Measuring Home and Community-Based Services (HCBS) Quality in Managed Long-Term Services and Supports Programs

September 27, 2013
Friday Morning Collaborative

With support from The SCAN Foundation, NCOA leads a coalition of national aging and disability organizations working to protect and strengthen Home and Community-Based Services.

For more information about The SCAN Foundation visit: www.TheSCANFoundation.org
Friday Morning Collaborative

- American Association on Health and Disability
- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Federation of State, County and Municipal Employees (AFSCME)
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer’s Association
- Bazelon Center for Mental Health Law
- Center for Medicare Advocacy
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Health and Disability Advocates
- Leading Age
- Lutheran Services in America
- National Association of Area Agencies on Aging
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Domestic Workers Alliance and Caring Across Generations
- National Health Law Program
- National PACE Association
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Spinal Association
- VNAA – Visiting Nurse Associations of America
Power Point

• Can I get a copy of the Power Point?
• Will an Archive of the webinar be available?

YES! YES! YES!

You will receive copies in a follow up e-mail early next week. Please share with others!

Materials from this presentation are also at:

www.ncoa.org/HCBSwebinars
Questions and Comments

All Lines Will Be Muted During the Call

To Ask A Question Use the Chat Function
Importance of Quality Measures

Quality and performance measures are critical tools for consumers and states to:

– ensure protections
– enhance choice and plan performance
– align incentives to meet desired goals
  (e.g. rebalancing, promoting options for self-direction, ensuring an adequate direct care workforce)
Challenges

• Medical model (clinical) orientation of existing quality measures and quality structures
  – Need to adopt a non-medical, person-centered framework for quality in HCBS

• Gaps in HCBS measure development
  – Recent NQF Duals Workgroup Report to CMS
  – Who will develop measures, and funding?

• Lack of federal guidance on a core set of HCBS quality and performance measures
Previous FMC Webinars

• Overview of Quality Measurement in MLTSS
• Development of HCBS Experience Survey

• Available at: www.ncoa.org/HCBSwebinars
Webinar Overview

Introduction

• Joe Caldwell (National Council on Aging)

Speakers:

• Tamar Heller (University of Illinois at Chicago)
• Randall Owen (University of Illinois at Chicago)
• Beth Mathis (The Council for Quality and Leadership)
• Katherine Bishop (New York State Office for People with Developmental Disabilities)

Questions and Answers (15 - 20 minutes)
DEVELOPMENT OF AN EXTERNAL EVALUATION OF A STATE MEDICAID MANAGED CARE PROGRAM: THE ILLINOIS INTEGRATED CARE PROGRAM

Tamar Heller, PhD and Randall Owen, PhD
Department of Disability and Human Development
University of Illinois at Chicago

http://www.idhd.org
Use of External Evaluation

- Advocate concerns about managed care
- Need for credibility with the disability and aging community
- Need for a balanced approach considering concerns of state agencies, MCOs, providers, advocacy groups, people with disabilities, and families
- Institute on Disability and Human Development has experience in conducting public policy evaluation research with people with disabilities
Integrated Care Program (ICP)

- Impacts 40,000 Medicaid-only seniors and adults with disabilities in Chicago area
- Mandatory Managed Care run by one of two MCOs (Aetna or IlliniCare [Centene])
  - Phase I: Acute health (5/1/2011)
  - Phase II: LTSS (except DD) (2/1/2013)
  - Phase III: DD LTSS (TBD)
- Reasons:
  - Save $200 million over 5 years
  - Improve health and quality of life outcomes
    - Prevention
    - Rebalancing of long-term services and supports (LTSS)
    - Coordination of care
Conceptualizing the Evaluation: Capacity Building Framework

Factors
- Systemic Factors
- Individual Factors

Assessments Areas
- Leadership & MCO Organizational Structure
- Resource Allocation
- Program Implementation
- Readiness (Awareness & motivation to participate)
- Knowledge & satisfaction with the program

Outcomes
- Increased consumer access to needed services
- Improved health Outcomes
- Consumer Satisfaction
- Increased Preventive Care

Cultural and Contextual Factors: (examples)
- Culturally competent service delivery
- Political support
- State budget, etc.
(Specific factors to be identified in the evaluation process)
What goes into the evaluation?

