting and Provider Feedback Logs (PFLs) are important quality monitoring mechanisms for ODA and the PAAs. (Even though the rule requiring PFLs was recently rescinded, some PAAs continue to use this system in addition to incident reporting.) These procedures serve several functions: they provide the PASSPORT program with information about provider quality, they are an important safeguard for participant health and safety, and the information from the incident reporting system is an important aspect of ongoing quality improvement.

The Incident Reporting System is managed by the Community Long Term Care Division at ODA. This division, in coordination with the PAAs, is in charge of assuring the health and welfare of consumers served under all of the Medicaid waiver programs administered by ODA. The goals of the Incident Reporting System are "protecting consumers from future and similar harm, remedying the discovered deficiencies in operating practice, and promoting improved treatment and services of all enrolled consumers" (p. 2, PAA Operational Manual, chapter 2, section 2).

Incident reports must be made by the PAAs to ODA within two business days of becoming aware of an incident. Incidents are defined as "any event that is not consistent with the routine care and service delivery to a consumer. Incidents include, but are not limited to: accidents and unusual events or situations which might result in injury to a person or damage to property or equipment. Incidents may involve consumers, caregivers (to the extent the event impacts on the consumer), providers, facilities, provider or facility staff, PAA staff, AA staff, ODA staff, and other administrative authorities" (p. 2, PAA Operational Manual, chapter 2, section 2). Some PAAs may have more stringent reporting requirements than others. For example, the Council on Aging of Southwest Ohio requires ODA to be informed of the incident

within one business day. An analysis of the incident data revealed that 80% of incidents reported to ODA were investigated within the mandated timeline of 2 days, and many of the remaining incidents were recorded in 5 days, which was considered within timelines because they occurred during a holiday weekend.

An electronic incident report form is completed by the PAA and saved into the PASSPORT Information Management System (PIMS). An e-mail notification regarding the new report is sent to staff at ODA. The PAA should document the events of the incident in the client's case notes, along with actions taken in response to the event, measurable goals or actions for preventing a future reoccurrence of the problem, and a plan for evaluating the prevention plan. The case notes will not reflect that an incident report has been created.

According to the PAAs, case notes are reviewed whenever an incident occurs. Most PAAs indicated that they take incidents very seriously, and work very hard to achieve a resolution to solve the client's problem, if possible.

When an incident meets any of the criteria listed below, written notification must be provided by ODA to the Ohio Department of Jobs and Family Service's (ODJFS) Protection from Harm Unit within four days, except where 1-day reporting is noted:

- Unnatural or suspicious consumer death;
- Any incident or allegation that implicates a PAA or ODA staff member, or the incident alleges abuse or neglect and the consumer is hospitalized or removed from his/her home or visits an emergency room;
- Hospitalization of a consumer as the result of illness or injury of unknown cause or origin;
- Allegations of theft or misappropriation of $500 or more when law enforcement is notified;
- Incidents or accidents resulting in harm to multiple consumers (1-day reporting);
- Adverse or negative media coverage related to a consumer (1-day reporting);
- Incidents involving correspondence with any member of the Ohio General Assembly, Governor's Office, the Centers for Medicare and Medicaid Services or the Office of Civil Rights (1-day reporting); or

- Any other incident deemed immediately reportable by ODA staff for protection of waiver consumers from harm.

ODA must provide ODJFS updates bi-weekly or more frequently until a prevention plan is documented, implemented, and the incidents are closed. Sixty-five incidents were reported to ODJFS in 2005.

As required, ODA prepares quarterly reports which summarize incident rates per 1,000 enrollees and provide a breakdown of the types of incidents statewide and by PAA. They also report the number of substantiated incidents statewide and by PAA in the areas of abuse and neglect.

In 2005, the incident rate declined every quarter, from 12.7 per 1,000 enrollees during the first quarter, to 6.45 per 1,000 in the last. “Theft greater than $100” was the most prevalent type of incident; more than one incident per 1,000 enrollees occurred throughout the year. Theft was followed by “other” (e.g. consumer behavior, worker ethics, utility problems and evictions) and accident or injury. Four unnatural or suspicious deaths occurred during 2005 and only two injuries of unknown cause were reported. Eight-hundred and sixty-five total incidents were reported in 2005--only 54% of the incidents reported in the first half of the year were verified; 77.5% were at least partially verified from July to December. It is also important to note that these incident rates do not include client falls. During the first half of 2005, 1035 incident reports were filed involving a client who fell. See following section for further discussion of falls.

