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Home and Community Based Services: Quality Management Roles and Responsibilities

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This is the first of three papers synthesizing the ideas and practices of states as they improve the quality of home and community based services (HCBS) and supports for older persons and persons with disabilities. In 2003, the Centers for Medicare & Medicaid Services (CMS) awarded grants to 19 states to enhance their quality management (QM) strategies for HCBS programs.¹ CMS contracted with the Community Living Exchange Collaborative² to assist states in their grant activities by promoting information exchange and facilitating discussions on topics of common interest. As part of its work with the Community Living Exchange Collaborative, the Muskie School of Public Service, together with grantee states, identified three priority topics for working papers:

1. Quality Management (QM) Roles and Responsibilities
2. Tools for Discovery, Remediation and Quality Improvement
3. Use of Quality Indicators

Working papers are not meant to be exhaustive research documents. The intent is to provide an account of current practice, and a structure for how states view their options and implications. When applicable, relevant federal policy and guidance are discussed. The goal is to show how states think about these issues, not to direct states to a single solution. A secondary goal is to identify areas where further research or development is needed to assist states in their efforts to develop effective quality management programs.

Focus and Purpose of Paper

Early in the development of this first working paper on QM roles and responsibilities, QA/QI grantees contributed to a preliminary outline of the issues to be addressed. A subset of grantee states agreed to more fully discuss their perceptions of the issues and to guide the exploratory efforts of Muskie School staff. While the initial list of issues was quite lengthy, it was subsequently reduced to four essential questions:

1. How is quality defined for HCBS?
2. What is meant by quality management?
3. How do states develop quality management expertise?
4. How do states organize their quality management strategies?

This paper attempts to answer these questions from the perspectives of the grantees and available federal guidance. The topic is limited to quality management strategies focused on the quality of services and supports for HCBS consumers and is not intended to represent the quality management field as a whole.

¹ QA/QI grantee states include: California, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Minnesota, Missouri, North Carolina, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Wisconsin, and West Virginia.

²The Community Living Exchange Collaborative is a partnership of the Rutgers Center for Health Policy, the National Academy for State Health Policy and Independent Living Research Utilization. Under contract with the Technical Exchange Collaborative, the Muskie School of Public Service is the lead for providing technical assistance in the area of quality assurance/quality improvement.

Section I: How is Quality Defined for HCBS?

The starting point for a quality management strategy is to define what is meant by “quality”. What seems like a straightforward proposition is actually somewhat unique for HCBS. For much of health care, quality is said to exist when services are delivered in accordance with professional standards. Managers and providers of HCBS programs are held to a higher standard. When accepting a participant into its HCBS program, a state agrees to assure the individual’s health and welfare, and to do so through a *prospective* assessment of needs and a qualified network of providers. HCBS programs do not simply purchase individual services; they design and execute a system of care that *anticipates* and meets participant needs.

The CMS *Quality Framework*³ describes quality outcomes for HCBS under seven focus areas:

- I. Individuals have access to home and community-based services in their communities.
- II. 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.
- III. There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
- IV. Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- V. Participants receive support to exercise their rights and in accepting personal responsibilities.
- VI. Participants are satisfied with their services and achieve desired outcomes.
- VII. The system supports participants efficiently and effectively and constantly strives to improve quality.

Taken together, these outcomes define quality for an HCBS program. Embedded within each of these outcomes are processes that, if implemented carefully, will yield the desired effect or quality. For example, the development of a personal services plan at the time of enrollment into the program and whenever needs change is a critical component to achieving the desired outcome of focus area II. The CMS *Quality Framework* proposes these process elements as well.

Indicators are used to measure how well a program is meeting its quality outcomes. States are at varying stages of developing indicators for determining how well each process is being implemented and if together these processes are achieving the above quality outcomes. The third working paper will be devoted to the selection and use and quality indicators for assessing how well a state’s HCBS program is performing.

Section II: What is Quality Management?

HCBS waiver programs began as small pilots in many states, with so few participants that it was possible to know each personally. Quality oversight in those days meant program administrators could stay in regular contact with participants and their families to make certain that needs were

³CMS correspondence from Glenn Stanton, Acting Director of the Disabled and Elderly Health Programs Group to State Medicaid Directors, State Directors for Agencies Administering the HCBS Waivers, CMS Regional Administrators, CMS Associate Regional Administrators, CMS Regional Offices, and the HCBS Inventory Group on February 17, 2004.

met. As the number of program participants grew, states could no longer rely on direct observation to oversee the quality of care. Direct observation primarily has become the job of providers of care and care managers. Knowing that they cannot directly oversee all aspects of care to all participants, states must rely on quality management strategies to conduct their oversight responsibilities.

A QM strategy is a multi-faceted strategy for organizing, tracking and improving HCBS programs to deliver quality outcomes. Fundamental features of a QM strategy include:

- designing HCBS programs in a way that increases the probability of quality. For example, quality is enhanced through the use of trained and experienced providers, information systems that assure the timely and effective provision of care, or early warning systems for knowing when things go wrong. These are aspects of the program that are put into place before the actual delivery of care to enhance the likelihood that outcomes will be met.
- using the processes of discovery, remediation and improvement to make certain the program is working as intended;
- synthesizing information to determine what aspects of the program should be targets for improvement, identifying actions to achieve improvement, and monitoring and evaluating the outcomes of those efforts; and
- assuring that all administrative entities and stakeholders understand the roles they must play in managing and promoting quality.

An effective QM strategy focuses both on the *prospective* actions that are taken to promote quality and the *retrospective* actions that are needed to make certain that services have the desired impact. Leading experts Donnabedian and Demming noted that structures and processes are the determinants of quality and that the purpose of quality management is to determine if the structures and processes are working and getting the intended outcomes.⁴ Most states perform the retrospective or “quality assurance” activities (an after the fact assessment to make certain that **minimum** thresholds of acceptable quality are met). Less common are prospective or “quality improvement” initiatives that work to make certain that waiver programs are designed and organized to support the **best possible** outcome. This paper focuses on how states are trying to integrate traditional quality assurance activities with a more prospective approach to identifying and targeting opportunities for quality improvement.