**Data Sources**
- Consumer Surveys
- Encounter Data
- Focus Groups
- MCO Data

**Evaluation Types**
- Process
- Outcomes
- Economic Impact

**Stakeholders**
- Consumers & Families
- Advocates
- MCOs
- Providers
- State Agencies
Survey Development (Ver. 1)

Focus Groups of people with disabilities to suggest key topic areas

Existing Surveys and Measures
- Consumer Assessment of Health Plans
- Assessment of Health Plans and Providers by People with Activity Limitations (Palsbo)

New/customized questions
Work with Dr. Palsbo for initial list

Stakeholder and Expert Review
- Issues and cultural competency

Pilot testing
Survey Composition

Baseline
- SF-12: Self-rated health status
- CAHPS/AHPPPAL: Satisfaction, Access and Utilization/Unmet Needs
- Heller et al. (2012): Community Participation

Added for 1st Year post-ICP
- Basic ICP Questions (which MCO, satisfaction, enrollment, health status post-ICP)
- Need/Receive and satisfaction with LTSS
- Lehman QOL: Living situation, family and friends
- National Core Indicators: loneliness, exercise

Added for 2nd Year post-ICP
- Quality of LTSS (not only satisfaction)
- Choice/self-direction related to LTSS/care plans
Increasing Response Rate

- Increase Awareness and Motivation
  - Notification and Reminder letters
  - After a few weeks make phone call reminders
  - Gift cards

- Return to Sender
  - Redistribute to new address if possible
  - Track them so you know who you don’t reach

- Follow-up with Residential Settings
  - Identify locations with multiple people in sample and do follow-up with staff
## Survey Responses

<table>
<thead>
<tr>
<th>Timing</th>
<th>Orig. Sample</th>
<th>Responses (N)</th>
<th>Resp. Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (ICP)</td>
<td>2,195</td>
<td>418</td>
<td>34.3%</td>
</tr>
<tr>
<td>1 Year Post (ICP)</td>
<td>2,158</td>
<td>540</td>
<td>38%</td>
</tr>
<tr>
<td>- Longitudinal</td>
<td>381*</td>
<td>208</td>
<td>74%</td>
</tr>
<tr>
<td>1 Year Post (comparison group)</td>
<td>2,000</td>
<td>408</td>
<td>31%</td>
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</tbody>
</table>

Response Rate is based on people with valid means of contact

* 37 people left ICP between baseline and Year 1
Overall Longitudinal Satisfaction with Health Care (n=208)

Measured a scale of 1 (very dissatisfied) to 5 (very satisfied)

* Statistically significant decrease
Longitudinal Survey Findings: Services

- No significant differences from Baseline to Year 1 for medical services, specialist services or medical equipment needed and received
- No significant differences from Baseline to Year 1 for preventive care received (i.e. being weighed, discussion with provider on healthy eating, physical exercise, STDs, etc.)
- No group differences in services
Focus Groups

- 16 groups with 110 participants
- Stakeholders
  - People with various disabilities
  - Providers
  - MCOs
  - State officials
  - Family members/caregivers
Focus Group Themes

- Confusion regarding enrollment
- Concern about adequacy of provider network
- Initial confusion with billing
- Helpful MCO outreach to providers
- Stakeholders’ desire for more MCO accountability
- Satisfaction with coordination of care mixed among those who received it
- Challenges with changes in prescription medication
- Usefulness of training by MCO staff
- Lack of awareness of prevention efforts
Select Findings from MCO data after Year 1 (healthcare): 1 of 2

- **Challenges and Progress in Network Development**
  - Continuity of care
  - Half of claims from out of network

- **Timeliness of Payment of Providers**
  - Only 1% of “clean claims” over 90 days
  - Difficulty submitting a clean claim

- **Pace of Enrollment**
  - Slow initial enrollment. Average time enrolled of 7 months
  - High use of auto-enrollment: over 70% initially

- **Risk Stratification**
  - Use of different processes: difficulty comparing level of need