Use of Monitoring Data for Quality Improvement

During ODA monitoring visits at PAAs, ODA staff review case notes to determine if an incident should have been reported and then verify that a report was made. They also review case notes and care plans where falls have been identified to see if appropriate care planning was done

to reduce the prevalence of falls and injuries resulting from falls. Based on in-depth analysis of falls information from incident reporting and record reviews, a more detailed reporting format has been put into place to collect additional data about the circumstances and consequences of falls. These data have been used to develop training about falls, and a falls prevention program to be implemented by the PAAs. Further analyses of the ODA falls data is currently being conducted by a statistician at Scripps; this research seeks to provide ODA and the PAAs with more information about risk factors for falls, which can help these organizations to refine their falls prevention programs and, ultimately, to reduce negative events for PASSPORT consumers.

Another quality improvement initiative that was undertaken as a result of ODA's analysis of monitoring data is the theft prevention flyer. Incident report data revealed that theft is the most common negative incident event by PAAs. A flyer for consumers about how to prevent theft was developed by ODA and then distributed to the PAAs, who had their home-delivered meals drivers give the flyer to all of the HDM participants. Since the flyer emphasizes prevention, it is distributed to all individuals receiving a new assessment and enrolled consumers due for a reassessment If a consumer experiences a theft, they are given additional information about theft prevention. ODA is tracking responses to the flyer, and will look at incident report data to determine whether there is any decline in the prevalence of theft that might coincide with the distribution of the flyer. The falls prevention and theft prevention initiatives, aimed at improving participant safety and well-being, are excellent examples of the use of monitoring data (from the incident reporting system) in the service of quality improvement.

PAA Quality Assurance

In addition to the involvement of PAAs in the quality assurance efforts guided by ODA, all are involved in provider quality assurance, and all have some level of internal quality

structures and processes, including clinical case management supervision, provider relations, and some level of utilization review (often focusing on documentation and compliance with waiver assurances such as "appropriate level of care determination"). Beyond these quality functions, the number and formality of quality-related committees varies. The range of PAA quality committees/functions includes: case manager peer review and CM supervisor peer review (beyond what is mandated for utilization review), review and refinement of policies and procedures (related to employees and to consumers), staff development, best practices committee (which reviews national literature on promising practices related to topics such as depression, falls, working with informal support, and then incorporates that information into peer review and/or staff training), and caregiver advisory groups. In addition, some PAAs use provider feedback logs to monitor and respond to complaints about their providers, some conduct their own consumer satisfaction surveys, and some regularly audit client casenotes in order to ensure that clients are receiving appropriate care and services. One PAA uses a provider quality feedback report and a technical assistance model as part of their monitoring process, assisting providers in improving practice so that all become high quality.

PAAs also differ regarding how their quality assurance processes are structured in the organization. Some have placed responsibility for quality assurance with one individual, while others share the responsibility among many different individuals. Sometimes quality assurance and provider relations are housed within one position in a PAA. Different process structures do not have differing impacts — regardless of structure, the PAA viewed quality monitoring and assurance as a large and important aspect of their activities.

In addition to the different strategies and structures adopted by each PAA to assure and improve quality, there is also some variability across the PAAs in the implementation of standard

processes. For example, incident reporting appears to be viewed differently by different agencies. Some have disproportionately low rates of incidents, and others have disproportionately high rates. Whether these differences reflect actual variability in occurrence of events, or differences in use of the reporting system, is unclear. ODA is addressing this variability through training on the purposes and utility of incident reporting.

Overall, ODA and the PAAs are strongly committed to participant health and safety. This commitment is made evident through attempts to deal with individual incidents as they occur, but also through examination of trends and patterns that may suggest systemic solutions to any problems that are detected. As shown by multiple data sources, there are multiple quality assurance processes in place to safeguard the health and welfare of consumers. Providers monitor individual workers; PAAs monitor providers; ODA monitors the PAAs; and ODJFS provides some monitoring of ODA, providers, and PAAs as well. Most providers get more than one type of monitoring or auditing in a typical year. Most also express satisfaction with the monitoring processes. While there are perhaps some concerns with consistency among PAAs, all PAAs take the health and welfare of their consumers extremely seriously. Current quality assurances for health and welfare monitor structure and processes, with increasing consideration being given to client outcomes such as satisfaction. For example, ODA's satisfaction surveys, and the PAA monitoring visit includes interviews with consumers about their experiences in the program. The PAA's also routinely track consumer experiences, including some clinical outcomes. In addition, ODA is developing a comprehensive quality management system which includes formalizing some benchmarks for the quality of the program. The broader definition of quality to include consumer outcomes as well as assurances about health and safety is consistent with the CMS Quality Framework. This issue is addressed further in the following section.