Few states have fully organized and operational QM strategies. Many states, however, are developing work plans that show how, over time, they plan to fully assess the design and implementation of their waiver programs and to improve overall system performance.

Chart 1 borrows heavily from work conducted in Wisconsin portraying how traditional quality assurance and quality improvement activities fit under an umbrella QM approach. **Appendix A** includes the draft concept paper used in Wisconsin to develop common language for describing quality-related activities across its waiver programs.

⁴ Demming, W.E., *Out of the Crisis*, Cambridge: Massachusetts of Technology, 1986 and Donnabedian, A., *Exploration in Quality Assessment and Monitoring*, Vol. 1. *The Definition of Quality and Approaches to its Assessment*, Ann Arbor, Michigan: Health Administration Press, 1980.

Chart 1: Conceptual Design for QM Strategy

<p>Quality Management: A systematic approach for assuring that QA and QI activities are integrated and working as intended to achieve desired results. Features of a QM strategy include:</p> <ul style="list-style-type: none"> • Shared values and principles that govern QM activities • A locus of responsibility for managing the overall QM strategy • The availability of skilled staff and resources to act effectively • Integration and management of processes for discovery, remediation and improvement activities • Indicators and standards against which performance is measured • The collection, synthesis and sharing of performance information • A cohesive and focused work plan that directs time, effort and resources 	
Quality Assurance	Quality Improvement
Discovery: Making certain that people, processes and products are working as intended to meet minimum requirements and/or outcomes.	Discovery: Ongoing data collection to assess progress toward goals and to identify areas for improvement.
Remediation: Bringing identified areas of weak performance up to minimum standards, by understanding and correcting the causes, and on preventing future similar problems.	Remediation: Not a function in QI.
Improvement: Improving system design flaws that caused or allowed weak performance.	Improvement: Establishing and sustaining higher levels of performance through improvements in skill levels, processes and products.

Future working papers will address specific data, tools and methods that states use to systematically measure and improve performance at the individual and system levels. In this paper, we describe the organizational features of quality management and how they operate within grantee states.

The remainder of this section addresses each feature of QM identified in Chart 1 above. If all these questions can be answered affirmatively, a quality management strategy can be considered to be fully defined even though it may continue to evolve.

Is the QM strategy based on shared values and principles?

The implementation of quality management activities is, for many states, a direct response to CMS and its call for heightened scrutiny of waiver programs. Values and principles are the means through which states transform the rhetoric of quality management into concrete concepts that are relevant to policymakers and their stakeholders. An articulation of values and principles transforms the underpinnings of a QM strategy from externally imposed directives to those that are personally embraced within a State.

While there are no federal mandates requiring states to adopt values and principles as a component of a QM strategy, several grantee states have done so as a way to create common purpose and vocabulary for both internal activities and for engaging the broader community of providers and consumers. Some states refer to the values and outcomes identified in the CMS *Quality Framework* as their organizing principles for quality management. Others have taken a

more deliberate approach to articulating a set of guidelines for shaping their QM strategies. The exercise of articulating shared values and principles is seen as especially helpful when trying to create a QM structure across waivers and/or across the Medicaid agency, administrative, operating and provider agencies.

States can find elements of value statements scattered throughout existing grant proposals, committee mission statements, contracts, memoranda of understanding, and published reports. Synthesizing these ideas into a single statement, discussing points of agreement and disagreement, and explicitly adopting shared values can later serve as useful guidance for resolving controversial issues. **Appendix B** provides examples of explicit values and principles adopted in Georgia, Ohio and Texas.

Has a locus of responsibility been defined for managing the overall QM strategy?

Everyone has a role to play in promoting and improving quality. Finding a locus of responsibility for quality management does not diminish but can strengthen the ability of everyone to target their efforts most effectively. A locus for quality management provides a forum for consensus building on priorities, focuses resources to avoid duplication of effort, provides standardized tools and approaches for measuring performance, and develops strategies for quality improvement that bring together system stakeholders. The locus of responsibility may be an individual, an agency or a unit within an agency.

States emphasize the importance of leadership in promoting and improving the quality of HCBS waiver services. Because of the decentralized nature of most HCBS waiver programs, finding a focal point for championing quality can be difficult. State Medicaid agencies are ultimately accountable to CMS for HCBS waiver performance. Oftentimes there are separate state agencies administering waiver programs, sub-state entities (*e.g.*, counties, area agencies on aging) operating the waiver, and finally, provider agencies contracted to deliver services. Within this confusing web, there are also state legislatures, oversight committees, professional and consumer advocacy groups, and other government agencies (*e.g.*, child/adult protective services) whose authorities and interests intersect with HCBS services or populations. In Section IV of this paper, we describe the various structures used by states, from the least to the most formal, to create a locus for HCBS quality management activities and authority.

Does the QM strategy draw upon skilled staff and resources to act effectively?

Quality management implies that staff and providers have the skills and resources to do their jobs well and to act in ways that contribute to positive outcomes. Building staff capacity and bringing in outside resources has been the primary emphasis of many of the QA/QI grants. In Section III of this paper, we describe the job positions and skill sets that grantees are developing.

CMS has devoted significant resources to providing technical assistance to states under the National Quality Contract.⁵ Assistance is aimed at building effective QM strategies through the collection, management and use of information. States can request assistance and, subject to approval by CMS, a work plan is developed to meet a state's needs.

⁵ The Medstat Group has been awarded the National Quality Contract to provide technical assistance and training to states in the area of HCBS quality assurance and improvement. The Human Services Resource Institute (HSRI) and the Muskie School of Public Service serve as subcontractors under this National Quality Contract.