- **Prior Approval/Authorization of Services**
  - Differences in processes: e.g., days to respond (10 v. 14)
  - Nature of requests. 35% for inpatient services, 13% for DME
Nature and Outcomes of Grievances and Appeals
- Improved data compared to FFS
- Resolution of appeals. Different categories and number of days to resolve (19 v. 10)

Changes in Emergency Department Events
- Decrease in emergency room (ER) use. 7% decrease
- Decrease in high frequency users. 39% decrease (15% to 9%)
- Decrease in ER to hospital admission. 15% decrease (20% to 17%)

Changes in Hospital Admissions
- Decrease in hospital admissions. 18% reduction
- Decrease in length of stay. 25% decrease (3.6 to 2.7 days)
Recommendations for the State Medicaid Agency: Year 1

- Improve development of new provider networks and continuity of care.
- Strengthen communication/involvement with stakeholders, providers, and state agencies.
- Expand the state's "readiness review" process to include more public participation and to accommodate smaller providers.
- Support the enrollment of and transition processes for new members.
- Improve consistency of reporting requirements for MCOs.
State Performance Measures

- HEDIS or State-defined for Medicaid Agency, MCOs, and/or External Quality Review Organization (EQRO) to report
- Most are # and % of:
  - Case managers meeting waiver provider training reqs
  - Service plans addressing risks identified in assessment
  - MCO participants who receive specified contact levels
  - MCO participants whose plans indicate choice between waiver and institutional services
  - MCO participants who received info on abuse, neglect and exploitation
What does our evaluation add?

- Focus outside of HEDIS/state measures tracked by EQRO
- Explanation behind changes
- Consideration of advocate, MCO, provider, state agency concerns (anecdotes, focus groups, interviews)
- Development of focal areas to investigate and understanding of focal areas
  - 16 focal areas including 98 questions
## Summary of Focal Areas

<table>
<thead>
<tr>
<th>General Areas</th>
<th># of Questions</th>
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<tbody>
<tr>
<td>Enrollments/Dis-enrollments</td>
<td>4 questions</td>
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<tr>
<td>Care Coordination</td>
<td>11 questions</td>
</tr>
<tr>
<td>Member Care Plans</td>
<td>10 questions</td>
</tr>
<tr>
<td>Physical Accessibility of Providers</td>
<td>6 questions</td>
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<tr>
<td>Transportation</td>
<td>6 questions</td>
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<tr>
<td>Medications</td>
<td>5 questions</td>
</tr>
<tr>
<td>High Cost Service Utilization (ER, Hospital, Radiology)</td>
<td>3 questions</td>
</tr>
<tr>
<td>Grievances and Appeals</td>
<td>7 questions</td>
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<tr>
<td>Prior Authorization</td>
<td>8 questions</td>
</tr>
<tr>
<td>Movement between LTSS settings</td>
<td>2 questions</td>
</tr>
<tr>
<td>Costs</td>
<td>7 questions</td>
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<tr>
<td>Adequacy of Provider Networks</td>
<td>6 questions</td>
</tr>
<tr>
<td>Prevention</td>
<td>4 questions</td>
</tr>
<tr>
<td>Dental Services</td>
<td>3 questions</td>
</tr>
<tr>
<td>Medical Home</td>
<td>5 questions</td>
</tr>
<tr>
<td>Timely Payment to Providers</td>
<td>3 questions</td>
</tr>
</tbody>
</table>
Care Coordination Questions

- How much contact (in person and other) does the typical MCO care coordinator have with each member?
- What are the case loads for the MCO care coordinators during the year?
- What is the turnover rate of the MCO care coordinators and what happens to the members on the departed care coordinator?
- What types of specialized training do MCO care coordinators receive that relate to special needs of ICP members who need SP2 services?
- How much contact do MCO care coordinators have with existing community care coordinators?
Member Care Plans Questions

- How do the MCOs ensure that the Waiver members' service plans address all personal goals, needs and risks that were identified by the assessment?
- How do the MCOs determine whether the care plans are being "adequately" followed?
- What % of waiver participants are able to hire and fire their own personal assistants and how do the MCOs track this?
- What is the process to ensure that members receive the “non-covered” Medicaid services they may need?
Physical Accessibility of Providers Questions