How congruent are the existing PASSPORT quality assurance processes with the new Centers for Medicare & Medicaid Services' (CMS) "Quality Framework" that Ohio will be required to fully implement by 2008?

ODA has undertaken a concerted effort to fully operationalize and implement the CMS Quality Framework. Based on the CMS framework, ODA's model is named Quality Management and Improvement System (QMIS). Regularly scheduled teleconferences with staff from the PAAs about the quality framework are a central strategy for disseminating and refining ODA's vision for quality management. The teleconferences are a significant opportunity for communication about QMIS. The conferences are a forum for PAAs to discuss their current quality management practices, to hear from ODA about the values and practices that are part of the emerging quality framework, and to provide feedback to ODA about the system. Issues discussed at some of the recent teleconferences include general discussions of the CMS framework for quality and ODA's vision for quality, as well as specific strategies for implementing a quality system, such as a PAA Record Review system with includes data evidence worksheets for documenting compliance with waiver assurances **and** congruence with the quality improvement focus of the new framework. It is clear that open and honest communication between ODA and the PAAs is essential for the new system to be an effective reflection of a shared vision for quality management. Notes from the teleconference meetings suggest that ODA is making modifications to the new system based on input from the PAAs; the "emergent" nature of the framework indicates that, even though ODA is taking the lead on this effort, PAA stakeholders are active participants in the development of QMIS.

These efforts reflect values that are consistent with the CMS Quality Framework, and with ODA's quality management goals: a strong focus on the consumer, use of data to improve the quality of the program, collaboration with PAAs in the process, and provision of technical assistance to the PAAs in the service of continuous quality improvement.

One of the hallmarks of the CMS framework is its emphasis on processes of discovery, remediation, and improvement. ODA is devoting significant staff time to the development of these processes with the PAAs, and to applying these steps to all of the focus areas within the framework. As noted above, the falls prevention and theft prevention initiatives are good examples of using data for quality improvement purposes; put into the language of the CMS framework, these initiatives are fully articulated examples of the "discovery/remediation/ improvement" functions that underlie the quality framework. As with other issues discussed in several aspects of this PASSPORT evaluation, one of the major challenges in implementing the CMS Quality Framework is striking the appropriate balance between the effectiveness of standardization and the local responsiveness of PAA flexibility.

Some of the PAAs expressed concern about the message underlying some CMS-driven changes. Many of the PAAs discussed their interest in having a monitoring/quality management system that allows a holistic focus on consumers and a responsible use of public dollars, rather than a medical-model compliance- based approach to quality. Some PAAs worry that lack of flexibility and a too-narrow focus on regulations and costs can sometimes be in direct conflict with the goals of the PASSPORT program; that is, goods or services that are outside a strict and inflexible interpretation of program guidelines might be actually a low-cost option that helps people live independently in their communities and in their homes longer and more safely.

To be sure, ODA is in the difficult position of balancing federal waiver guidelines and mandates, state policy, and the PAA's need for the agility to best respond to individual consumer needs. While the challenge facing ODA is clear, so too is their vision for a quality management system that 1) promotes continuous improvement of the program; and, 2) meets the goals of public accountability and consumer focus. ODA and PAA staff share a strong commitment to

consumers, and they agree on the importance of communication about program goals and effective strategies to achieve those goals. ODA staff articulated clearly the challenges and opportunities facing ODA and the area agencies on aging, including the following specific issues related to quality management:

- Maintaining a clear vision of quality
- Communicating that vision effectively throughout the system
- Balancing ODA's regulatory, technical assistance, and supportive roles with the PAAs
- Providing effective training and education about quality management
- Improving communications among all agencies involved in participant health and safety
- Establishing appropriate levels of statewide consistency in service delivery and quality assurance

The teleconferences about ODA's Quality Management and Improvement System seem to be a very effective strategy for dealing directly with some of these challenges and opportunities, and for moving ahead with the development and implementation of a quality management strategy.