Staffing of HCBS waiver programs is modest and has changed little in many states since programs began as small pilots. Most do not have staff dedicated to quality management. States look to the significant infrastructure that has been developed to improve nursing facility quality and believe that similar federal investment will be needed to assure adequate capacity to do what many consider the more difficult task of monitoring in-home care. A few states, such as Maine, have looked to whether tools and skills of the state's nursing facility oversight program could be applied to its home and community based care waivers. For example, the federally required nursing facility complaint system, known as the Aspen Complaints/Incident Tracking System or ACTS, offers the potential (with modification) to serve as a platform for meeting the needs of HCBS waiver programs. Others look across waiver programs to determine if there are ways that resources and skills can be leveraged to better advantage. A State's waiver program for older persons may benefit from the extensive experience and information systems for collecting and monitoring critical incidents that are found in its waiver program for persons with mental retardation.

State legislatures also are being called upon to acknowledge the need for additional funding as more and more older persons and persons with disabilities choose in-home alternatives. The vulnerability of these populations and the unsupervised nature of the home as a setting of care add to the need to assure maximum safeguards and quality.

Are processes for discovery, remediation and improvement articulated, integrated and managed?

As an early step to creating QM strategies, many states have conducted an inventory of their current practices and data for monitoring and improving the quality of care. Sample formats for capturing this information are included as **Appendix C**. These exercises highlight the wide variety of quality-related activities currently underway and opportunities for building business practices that systematize and link related functions. For example, care managers may make monthly calls to participants but not document findings in a way that can be aggregated and used for quality improvement purposes. Or complaint information may never be combined with incident reports to get a more complete profile of potentially problem providers.

Many tools are manual or, when automated, do not link with each other or with Medicaid claims, eligibility or provider files. This severely limits the ability to synthesize information, analyze trends, or produce useful "evidence" on how the system is performing and to target improvement priorities. Many states have only pieces of information that alone cannot tell the complete story.

Fragmentation also occurs between states and their sub-state offices. Connecticut has placed priority on integrating quality review and improvement processes between the central and regional state operations, creating the ability to share information and follow-up actions horizontally across sub-state entities and vertically with the central office. The State is also looking to integrate safeguards, such as human rights protections, medication administration and abuse and neglect reporting as well as investigations, into the new quality system. Minnesota is developing a protocol for establishing and monitoring expectations for county performance in the administration of their waiver programs.

Section IV describes the QM structures that states are adopting, in part driven by the need to better synthesize and integrate the information that is available. A second working paper will be published on specific sources of data, tools and discovery methods used by states and practices that integrate information for quality improvement.

Does the QM strategy measure performance against clearly articulated indicators and standards?

Measurement is a means for standardizing data so that it can be compared over time, across populations, or across programs. A logical place where states have begun the exercise of selecting domains and indicators has been the CMS *Quality Framework* which defines focus areas and desired outcomes for HCBS waivers. For example:

Chart 2: Sample indicators based on CMS Focus Areas and Desired Outcomes

CMS Focus Area/ Sub-domain	CMS Desired Outcome	Sample State-Specified indicator
Participant Access/ Prompt initiation	Services are initiated promptly when the individual is determined eligible and selects HCBS.	Services should be initiated within 30 days of being determined eligible for the HCBS waiver.
Participant Safeguards/ 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.	There will be a home assessment conducted on all high-risk participants.

Most states have not had a long history of using quality indicators and thus have limited means for establishing the standard against which performance should be measured. In the above example, setting the standard for service initiation at 30 days may be based on historical experience or state policy. Over time, standards may be adjusted to take into account improved methods of service delivery or other considerations.

Other indicators are relevant to HCBS waivers. Consumer experience measures are the most common, captured through use of consumer surveys such as the Participant Experience Survey⁶ and the National Core Indicators survey.⁷ Through its Systems Change grant, Maine has

⁶ Developed by MEDSTAT under a contract from CMS, the Participant Experience Surveys (PES) capture data that can be used to calculate indicators for monitoring quality within the waiver programs. There are currently two versions of the PES, one for frail elderly and adults with physical disabilities and another for adults with MR/DD. Additional versions of the PES, including one for consumers who direct their services and one for adults with acquired brain injuries are in the process of being tested in the field. www.cms.hhs.gov/medicaid/waivers/consexpsurvey.asp

⁷ The National Core Indicators project, launched by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI), includes a number of data collection tools and nationally recognized indicators that enable developmental disabilities policy makers to compare their state’s performance to national benchmarks, as well as track system performance and outcomes over time. The core indicators are the foundation for the project. The current set of performance indicators includes approximately 100 consumer, family, systemic, cost, and health and safety outcomes. Associated with each indicator is a source from which the data is collected. Sources of information include consumer survey (e.g., empowerment and choice issues)

developed a web-based database of existing measures, organized by domains from the CMS Quality Framework. The database can be found at <http://qualitychoices.muskie.usm.maine.edu/qualityindicators>. **Appendix D** shows performance measures developed by Georgia and Kentucky, organized by domains of interest.

The final working paper in this three-part series will be on quality indicators for evaluating HCBS performance.

Does the QM strategy routinely collect, synthesize, use, and share its performance information?

A basic tenet of a QM strategy is that information is available on how well the system is performing and that it is used to improve individual and system performance. This happens in two ways. First, through knowing what is happening to an individual participant and acting to remediate problems. Second, through determining how often a given event or process occurs across all participants and working to change behavior, policies or procedures to effect system improvement. To achieve systems change, data must be collected consistently across the program so that it can be counted in the aggregate. To do so:

- *Providers, agencies and policy makers must know what data to collect.* Reporting requirements are most often included in contracts, although there is variation in how clearly they are specified. **Appendix E** highlights Oregon's contractual requirements for record maintenance and reporting by Community Developmental Disability Programs for the State's DD waiver.
- *Data must be consistently collected according to defined specifications.* Some states are in the early stages of designing data collection tools to assure that information submitted by sub-state entities and providers are consistently reported. The second working paper on discovery methods will address models that states are using to specify and collect consistent data.
- *Data must be stored in a manner that allows for convenient retrieval.* States report that the results of many quality assurance activities never get properly documented in ways that allow for further analyses. Data may be stored in lengthy narrative telephone logs. Records may describe problems found during case reviews but fail to indicate how many records were reviewed to better understand statistical significance of results. Because of the often decentralized nature of how data are collected and the multiple sources of information, states are particularly challenged in standardizing data collection and retrieval.
- *Appropriate analyses must be conducted to understand how to interpret data findings.* In Section III, we describe how states are trying to build their analytic expertise by reaching out to other state agencies and/or contracting with public and private organizations that can assist in data analysis and interpretation.