- How do the MCOs monitor the providers to ensure they are physically accessible to members?
- Do the MCOs require the providers to submit some documentation or "evidence" of their accessibility?
Medications Questions

- How do the MCOs monitor polypharmacy (possible overutilization of medications) use among members?
- What criteria do the MCOs use to identify members that might need to reduce their medication use?
- What criteria do the MCOs use in determining whether to approve brand name versus generic for various medications, either overall for all members or for specific members?
- How is it determined what medications are placed on the PDL and what medications require prior approval?
- How do the MCOs ensure that members receive an adequate supply of medications between prescription renewals?
Prior Authorization Questions

- How does the MCO decide what services need prior authorization and how often is this policy reviewed?
- Who is involved in deciding whether a request is approved or not?
- How long does it take for the MCOs to provide answers to prior approval requests?
- Is there a significant difference between the two plans in terms of how Rule 132 mental health services are approved?
Prevention Questions

- Has the use of prevention services changed during the ICP as compared to the baseline period?
- Has the amount or type of follow up that members receive after an ER event changed from what occurred during the baseline?
- Has the amount or type of follow up that members receive after a hospital admission changed from what occurred during the baseline?
- Do the MCOs have any contracts with community based providers that offer evidenced based health promotion programs? If so, do they offer access to those programs as a benefit?
Dental Services Questions

- What are the main differences in the process of how dental services are provided to the FFS members versus the ICP members?
- Has the number of members receiving non-emergency dental services increased or decreased under the ICP?
- Has the number of members receiving emergency dental services increased or decreased under the ICP?
Challenges

“Apples and Oranges”

“Trudging through the Mud”

“Watching Sausage Being Made”

“See the Forest, not the Trees”
Acknowledgements

- Evaluation Team
  - Tamar Heller - Principal Investigator
  - Randall Owen - Project Coordinator
  - Dale Mitchell - Data Manager
  - Chris Keys - Focus Groups
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  - Coady Wing - Health Economist
  - Yochai Eisenberg - Data Analyst
  - Fabricio Balcazar - Consultant
  - Susan Hughes - Consultant
- Funded by the Illinois Department of Public Health
- Year 1 Report: http://www2.illinois.gov/hfs/sitecollectiondocuments/uicevaluationicp.pdf
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Quality of Life: Measurement and Managed LTSS

Friday Morning Collaborative – September 27, 2013
Who we are …

International not-for-profit organization dedicated to the definition, measurement and improvement of personal quality of life for people receiving human services and supports.
Personal Quality of Life
LTSS and Personal Quality of Life

• The Kaiser Commission on Medicaid and Uninsured: http://www.kff.org/medicaid/upload/8278.pdf
• Center for Health Care Strategies – November 2010 report http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261188
• LTQA Quality Measure Workgroup http://www.ltqa.org/2011-12-23-measurement-opportunities-gaps.html
PERSONAL OUTCOME MEASURES
MEASURING PERSONAL QUALITY OF LIFE

PERSON-CENTERED EXCELLENCE — WHAT REALLY MATTERS
Clinical Outcomes
  • Cure and symptom reduction

Functional Outcomes
  • Increasing functional status

Personal Outcomes
  • Issues that matter most to people in their lives
We Measure Two Things

• Outcomes = Quality of Life

• Supports = Quality of Services
Personal Outcome Measures®

- Self-advocates
- Peer specialists
- Stakeholders
- Literature review
- Delphi Panel
- Providers, stakeholders
- Consultants, thought leaders
- Pilots and field tests