Participant outcomes and satisfaction

As previously noted, the only major dimensions of the CMS Quality Framework not covered in the other topical reports is, "participant outcomes and satisfaction." PASSPORT consumers are surveyed or interviewed for several different purposes, using several different instruments. A review of the goals and utility of the data that result from these parallel efforts might suggest ways to achieve greater coordination of efforts, greater depth of information, and more effective utilization of information for purposes of quality improvement.

ODA surveys of PAA consumers

ODA's biannual quality monitoring of PAAs includes interviews with a small sample of consumers from each of the six PAAs being reviewed in a given year. ODA's Community

Long Term Care Division prepares and disseminates to the PASSPORT site directors a report of survey results. After using the Participant Experience Survey for a few years, ODA decided to revise the instrument to make it more appropriate to the PASSPORT program and to the questions that ODA wants to explore for purposes of quality monitoring and improvement.

Data from the past two years of these in-person interviews reveal high levels of satisfaction with PASSPORT services and workers. The vast majority (over 85%) of participants in each year of the survey reported that they can talk to their case manager whenever they needed to; 90% or more said that their case manager always helps when they ask for something. The revised version of the survey that ODA began using in 2006 includes additional questions that can be very useful in assessing and improving the program. For example, there are questions about missed service during the last month, and, if that happens, how the consumer gets by. Though the sample was small (78 consumers), the findings are interesting. Twenty-five percent of the consumers surveyed (20 people) said that they missed or cancelled a personal care service appointment. In half of these cases, the consumer cancelled the scheduled appointment. Of those who did miss a service appointment, half said that they could get by for a day or two; the remaining consumers said that family or friends stepped in to help or they were able to reschedule a time with the provider. Only two consumers said that their needs were not met when a provider could not provide the service; five consumers who had cancelled their own appointments said that they were not able to have their needs met. These data convey a positive message about the program, but they also point to areas that might be fruitful for further exploration with a broader sample of participants. Who are the participants most at-risk of having needs unmet if there is a problem with a scheduled provider visit? What is the impact on providers when a consumer is unwilling to accept a contingency worker? Who are the consumers

who cancel appointments and have unmet needs? How do participants and their support networks adapt when there are missed service appointments? Information from any of these questions could be helpful in even further improving the quality of the program. And, obviously, significant effort would have to be invested (and presumably reallocated from existing priorities) in order to address these questions.

Another interesting issue that was raised by the most recent round of monitoring-related consumer surveys involved preference for providers, and for when and how their services would be received. More than three-quarters (78%) said they did have a preference about how and when services would be delivered, and 90% of these consumers said that their preferences were being honored. With respect to preference for provider, a little over half (53%) of the consumers said that they did have a preference for a particular provider. This proportion seems lower than the anecdotal evidence from PAA site directors, who suggested that 75 to 90% of consumers had a provider preference. More importantly, of those consumers who said they did NOT have a preference, half (52%) said that their case managers gave them information so they could make an informed choice. The other half said that they did not receive information, or were not sure if they had. This is an extremely complicated and significant issue that came up in several facets of this evaluation. Since case managers do not have formal data about provider quality and cannot give participants any information about their perceptions regarding provider quality, it is difficult for consumers to make an informed choice. It also places case managers in an awkward situation if clients ask for guidance that the case managers do not have or are not allowed to provide. This issue is clearly related to a host of others, and, as it relates to quality of the PASSPORT program, warrants further scrutiny.

ODA annual survey of consumers

In addition to the monitoring-related survey of consumers, ODA also conducts an annual survey with a large sample of participants in the PASSPORT program. This survey focuses on PASSPORT experiences in general, as well as case management. Results from this survey are analyzed to allow comparisons among the PAAs and are shared with the PAAs so that they can use the information in their quality management processes. In the most recent round, 4166 surveys were sent out and 2419 were returned, for a response rate of 58%. The data from this most recent survey are currently being analyzed.

The instrument used in the annual survey asks a few questions about satisfaction with the PASSPORT program, and some questions about case management. As is probably appropriate in a mailed survey for this population, the survey is brief and the questions are general. Certainly it is difficult to balance pragmatic issues related to a mailed survey for frail older people against the potential value of more detailed information. Since this is only one of the surveys/interviews done with PASSPORT consumers each year, it might be providing just the right kind of information. However, it would be helpful to review each of the consumer data collection efforts in the context of all the others to insure that there is good agreement about what questions need to be asked during which process for what purposes.