family surveys (e.g., satisfaction with supports), provider survey (e.g., staff turnover), and state systems data (e.g., expenditures, mortality, etc.). <http://www.hsri.org/nci/>

- *Information must be presented in useable formats for policy makers, providers and consumers to use it for decision-making.* An early effort at presenting quality-related information was conducted by Georgia in its FY 2003 Performance Profile MHDDAD Statewide Summary (see **Appendix F**). Much has been written about adapting information for use by providers of care and consumers. TalkingQuality (<http://www.talkingquality.gov>) and Healthscope (www.healthscope.org) are two useful references on how to convert complex information for a consumer audience.

Each one of the above activities is complex and requires careful consideration so that the QM strategy is not overwhelmed with meaningless or conflicting data.

Does the QM strategy operate under a cohesive and focused work plan that directs time, effort and resources?

A QM work plan acknowledges that choices must be made about what can be effectively accomplished within a prescribed period of time. Even after a QM strategy is organized, work plans help a state focus on priority issues and objectives.

Georgia requires annual work plans to assure that state Division leadership and regional office staff are on the same page as to what are the highest priority improvement areas to tackle in a given year. Quarterly reporting and annual program evaluations are based on how well the state is meeting its goals. By assigning timeframes and responsibility in a work plan, individual staff members and committees can easily ascertain how their efforts fit into an overall plan for improvement.

Many elements of a QM work plan are not discretionary. This is especially true for activities related to assuring that providers and services meet minimum threshold requirements. Other activities may be mandated by state legislatures or assigned after the fact on the basis of an unanticipated event. But even in these circumstances, work plans provide a guide post on how to accomplish the necessities and, in the meantime, prioritize discretionary activity.

Our goal in this section has been to convey the breadth of activity that constitutes a QM strategy and to show examples of how states are making progress in meeting these challenges. The following sections describe how states are positioning themselves to do this work through staffing arrangements and organizational structures.

Section III: How Do States Develop Quality Management Expertise?

This section describes the range of expertise that currently exists in states to conduct quality management and the strategies used by states to enhance that capacity.

Who conducts quality management activities for HCBS waivers?

States identify many individuals and entities as having official and non-official responsibilities for evaluating and improving HCBS quality. Again, the challenge in creating an effective QM strategy is to harness the expertise, experience, and data that may come from these entities.

Listed in the following chart are the most commonly mentioned entities and their quality management related roles.

Chart 3: Activities that Support QM

Entity	Activities that can support QM
Waiver Policy and Program	
Medicaid	Compliance with state and federal requirements Claims analysis to assess services received; patterns of use Medication management Waiver policy and benefits Medical management Facilitator/convener of stakeholders Resource allocation Provider payments
Administrative agency	Facilitator/convener of stakeholders Complaint tracking Contract management Chart reviews Payment and program policy
Operating entity/counties	Site visits Provider chart reviews Consumer surveys Provider surveys Incident management Complaint tracking Provider contracts/data reporting
Assessing unit	Level of care determinations Plan of care development
Care coordinating entity	Service initiation Change in status review Identification of service barriers Case conferences Complaint tracking
Quality Committee	Quality oversight Guidance on goals and priorities Priority ranking of QI projects
Service Delivery	
HCBS Provider Agency	Provider training/supervision Verification of provider credentials Protocols for service delivery Complaint tracking Provider chart review Data reporting
HCBS Community Providers	Eyes and ears of the system Service documentation
Hospitals, primary care physicians, specialists	Preventive and acute care Outreach, education, self-care management

Entity	Activities that can support QM
Related Functions	
Licensure	Provider qualifications/licensure Work force certification Competency examinations Individual investigations Incident management
Utilization Review	Fraud detection Analysis of cost or use outliers Individual investigations
Adult Protective Services	Reports of abuse Investigations
Ombudsman programs	Complaint tracking Outreach and education
Consumer/Family/Citizen Monitoring Groups	Problem identification Quality improvement strategies

Understanding that the efforts of multiple people, agencies and systems of care impact participant outcomes is an important component to building an effective QM team. In the past, waiver programs were insulated units focused on their discreet responsibilities for meeting the health and welfare needs of participants. The scope of HCBS quality management was rarely envisioned (or organized) to capture the data, resources and experience of the broader universe of state agencies with overlapping quality oversight authority and other service systems of care serving the same participants. This broader universe of stakeholders both complicates and liberates how quality management functions are staffed and organized.

What core capacities are needed for an effective QM strategy?

A QM strategy needs the following core capacities.

- Leadership:**
 - Articulation of policy and expectations
 - Priority setting and resource allocation
 - Support, appreciation and feedback to those who do the work
- Administration/Management**
 - Task assignment, supervision and direction
 - Articulation of waiver policy, assurances, expectations
 - Liaison to organizational leadership, provider and consumer communities
 - Liaison to other state agencies with quality oversight responsibilities
 - Priority setting, work plan development
 - Training
 - Business practices to facilitate efficient, effective organization
 - Contract management
 - Grant management
 - Establishment and management of advisory committees and boards
 - Work plan development
 - Preparation of reports and grant proposals

Care process:	Clear understanding of the health and clinically-related conditions affecting the waiver population Practice guidelines Risk management
Data management:	Design of data collection tools and protocols Sampling Reliability testing Database construction, maintenance and retrieval
Analytic:	Software applications Performance measurement Statistical analyses Root cause analysis
Presentation:	Graphics Report writing/plain language skills
Group process:	Facilitation Brainstorming Priority setting

How do states staff their QM strategies?