Personal Outcome Measures® (POMs) is a tool designed to measure outcomes and performance in various settings, including healthcare, education, and social services. It is used to assess the effectiveness of programs and services by focusing on individual outcomes and the impact they have on clients' lives. POMs incorporate a variety of methods to gather data, including interviews, focus groups, and surveys, and it emphasizes the involvement of clients and stakeholders in the measurement process.
<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>People are Safe</td>
<td>86.5%</td>
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<tr>
<td>People are Free From Abuse and Neglect</td>
<td>84.0%</td>
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<tr>
<td>People Realize Personal Goals</td>
<td>82.7%</td>
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<tr>
<td>People are Respected</td>
<td>78.7%</td>
</tr>
<tr>
<td>People Experience Continuity and Security</td>
<td>78.5%</td>
</tr>
<tr>
<td>People Decide When to Share Personal Information</td>
<td>78.2%</td>
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<tr>
<td>People Use Their Environments</td>
<td>76.7%</td>
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<tr>
<td>People have the Best Possible Health</td>
<td>74.4%</td>
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<tr>
<td>People Interact with Other Members of the Community</td>
<td>72.2%</td>
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<tr>
<td>People have Intimate Relationships</td>
<td>70.4%</td>
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<tr>
<td>People Participate in the Life of the Community</td>
<td>70.0%</td>
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<tr>
<td>People Remain Connected to Natural Support Networks</td>
<td>61.7%</td>
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<tr>
<td>People have Friends</td>
<td>56.3%</td>
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<tr>
<td>People are Treated Fairly</td>
<td>55.7%</td>
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<tr>
<td>People Choose Personal Goals</td>
<td>51.3%</td>
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<td>People Choose Services</td>
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<td>People Exercise Rights</td>
<td>49.8%</td>
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<td>People Choose Where and With Whom they Live</td>
<td>46.2%</td>
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<td>People Choose Where they Work</td>
<td>40.6%</td>
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<td>People Live in Integrated Environments</td>
<td>37.5%</td>
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<tr>
<td>People Perform Different Social Roles</td>
<td>32.5%</td>
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<tr>
<td>Specific Outcomes Correlated with Total Outcomes – Predictors</td>
<td>HIGHEST</td>
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<td>-------------------------------------------------------------</td>
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<tr>
<td>Exercise rights</td>
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<tr>
<td>Choose where and with whom they live</td>
<td>.528</td>
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<tr>
<td>Treated fairly</td>
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<tr>
<td>Choose where to work</td>
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<td>Interact with other members of the community</td>
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<td>Perform different social roles</td>
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<td>Decide when to share personal information</td>
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<td>Have the best possible health</td>
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<td>Free from abuse and neglect</td>
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<tr>
<td>Experience continuity and security</td>
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<tr>
<td>Are safe</td>
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</table>
A world of dignity, opportunity and community for all people

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Putting People First

NYS Perspective: Outcome Measures and Managed Care for People with Intellectual/Developmental Disabilities

September 27, 2013
Why CQL – System Transformation

As OPWDD pursues development of the People First Waiver (1915 b/c), we are working with CMS to define priority elements of system transformation:

- Expanding opportunities and supports for **EMPLOYMENT**
- Expanding **COMMUNITY SERVICE OPTIONS** – supportive housing, community-based services
- Expanding **SELF DIRECTION** options
- **OLMSTEAD PLAN** - Creating opportunities for people to move from institutions to integrated settings
CMS—10 key principles inherent in a strong Managed Long Term Services and Supports Program Including:

- # 6. “**Person-centered Processes**: Ensuring beneficiaries’ medical and non-medical needs are met and they have the quality of life and level of independence they desire within the MLTSS program start with person-centered processes”

“holistic service plans based on comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to self-direct their community based services, fostering independence, with assurances of appropriate supports….”
National Council on Disability (NCD) Managed Care Principles:

**Principle 1:** Community Living: The central organizing goal of system reform must be to assist individuals with disabilities to live full, healthy, participatory lives in the community.

- Focus: Living healthy, productive lives in the community – most integrated settings
- Integrating medical and non-medical social supports to enable self-direction, independence, and personal responsibility

**Principle 2.** Managed Care systems must be designed to support and implement person-centered practices, consumer choice and consumer direction

**Principle 18:** Comprehensive QM system must not only ensure health and safety but also measure the effectiveness at achieving individual and system outcomes

Measuring Progress and Outcomes

Managed care is more than a financing mechanism. Defining quality outcomes for people with I/DD, seeking opportunities for integrating care, and supporting more people and their families in the community = Progress

But…While Performance Outcome Measures are available for acute health care, they are not well established for LTC supports for People with I/DD