Other consumer survey processes

ODJFS' monitoring of ODA includes a survey of an estimated 400 consumers. Some PAAs also conduct their own consumer surveys, but others do not. Among those that do collect their own data from consumers, there is variability in terms of how these data are used, ranging from internal quality monitoring to issuing provider-specific reports of quality. As noted earlier in this document, one PAA uses data from an annual, large-scale consumer satisfaction survey to monitor the quality of the program overall, and to help providers improve the quality of their

services.

ODA staff are quite clear about their interest in having survey instruments, processes, and resources that will yield useful information from consumers about their experiences with the program. They and PAA staff are also interested in strategies for using these data to improve the program. ODA, in collaboration with the PAAs, might want to consider a streamlined consumer survey process that yields representative, meaningful, and routinely utilized data on consumer outcomes as well as consumer satisfaction. Certainly a systematic review of current goals and practices regarding consumer surveys would be advisable. What questions are asked of which consumers at what time for what reasons? It may be that the different purposes of the multiple data collection efforts will mean that different instruments are used at different times for different goals; even so, a comprehensive review of current practices would be useful, if only to confirm the wisdom of those practices.

SUMMARY AND RECOMMENDATIONS

PASSPORT quality assurance mechanisms are in place and working effectively to safeguard participant health and safety, and to meet the other waiver assurances. By virtue of meeting the required waiver assurances, PASSPORT is already in compliance with CMS mandates. In addition, the PASSPORT program is being led by ODA and supported by the PAAs in a concerted effort to move toward the CMS Quality Framework with its emphasis on participant centered planning, delivery, and outcomes. The development of the PASSPORT Quality Management and Improvement System is solidly grounded in the principles and functions of the CMS framework and appears to be on track to be fully operational in 2008. PASSPORT already has numerous pieces of the framework in place, including a vision for quality management; a focus on consumers; strategies for ongoing communication among all

stakeholders in the quality process; and structures for routinizing the essential steps of discovery, remediation, and quality improvement.

Following are some recommendations related to quality assurance and quality management:

- ODA, in collaboration with the PAAs, might want to consider a streamlined, well-coordinated consumer survey process that yields representative, meaningful, and routinely utilized data on consumer outcomes as well as consumer satisfaction. Certainly a systematic review of current goals and practices regarding consumer surveys would be advisable. What questions are asked of which consumers at what time for what reasons? How effectively are data from consumers used, at state and local levels, to improve the PASSPORT program?

- Based on data from the 2005 and 2006 interviews with consumers (done as part of PAA monitoring), there is a high level of satisfaction with the program. The 2006 survey including some additional questions about informed choice. Even though the sample was small (N=78), the data suggest that consumers do not feel well-informed as they are choosing a provider. Only about half of the consumers who did not already have a preference for a particular provider felt that they got adequate information to make an informed choice. These data echo findings from some of the other topical studies. Consumers would like more information about the quality of the providers they might choose to provider their services.

- PASSPORT is well on its way toward development and full implementation of a comprehensive quality management system (QMIS) that is congruent with the CMS Quality Framework model. One of the challenges in implementing this system will be balancing necessary standardization of discovery, remediation, and improvement processes with the effectiveness of local flexibility and autonomy in solving problems and improving quality. Achieving this balance is related to another challenge: ODA's dual roles of monitoring compliance, and providing technical assistance and support for continuous quality improvement.

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APPENDIX

CMS Quality Framework

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

CMS HCBS Waiver Assurances

I. **State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization**

The State must demonstrate that it implements the processes and instruments(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with the care provided in a hospital, nursing facility or ICF/MR.

II. **Plans of Care Responsive to Waiver Participant Needs**

The State must demonstrate that it has designed and implemented a system to assure that plans of care for waiver participants are adequate and services are delivered and are meeting their needs.

III. **Qualified Providers Serve Waiver Participants**

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

IV. **Health and Welfare of Waiver Participants**

The State must demonstrate that it assures the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.

V. **State Medicaid Agency Retains Administrative Authority over the Waiver Program**

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

VI. **State Provides Financial Accountability for the Waiver**

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.