While the above list of desired skills and capacities is formidable, states use many different ways to develop or get access to the expertise needed to conduct their QM activities. These strategies include:

- *Direct staff:* Some states are fortunate to have resources to directly hire QM staff positions. A number of grantee states have or plan to hire Project Directors whose roles closely parallel those of a QM Coordinator or Manager (CO, GA, MO, NC, PA, TN). Others use grant or state funds to recruit specialists who can augment the skills of existing QM coordinators. **Appendix G** includes job descriptions from several states. QM staff, whether housed in the Medicaid agency or administrative agency, are eligible for federal Medicaid match. Enhanced federal match (75/25) is available to support in-house clinical staff.

In addition to hiring new staff, states are enhancing the QM skills of existing staff through conferences and other professional development activities. Most urban areas have local voluntary organizations of professionals in the field of QM; in some areas these might be specific to public sector or to human services.

- *Expertise from other state agencies or units:* There are many state entities that conduct quality management activities very much related to those required by HCBS waiver programs.

Chart 4: Sources of QM Expertise within State Government

Department/Agency	Kinds of Expertise
State Licensure	Provider licensure requirements Provider shortage areas On-site investigations Data collection tools Root cause analysis techniques
State Medicaid Agency	Knowledge of federal policy Medical/pharmacy claims analysis Medical management Eligibility and provider files Analytic capacity
Health Department	Clinical expertise Epidemiology, statistics, population-based measurement Vital statistics data Consumer-based surveys Public health data
Mental Health and Substance Abuse	Population expertise Knowledge of co-morbidities Linkages to provider community Self direction
Rehabilitation	Program knowledge Application of functional assessments; risk management Employment and education resources

As in Georgia, states have capitalized on available internal resources by including representatives from other departments/agencies to serve on project steering committees and task forces. Minnesota is considering bringing in the performance measurement skills developed for the state’s managed care program to use in the waiver programs. The Texas Health and Human Services Commission has created the Center for Policy and Innovation and the Center for Program Coordination specifically for the purpose of coordinating programs and facilitating consumer and stakeholder involvement within state government. Both of these Centers work with the Texas QA/QI grant in the identification, coordination and monitoring of performance measures related to their program (see **Appendix H**).

- *Develop long term partnerships with external organizations:* As states commit to quality management, they find other organizations with similar interests with whom to partner and contract. South Carolina works with the First Health Services, a federally designated Quality Improvement Organization (QIO) historically conducting quality management activities in hospitals, to enhance its analytic capacity. **Appendix I** highlights the major activities that are part of the First Health Services partnership. Wisconsin’s Family Care program works with Metastar, a Quality Improvement Organization (QIO) typically contracting with Medicaid managed care programs for external oversight. Metastar’s work with Wisconsin waiver

programs focuses on quality assurance through site visits, technical assistance and trainings, and member outcome interviews. Similarly, Maine, Massachusetts and West Virginia work closely with their state university-based health services research programs to add analytic capacity to their program, assessment and claims data.

- *Ad hoc consultant contracts:* Oftentimes states look to consultants to fill what is expected to be short term or specialized skills for quality management. For example, a number of the QA/QI grants focus on the design of an information technology (IT) infrastructure for the collection, management and analysis of QM data (CT, DE, GA, IN, MN, MO, NY, OH, OR, PA, TX). Consultants in these cases work with state IT departments and other state and provider agencies with which the system must interface.
- *In-kind contributions:* States have access to a wealth of expertise at no charge. Participants on committees and provider agencies lend their advice on numerous projects and offer the services of their staff when appropriate.

Despite the opportunities, many states struggle to fund, find and retain good staff for their QM activities. For the most part, these are not dedicated positions except in the large states with sizeable programs. In the next section, we discuss models for how states structure their QM programs to gain maximum advantage and accountability at all levels.

Section III: How Do States Organize their QM Strategies?

For many grantees, the organization of their QM strategies is still evolving. CMS guidance over the past two years has highlighted the priority that must be given to quality oversight and improvement. The Systems Change grants have been an opportunity to determine how the tenets of a QM strategy, as outlined in Section II, can be translated into an organizational structure that facilitates communication, action and quality improvement. This section of the paper outlines the issues states are addressing as they contemplate methods for organizing their QM strategies.

What components of the system must be organized?

Even without official re-organization, states are changing their perspectives on how to conduct QM activities. For these states, as well as those that have made structural changes to staffing and reporting relationships, the question has been the same: how to align the mandate for quality management and improvement with the activities and roles of state staff, operating and sub-state entities, and provider organizations? In other words, how to diffuse responsibility for quality throughout the organization and service system in a manner that facilitates, and holds each level accountable for, discovery, remediation of problems, and system improvements?

The following chart arrays the activities involved in the administration of a waiver program. States have many different organizational structures, but all can be described as having administrative, program management and direct service components. What varies among states are the entities that perform these roles, the extent to which these activities are performed, and the linkages across activities.

Chart 5: Activities and QM Responsibilities by Sectors

	Program Activity	Information They Produce to Support QM	Their Role in QM
Direct Services	Direct Observation Care Delivery	Record documentation, claims generation	Is care provided according to the requirements of the care plan? Are needs observed and reported as they change? Is care provided according to professional standards? Are records of care/observations timely, complete, and accurate? Do others have access to the information in time to make informed decisions? Has a trusting, respectful relationship been established with the participant? What problems can be identified? What are possible solutions to problems?
Program Management	Care coordination	Case record documentation, phone call logs, assessments, plans of care, risk management plans	Is care being provided according to the plan of care? Have services responded to changing needs? Have adequate provisions be made to assure the safety and welfare of high risk participants?
	Complaint/Incident Management	Complaint logs, incident reports, investigation reports, root cause analyses, trend analyses	Are there easy and timely ways to report problems? Are problems reviewed and remediated quickly? Is there documentation of actions and follow up to see that it had the intended result? Are there patterns that suggest system failures? Are timely reports made for appropriate action?
	Provider Contracting	Required provider reporting, provider audit reports, validation of provider qualifications, licensure reports, provider files	Is there a sufficient qualified provider network to meet needs of participants? Is there evidence that providers are meeting professional standards of care? Are actions taken when providers do not meet contract expectations?
	Consumer Feedback	Consumer survey findings	Does consumer feedback suggest opportunities for improvement? Are there patterns in consumer experience based on geography, provider agency, condition, service type? Are timely reports made on findings?
Administration	Waiver policy/assurances/design	Evidentiary reports	Is the program fulfilling its federal and state assurances? Is the program working/ performing as intended?
	Inter-agency coordination	Committee/Staff minutes, data sharing	Are there effective processes to coordinate activities with state units with intersecting QM responsibilities?
	Stakeholder involvement	Committee minutes	Is the program benefiting from the perspectives of diverse stakeholders?
	Priority setting	QM Work Plan	Are there clearly defined QM goals and objectives? Is management fully engaged and committed? Have these been shared with operations and direct care?
	Performance measurement and improvement	Quality indicators	Is the program meeting performance expectations? Are there strategies in place for improving?