Source: Managing Life Long Services and Supports, NASDDDs presentation Charles Moseley Ed.D. Barbara Brent
Elements of the DD Transformation--Quality Framework Design by “Level”

Goal: Help individuals lead richer lives

Data Collection and Analysis for System Improvement and Ensuring Individual Outcomes

OPWDD Quality Oversight and Monitoring Mechanisms and Measures

<table>
<thead>
<tr>
<th>Individual Level</th>
<th>Organization Level</th>
<th>System Level</th>
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<tbody>
<tr>
<td></td>
<td>DISCO</td>
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<tr>
<td>CAS/UAS Assessment</td>
<td>DISCO Contract/RFA</td>
<td>Waiver Assurances</td>
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<td>EISP</td>
<td>Care Coordination</td>
<td>National Core Indicators (NCI)</td>
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<td>CQL Personal Outcome Measures</td>
<td>Review Tools and Processes</td>
<td>Transformation Agreement</td>
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<td>DISCO/CQL Sample</td>
<td>Quality Strategy</td>
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<td>Satisfaction Surveys</td>
<td>Evaluation Plan</td>
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<td>NCI Sample-- DISCO level</td>
<td>Accountability Plan</td>
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<td>External Quality Review (EQRO)</td>
<td>Commissioner Dashboards</td>
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<td>QARR Measures</td>
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<td>Provider</td>
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<td>MHL/Site Visits &amp; QA Surveys</td>
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<td>Incident Management</td>
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<td>Mortality Review</td>
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<td>Provider’s QI Plan</td>
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<td>Provider Satisfaction Surveys</td>
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<td>HCBS Setting Standards</td>
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<td>Regulatory Reform</td>
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Understanding Personal Outcome Measures®

- Measures the *presence* of the outcome (yes or no)
- Each person is a unique sample of one … There is no norm or standard definition for an outcome
- Aggregates data on items that are personally defined (versus standardized measures)
- Links outcomes to the services and supports that facilitate – or are needed to facilitate – the outcome
- Provides information for the design and provision of person-centered services
Operationalizing Personal Outcome Measures (POMs) in DISCO Pilots – Key Components

- Care Coordination Framework
- Practice Guidelines
- QI Plan—Use of CQL Data in DISCOs for Quality Improvement
- Communication and Learning throughout the OPWDD system
Operationalizing POMs and DISCO Reviews

**DISCOs will Need to:**
- Have access to reliable/certified CQL interviewers or trainers to conduct POM interviews on a sample of members
- Report POM results to OPWDD annually
- Use POM process for continuous quality improvement and connect back to individual plans for those in the sample

**OPWDD Will Need to:**
- Validate that DISCOs are using POM measures and approach in continuous quality improvement
- Develop Care Coordination Review Tool to review effectiveness of Care Coordination in working with people on their individual outcomes (and other components of comprehensive care coordination)
- Continue MHL site visits
- Monitor DISCO contract compliance
- Continue DD provider level oversight activities
In Addition to CQL, Other Measures Still Needed for Managed Care

- Measures for 1915 c HCBS Waiver assurances
- Access and Availability measures

National Core Indicators (NCI) and other DD system measures such as competitive employment

CQL POMs; Clinical/functional; health related;
DISCO QI Plan

Person Centered Planning Approach
- POMs
- OPWDD outcome areas
- Self-direction opt. for all who want them
- How care coordination effectiveness will be assessed by the DISCO

Qualifications and Capacity
- Credentialing
- How DISCO ensures network providers are qualified and meeting quality expectations
- Workforce competencies, training, etc.

Quality Improvement Processes
- Methods for review of individual needs/goals and outcomes
- Roles and Responsibilities for QI
- Goals/Objectives and Measures
Organizational Factors that Enhance Personal Outcomes

Source: *Quality of Life for People with Intellectual and Developmental Disabilities, Applications Across Organizations, Communities and Systems.* By Robert Schalock, James F. Gardner, and Valerie J. Bradley; 2007; p. 50
Questions???
Questions

We are now taking questions
Webinar Materials and Resources

• Power Point and Archived Recording

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