Are QM strategies organized for single or multiple waivers?

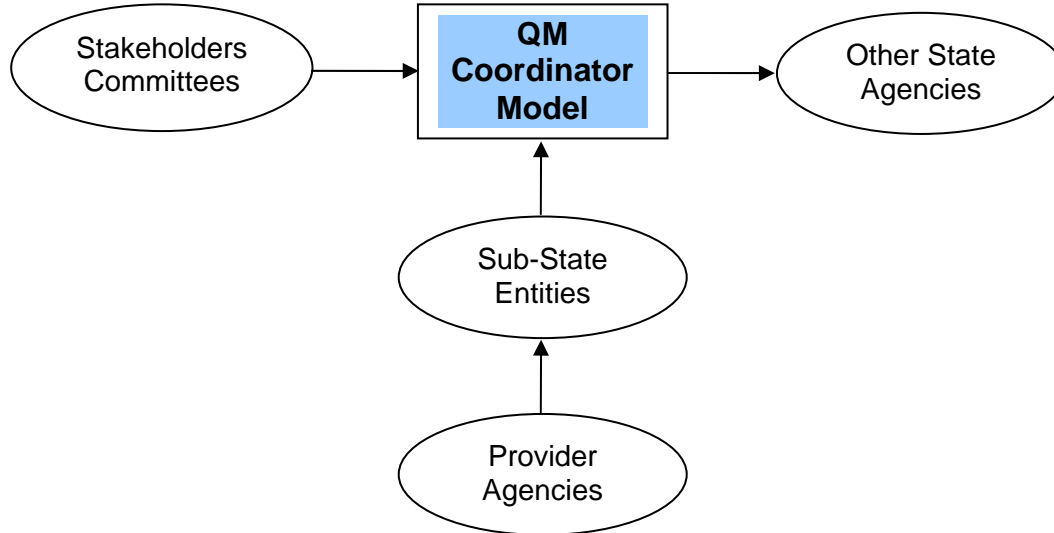
Several states are working across waiver and long term care programs to leverage available resources and skills for QM. In Wisconsin, the Division of Disabilities and Elder Services is now responsible for administering the state's waiver programs. A goal of the State's QA/QI system is to create a more effective and coherent Department-wide QA/QI system. A necessary first step to achieving that goal was to overcome major differences in how the different HCBS programs define quality management and to develop common language and purposes for joint activity. Further complicating the State's efforts at coordination are the different models used within waiver programs to conduct QM activities. In Family Care, which operates under both (b) waivers for its managed care features and (c) waivers for its HCBS features, the five local Care Management Organizations (CMOs) conduct significant quality management activities at the local level and are subject to periodic review by an external quality review organization (EQRO). The EQRO also conducts technical assistance and training to the CMOs. Wisconsin's other waiver programs, which operate under (c) waivers only, centralize more QM responsibilities at the state level and rely heavily on state or other contract staff to conduct QM activities. In these programs, sub-state entities have minimal QM systems to support the quality efforts carried out by care managers at the individual level.

The ability to leverage expertise is greatly facilitated in Wisconsin by the Family Care EQRO and by the quality systems consultant serving the Elder/Physical Disability waiver, which provides a mechanism to infuse new quality techniques and knowledge into the state's waiver programs via collaboration with external quality experts.

Ohio is taking a bold step in designing a QM strategy across all long term care (LTC) services for their population with developmental disabilities, not just HCBS waiver services. As they work to eliminate the silos in their LTC program (e.g., residential services, day services, other community supports) it seems only natural to devise a QM strategy that addresses the continuum of care.

What models are emerging for organizing HCBS QM programs?

The following charts try to portray how QM strategies look at three very different stages. Examples are given of states at each stage with the caveat that few states fit the pure definition of any one model. The models serve to provide a reference point for states to evaluate where they currently are and where and how they can move to the next stage.



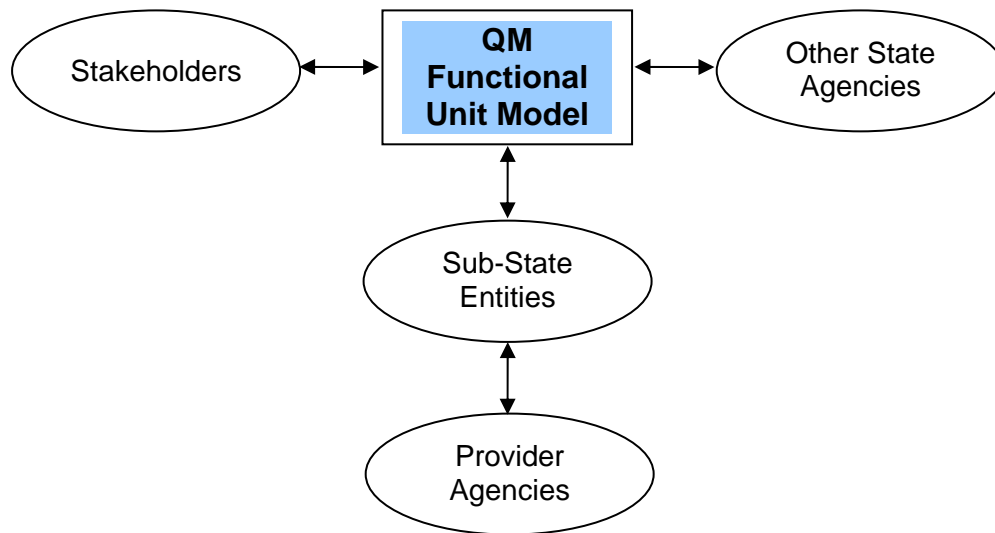
Characteristics

- Single person/unit with responsibility for coordinating QM activities throughout the program.
- Upon request, sectors submit existing data to QM Coordinator for synthesis and reporting to management, CMS, etc.
- Limited standardization of data collection methods within and across sectors.
- Limited information/analysis back to sectors.
- No real change in operation/behavior of program sectors.

Examples

Many states are at this early stage of quality management design. Primarily in response to CMS waiver requirements and guidance, states are conducting inventories of quality-related activity and data across sectors and working to collect and organize data in ways that assess existing performance against CMS waiver domains. These activities have prompted reviews of current practice and, to a lesser degree, are resulting in reforms in how waiver services are delivered.

An early and common activity during this stage is the creation of a committee structure to provide leadership, guidance and oversight to emerging QM efforts. Under its 2001 Real Choices Grant, **Minnesota** created The Quality Design Commission to serve as a forum from which to build consumer input into waiver quality management. In addition, senior managers responsible for the waiver programs in Minnesota have been meeting to develop common concepts for evaluating the performance of the State's waiver programs and county operations. **Maine** established an Inter-departmental HCBS Quality Work Group comprised of staff members from each of the State's five waiver programs. Meeting monthly, this past year has been spent sharing QM tools and methods to determine opportunities for coordinated or collaborative effort. A Quality Improvement Committee established by **Georgia's** Division of Mental Health, Developmental Disabilities and Addictive Diseases, comprised of representatives from central and regional state offices, provides direction for quality improvements and evaluates results.



Characteristics

- Multi-skill set within QM unit to enhance data retrieval, analysis, synthesis, and interpretation.
- Exchange of information/knowledge between sectors and QM Unit.
- Greater standardization of data collection methods within sectors.
- Potential for new data collection to support QM activities.
- Follow up with sectors on actions taken.
- Gradual transformation of sector operations through improved reporting, analysis, identification of opportunities for improvement, and technical assistance.

Examples

Creating a two-way communication with sectors to the point of influencing their operations is a significant challenge in this stage, especially for states that are dependent upon sub-state entities for waiver operations. The second major challenge is developing expertise that can be leveraged by program sectors to improve their operations. Examples of state strategies include:

- **Protocols and Contracts.** Without altering their operational structures, states are revisiting requirements placed on direct care and operations staff for service provision and monitoring. **Massachusetts** requires quality plans and projects as part of proposals submitted by their 27 case management agencies. Through a contract with the University of Massachusetts, records are reviewed to assure consistency with the proposed plan. **Connecticut** is developing certification standards for providers of service that incorporate all relevant components of the CMS *Quality Framework*. The Department of Human Services, Seniors and People with Disabilities in **Oregon** strengthened quality management provisions in contracts with their Community Developmental Disabilities Programs. Standards specify activities, reporting requirements and reporting specifications to assure consistency across the State's waiver program. **Minnesota** is developing a county review protocol, and has hired country reviewers, to assess performance of the counties in meeting requirements for operating the waiver programs.

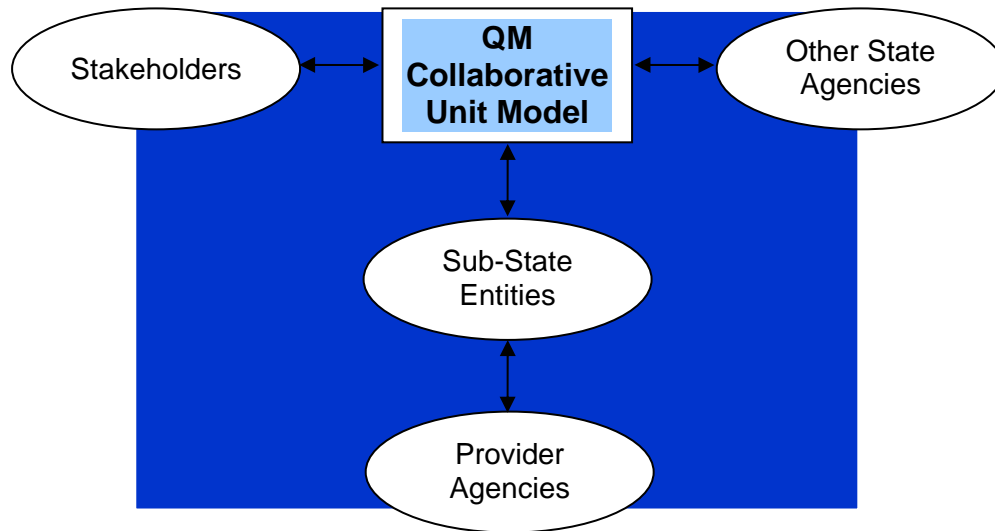
- **Creation of new QM Entities:** Indiana, Pennsylvania and Texas have each created new entities to conduct QM activities for their states' waiver programs. **Indiana** has created the Bureau of Quality Improvement Services (BQIS), the purpose for which is "to develop and implement quality assurance and improvement systems across the Division of Disability, Aging and Rehabilitative Services (DDARS) to assure the health and safety of individuals receiving community-based services." Established in 2001, the Bureau initially focused on the waiver for persons with developmental disabilities. The purpose of Indiana's Systems Change grant is to replicate the QA/QI system developed for DD for other waivers under the jurisdiction of DDARS. Services offered through this new bureau include:
 - Assist in the development, adoption and implementation of provider standards to ensure that the health and safety of the individual are protected.
 - Conduct provider quality assurance surveys to all service providers to ensure compliance with prescribed standards.
 - Monitor and track all incident reports and complaints, including investigations and follow-up.
 - Establish and convene standing committees for identifying and recommending system improvements.
 - Work in collaboration with the waiver programs in the development/responses to CMS waiver reviews.
 - Provide training and education to staff and providers.

Texas established the Center for Policy and Innovation and the Center for Program Coordination to develop policies, coordinate programs and facilitate consumer and stakeholder involvement across four departments, including their waiver programs. These Centers offer services such as:

- Develop and promulgate best clinical practices
- Conducts research.
- Identifies and analyzes performance measures for assessing program performance
- Assures stakeholder involvement in program policy development
- Assesses program performance for quality improvement opportunities.
- Identifies program operational redundancies
- Ensures integrated approaches to program service delivery.

Pennsylvania established the Bureau of Program Integrity to assess individual and collective performance of the Area Agencies on Aging which operate the state's waiver for older persons. The Bureau manages and monitors contracts; collects, reviews and analyzes reported data; conducts onsite visits to review case records; provides technical assistance; and prepares reports and recommendations for consideration by the Department of Aging Secretary which administers the waiver program.

Each of these states have created entities to perform QM functions that require specific expertise and which successfully can be conducted by a third party with input from waiver program administrators. By performing these functions centrally, waiver programs can focus their efforts on remediation at the individual level and systems improvement.



Characteristics

- Multi-skill set within QM unit to enhance data retrieval, analysis, synthesis, interpretation and action
- Exchange of information/knowledge between and among sectors and QM Unit.
- Infusion of expertise within sectors/development of pockets of expertise.
- QM philosophy and function embedded within business practices of sectors.
- Continual transformation of sector operations through knowledge sharing, enhanced capacity and technical assistance.

Examples

What distinguishes the QM Functional Model with that of the QM Collaborative Model is the permeation of quality management throughout the system such that it simultaneously improves business practices and performance within sectors while connecting that experience and expertise to the broader system. QM functions that historically were performed centrally may be assumed within sectors (e.g., data analysis) and/or certain sectors may emerge as having specialized skills that benefit the common cause. The breadth of sectors may be expanded beyond those of a single waiver to include other waivers, long term care or potentially other settings of care.

A pre-condition for the QM collaborative model to work effectively is continuous and timely communications within and across all sectors. Many states have automated systems that do not link together or have manual systems that make data retrieval time consuming, burdensome and imprecise. These states are using their Systems Change grants to move information up, down and across their system so that data collection efforts can be more efficient and findings can be used to inform service providers, correct individual problems, and ascertain trends that suggest the need for system improvement. Features of the Information Technology system that seem particularly important to achieving the vision of the QM Collaborative Model include:

- Leadership to galvanize common vision, resources, and commitment.
- Standardization of data and data collection tools whenever possible;
- Data transparency that allows maximum use of information for multiple purposes.
- Productive forums for the exchange of knowledge, expertise and findings across sectors.

The examples provided under the QM Functional Model provide a glance at how states begin to move toward a collaborative model. It is hoped that future updates of QA/QI grantee activity can demonstrate real progress toward the collaborative model.

The above models are illustrative of organizational arrangements that are emerging for QM. Within each model, there are structures that states must put into place to accommodate their unique staffing and sub-state organizational arrangements. The models are intended to help a state assess its current position and determine potential future directions.

How do QM programs evolve?

Concepts from organizational theory and organization design may help to describe the evolution of quality management within state waiver programs.⁸ According to some theorists, quality management often begins with a strong “ceremonial” or “rhetorical” component that leads to lots of discussion but little action or change of behavior. Even after an organization adopts QM concepts, it can take a long time before it becomes embedded in actual practice at the direct service site. Only upon constant and consistent use is QM fully realized at all levels of the organization. It is retained through incorporating learning back into the rhetoric, adoption, and use stages.

At the risk of simplifying complex concepts, Chart 6 introduces these ideas to the design of a QM strategy for HCBS waivers.

⁸ Zbaracki, Mark J., *The Rhetoric and Reality of Total Quality Management*, Administrative Science Quarterly, 43 (1998).

Chart 6: Evolution of a QM Strategy across Waiver Sectors

	Administration	Program Management	Direct Services
Rhetoric	CMS Quality Framework CMS waiver requirements QM values and principles		
Development	QM Committee Stakeholder involvement Assigned QM responsibilities Data reporting requirements Selection of quality indicators QM training/skill enhancement Development of QM work plan	Re-design/integration of business practices QM provisions in provider contracts QM training/skill enhancement Consumer/provider surveys Data collection tools/reporting requirements	
Use	Creating analytic capacity Conducting trend analyses Identification of areas for improvement Evidence of system performance Public reporting	Trend analysis Identification of areas for improvement Implementation of QI projects Evidence of system performance Performance incentives	Record documentation Use of practice guidelines Performance reports Information sharing
Retention	Evaluation of system performance QM program refinement	Evaluation/refinements of business practices Ongoing system improvements	Practice transformation

Most states are in the early phases – incorporating the rhetoric and moving toward adopting QM principles into their business practices. A few have made structural changes to facilitate the permeation of QM throughout the waiver program; others are changing processes on a more incremental basis.

Conclusion

This working paper was prepared as guidance to states as they think through available options and implications for establishing a QM strategy. It has highlighted approaches used in various states and some of the tradeoffs that may result. This mini review has also revealed the embryonic stage of most states’ QM strategies and the lack of definitive models for how best to advise states to proceed.

Grantees identified the following areas as being especially ripe for further research and development:

- Model sub-state and provider contract provisions relating to quality management roles and responsibilities.
- Model job descriptions for Quality Management Coordinators and other staff.
- Model Memorandum of Understanding specifying working relationships among state units and agencies with overlapping responsibility for quality management.
- Standardized training curriculum for use by new and existing staff on the QM strategy and process.